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NHTC Capacity Assessment Report

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Strengthening Health Systems-Improving Services

Report

24 September 2012

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TABLE OF CONTENTS

ACRONYMS 4

EXECUTIVE SUMMARY 5

1 INTRODUCTION 11

2 METHODOLOGY 13

3 FINDINGS 15

3.1 In-Service Training System 15

3.2 Environmental Influences 17

3.3 Mandate and Functions of NHTC 19

3.4 Capacity: Organisation Structures 20

3.5 Capacity: Staffing 21

3.6 Capacity: Skills 24

3.7 Capacity: Processes 25

3.8 Capacity: Facilities and Resources 27

3.9 International Training 28

4 OPTIONS 30

4.1 Future Role 30

4.2 Organisation Structure 33

4.3 International Training 33

4.4 Autonomy 34

4.5 Options for Developing Capacity 35

5 Conclusions, Recommendations and next steps 37

5.1 Recommendations 37

5.2 Next Steps 38

Annex 1: Terms of Reference 39

Annex 2: List of People Interviewed 48

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
DoDA	Department of Drug Administration
DOA	Department of Ayurveda
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)
NHTC	National Health Training Centre
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	Technical Working Group
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development

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.

IN-SERVICE HEALTH TRAINING SYSTEM

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 staff, however, have undergone a training of trainers programme. Only two staff 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 MoHS/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 organisation 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. The Regional Training Centres (RTCs) could continue with their upgrading training programmes but the delivery of this training would no longer be the responsibility of NHTC. The regional directorates or the relevant MoHP/DoHS divisions could take responsibility for training in the RTCs. A training management body would enable the necessary expertise to be pooled in a single entity serving the needs of the technical divisions/centres 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 the 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.

International training and autonomy

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 organisation 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 organisation 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. 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 follow:-

- 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 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. 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 and its departments. 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.

1 INTRODUCTION

The Ministry of Health and Population (MoHP) launched a second phase of the National Health Sector Programme (NHSSP-2) in mid-2010 which runs to mid-2015.[1] Its goal is to improve the health status of the people of Nepal by improving the utilisation of essential health services and other services, especially by women and disadvantaged groups. Having sufficient numbers of skilled providers in service delivery outlets will be critical to the achievement of the service delivery targets in NHSP-2, as will be the development of competent managers at different levels of the health system. The NHTC will have a key role to play in in-service training (though not pre-service training) alongside other training providers. The NHSP-2 envisages that NHTC would be established as an autonomous national health training centre to: "design, develop, implement, monitor and evaluate national training programmes and conduct international training for participants from South and Southeast Asia meeting high standards with a minimum of bureaucratic hurdles." Significantly, the Plan also anticipates that the planning and delivery of training would be devolved to the district level together with the transfer of financial resources for training.

Earlier in 2004, the National Health Training Strategy had recognised the NHTC as an "apex body," a mandate which was inherited from the now expired Tenth Plan of 2002-07.[2] In this capacity, the Strategy envisaged NHTC would oversee and coordinate all the Ministry's training (both pre-service and in-service) and provide all in-service training for the divisions and centres of the Department of Health Services (DoHS), as well as the Departments of Drug Administration and Ayurveda in the MoHP. At Annex 7 of the Strategy, the responsibilities of the NHTC and its regional centres, which were established in 1993/94, are set out in some detail. The key responsibilities identified there are to:

- Formulate policy, strategies and guidelines for national health training;
- Approve training standards and packages by other organisations;
- Ensure the maintenance and quality training conducted by various organisations at all levels;
- Monitor, supervise, follow-up and evaluate training at all levels;
- Establish and operationalise a training management information system (TMIS)
- Carry out training needs analysis
- Conduct training
- Coordinate with all stakeholders[3]

Since 2004, these responsibilities have been enlarged and elaborated upon. For instance, the 2008/09 annual report has added to these responsibilities the design of training materials, the training of trainers and the orientation of newly recruited health workers.[4] Most recently, our Terms of Reference have added the organisation of international training,

[1] National Health Sector Plan II, 2010-15, Ministry of Health and Population, 2010
[2] National Health Training Strategy, National Health Training Centre, September 2004
[3] It is not explicitly stated that the training referred to under these responsibilities is in-service training, though we assume this to be the case.
[4] Annual Report, Department of Health Services, 2008/09

which is presumably taken from the NHSP-2. In spite of the expansion of NHTC's mandate, there is currently no reference to GESI concerns in its objectives, which has resulted in technical training which fails to recognise the social determinants and dimensions of health.

Taken together, these responsibilities represent a very wide mandate indeed which the NHTC has not yet fulfilled effectively. This is the rationale for the current study which has been divided into two separate phases. The first phase is the assessment of NHTC's capacity and the second phase is the development of a revised national health training strategy. The specific objectives are as follows, namely to:

Phase 1

- Assess the capacity of NHTC to oversee, coordinate and provide in-service training for MoHP as stipulated in the National Health Training Strategy (2004);
- Assess the capacity of NHTC to meet the objectives stipulated by NHSP-2 with regard to national and international training and to achieve the milestones and targets set out in the NHSP-2 Results Framework;
- Identify opportunities and options for improving the capacity of NHTC;
- Identify specific improvement areas for the delivery of its current mandate and for an expanded role, including areas such as infrastructure, staffing, practicum/training sites, institutional approaches, information systems, HR systems and practices, financing and the use of ICT, etc.;

Phase 2

- Use the findings of the institutional capacity assessment to support NHTC facilitate stakeholder inputs to the revision of the National Health Training Strategy (2004) and the development of a revised strategy.

This report presents the findings of Phase 1 of this assignment, together with a discussion of options for change and key recommendations. In the relevant findings it includes analyses of capacity from a gender equality and social inclusion (GESI) lens. In addition, however, we make suggestions regarding the precise scope of Phase 2. The Phase 1 assignment was conducted over a two week period from 9-25 July 2012. Phase 2 will be initiated when the Ministry's management has made a decision on the key recommendations presented in this report.

2 METHODOLOGY

The two consultants were required to agree the scope and methodology for the assessment with the Training Working Group (TWG) before commencing work. A useful discussion was first held with the core members of the TWG and, following this, the consultants made a presentation on the proposed methodology to the full TWG. After discussion, the approach and methodology were broadly accepted by the TWG, subject to a few final amendments.

The number of steps was subsequently adjusted because it was not possible to convene any meetings of the Steering Committee, either to brief the members on the assignment or to present preliminary findings. Instead, the consultants met with the Secretary and the Director-General of the DoHS to solicit their views on the role and priorities for NHTC and the Secretary was invited to chair the final stakeholder discussion. The four main steps in the assignment were as follow:-

- *Step 1:* Agreement on process and methodology
- *Step 2:* Carrying out assessment
- *Step 3:* Presentation of preliminary findings and options to national stakeholder forum
- *Step 4:* Preparation of report

The following methods were employed to carry out the assignment:

- Documentation review
- Individual interviews
- Focus/discussion groups
- Field visit
- Review of NHTC evaluations and reports
- Questionnaire to obtain profiles of NHTC/RHTC training professionals

The assessment was heavily reliant on individual semi-structured interviews and the field visit to Biratnagar and Dhankuta RHTC. Checklists were prepared prior to interviews and adjusted as necessary as new information emerged. Unfortunately, only a minority of training professionals returned the questionnaire, although we believe the results from the sample are broadly representative.

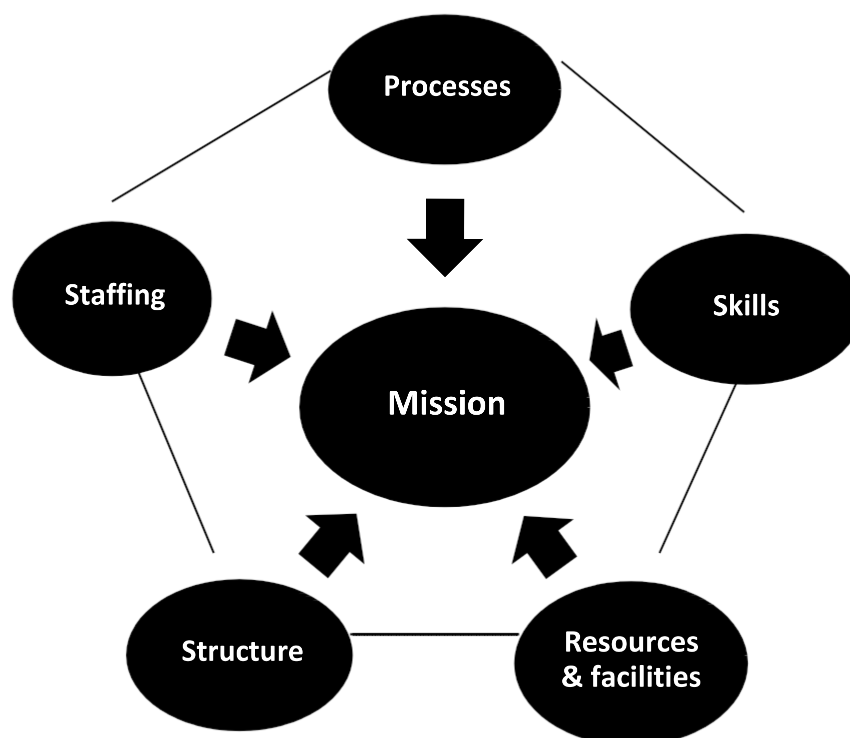
A similar methodology was adopted for the GESI analyses, which focused on consultations, semi-structured interviews and documentation review. In addition, formats to construct the personnel profile of training professionals were prepared to identify their skills and competencies on GESI and to understand the level of diversity in the NHTC headquarters and all regional offices. Training professionals were requested to complete these profiles.

In addition to the methodology, the consultants employed a conceptual framework to guide the search for data and to organise the findings. We identified five critical capacity factors as having a potential impact on the effectiveness of NHTC, which are shown in Figure 1 below.

For a public sector body, such as NHTC, effectiveness means it is achieving its mission or mandate. For this reason, "mission" is placed at the heart of our model. In addition, as a governmental organisation, NHTC operates within a wider environment and is therefore subject to variety of influences which have both positive and negative impacts.

These influences include both the "rules" of the wider civil service system in which the NHTC sits and the different stakeholders that make up the national in-service training system of which it forms a part.

Figure 1: Capacity Framework



The purpose of the GESI analysis in this report is to assess whether issues of gender and social inclusion are mainstreamed in the objectives, staffing, skills, and systems and processes of the NHTC. The twin concepts of gender equality and social inclusion describe the experience of groups that are systematically and historically disadvantaged by virtue of discrimination on the basis of their income, caste, gender, ethnicity, disability or religion or a combination of these. Gender relations are a cross-cutting dimension of discrimination which prevails, with varying degrees, across all social groups in Nepal. Based on Government mandates derived from the Interim Constitution (article 13.3), the Three Year Plan of the GoN and its own experience of Nepal, MoHP has defined the "economically excluded" as the poor of all caste, ethnicity, religion, location and gender and the "socially excluded groups" as women, Dalits, Adibasi, Janajatis, Madhesis, Muslims, people with disabilities, sexual, lingual and religious minorities and people experiencing regional/geographical remoteness. Each of these groups has a specific cause of social exclusion.

3 FINDINGS

The findings presented in this section are based on the evidence obtained from:

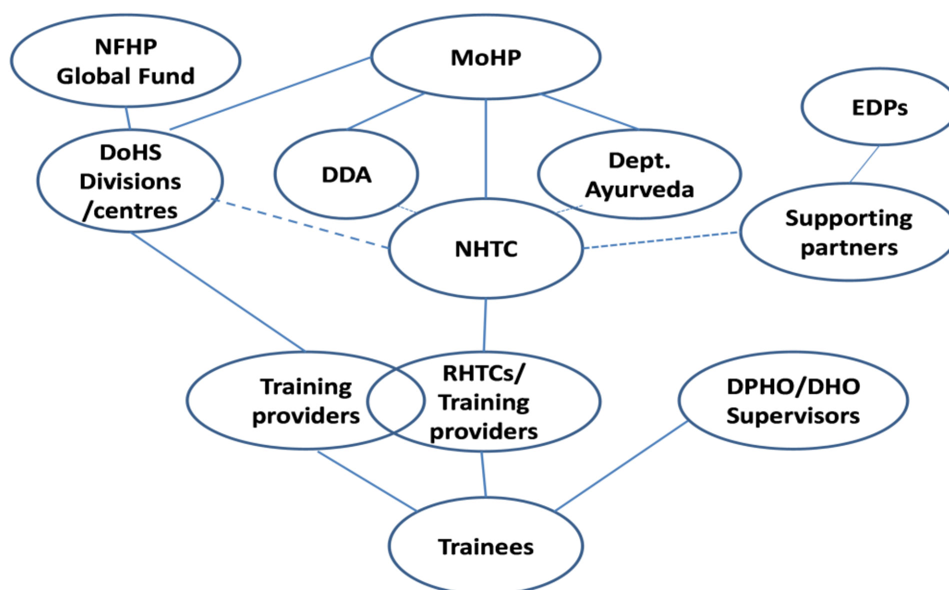
- Key documents we were given;
- 28 interviews with key stakeholders;
- Three discussion groups with DPHOs/DHOs, EDPs, SBA trainers;
- Field visit to Biratnagar and Dhankuta RHTC;
- Six questionnaires which assembled data on the qualifications, skills, experience and motivation of training professionals in NHTC/RHTCs

The full list of persons met is provided at Annex 2.

3.1 In-Service Training System

In order to place NHTC in context, we have developed a map of the current in-service health training system which captures all the key stakeholders and the relationships between them. The system is shown in Figure 2 below. It should be emphasized that the lines in the diagram do not necessarily represent reporting or accountability relationships, although in some cases they do.

Figure 2: Current Health In-Service Training System



NHTC is located at the heart of this system and the Director answers to the DG, DoHS for programme finalisation. It either carries out training directly through the RHTCs or by "contracting" training providers to conduct training on its behalf where it lacks skills in- house. Over 75% of NHTC's programmes are delivered by contractors. (Contracting tends to be done informally by asking qualified individuals who work in the government/private health system.) NHTC's main clients (or potential clients) are the DoHS divisions, although it is also expected to service the DDA and the Department of Ayurveda. Supporting partners[5] (such as JHPIEGO, JSI, NSI, PSI) coordinate with NHTC to deliver specialised training for which they have been funded by external development partners (EDPs.) DoHS divisions and centres also conduct training directly which is not coordinated through the NHTC, either using their own staff or by contracting trainers. Some of these training providers may be the same people as those engaged by the NHTC. Some of this direct training carried out by divisions is commissioned and funded by international projects, such as NFHP and the Global Fund, but not by EDPs themselves. Trainees are selected by the district health offices and the Regional Health Directorates.

In some respects this system works well. In particular, there is a strong relationship between supporting partners and the NHTC, and unlike other countries, donors do not commission training directly without coordinating or consulting with government authorities.[6] However, there is a weak relationship between the NHTC and the divisions of the DoHS, except the FHD. Most divisions, with the notable exception of the Family Health Division (FHD), do not coordinate their training through NHTC. They have their own training budgets which they manage directly, resulting in health professionals spending a significant amount of time on the administration of training. It also leads to parallel training activities carried out by the divisions and the NHTC (through the RHTCs), which often compete for the same participants. The training provided by the divisions is usually provided in order to introduce new tools, techniques and protocols for health workers and it doesn't necessarily duplicate the training offered by the NHTC. Because all of this parallel training is imposed on the districts by the centre, it frequently results in service providers being taken away from their jobs for several weeks or even months at different occasions during the year. The large volume of uncoordinated training is reinforced by the financing practices of some international projects, in particular the Global Fund which works exclusively with the HIV/ AIDS division. A final weakness in the system is that the district health offices and line managers play a very limited role in the training of their staff; they do not identify training needs linked to performance gaps, nor do they follow up training to ensure it is meaningfully transferred to the workplace.

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[5] Supporting partners is the term used for organisations (firms and foundations) which provide specialised training services to NHTC. This may involve curriculum design, monitoring and follow up, but not usually delivery. Most of these organisations have contracts with EDPs, such as USAID, to provide specific services to the Government of Nepal. But others are independently funded.

[6] The one exception is UNFPA which is not permitted by its headquarters to fund training through NHTC because of concerns arising from an earlier financial audit.

3.2 Environmental Influences

We have identified six key external influences on NHTC's effectiveness – five threats and one key opportunity - which are discussed below. In our view, it should be possible for the GoN to address three of the five threats; the remaining two will need to be carefully managed to minimise their impact. The restricted cadre system appears to be a binding constraint which, if not tackled, will condemn NHTC to permanent ineffectiveness whatever its future role may be. We therefore examine this particular problem first. The other threats are discussed in order of their perceived impact.

Restricted cadre system

When NHTC was established, we learned that the Director position was open to professionals from all the health service groups. But in recent years all professional positions were reserved exclusively for the cadre of the health inspection group. This is very evident from the staffing pattern. The majority of technical staff is health education officers or heath assistants; there are only three persons with clinical skills (of which two are medical officers on deputation.) And by virtue of their skill sets, the majority of current staff at NHTC occupies relatively junior grades. Many though have been trained as trainers. Because NHTC's staffs lack clinical skills, the divisions/centres of DoHS (who are NHTC's main clients or potential clients) have concluded that NHTC lacks the capacity to conduct training appropriate to their needs. This concern was mentioned by virtually every divisional director we met. It is clear that NHTC therefore lacks the credibility to function as an apex body for in-service training through no fault of its own. What is less clear is why the qualification requirements for NHTC's posts were so narrowly circumscribed in the first place.

Frequent staff transfers

This constraint is related to the entrenched cadre system which pervades the government health system, indeed the whole of the civil service. All health professionals belong to a particular cadre and they build their respective careers within that cadre. They are transferred and posted to different locations and parts of the public health system in accordance with the interests of that cadre rather than the needs of the divisions, centres or units where they are working. Postings are typically made for a three year period (or two tears for terai districts) by either the relevant Regional Health Directorate or the DoHS depending on the grade of the individual. Someone who is deployed to NHTC as a training professional in the RHTCs is likely to receive a short training of trainer course and he will then hone his skills as a trainer for a short period, but this expertise will be lost to the organisation when he is transferred. His replacement will have to start the learning process all over again. Frequent transfers undermine the development of competencies essential for a professional training organisation.

Training as a personal incentive

In theory, training should be designed to address the knowledge, skill, attitude and experience gaps which are holding back individual and organisational performance. In practice, however, training is often seen by trainers and participants alike as an opportunity to visit Kathmandu and/or earn additional income from training budgets and allowances. Individual participants, for example, may compete for scarce places and use their relationships with a powerful sponsor to secure a training nomination. Equally, decision-makers may dispense training opportunities as a form of patronage to individuals in return for loyalty, not necessarily because they need the skills. It was learned that divisional staffs too benefit from the allowances and remuneration legitimately paid for managing, coordinating or delivering training if the division retains control over its in-service training budget. And, importantly, training resources may be diverted to the large networks of staff at clinical training sites in hospitals, even if they are not personally involved in the delivery of training. Training budgets therefore are seen as offering personal incentives which need to be widely shared, rather than scarce resources which should produce value for money.

Of course, even if training offers financial incentives to individuals, it does not follow that good training cannot be provided. But it does compromise its impact at the workplace. If training is sought for questionable motives, both learning and its application on the job is likely to be impaired.

Vertical donor funded training

There is a pooled fund for training which has been created under the NHSP-2 into which both donor (including GAVI) and government resources are channelled. These resources can be allocated in accordance with the Ministry's training priorities, rather than being distorted by particular donor interests. In contrast, the Global Fund provides parallel resources earmarked for training in HIV/AIDS, malaria and tuberculosis which are channelled directly through the Centre for AIDS and STDs. This training is therefore managed and delivered directly by this centre and it is not coordinated with the NHTC. We also understand that the global fund pays higher allowances to participants than NHTC is able to pay under civil service rules, giving it an advantage in "competing" for participants. In this way, the Global Fund undermines a coordinated in-service training system.

Late budget releases

Although as a "centre" NHTC enjoys some autonomy as a self-accounting entity, it remains dependent on government's financial disbursement system. Resources are not always made available in accordance with the approved budget. Funds are released on a trimester basis and they often arrive late in the trimester. Even though the NHTC develops an annual training plan and calendar at the start of the year, it is obliged to re-plan each quarter again after it has received the respective quarterly release. If funds arrive late, training events must be organised at short notice so that the resources can be spent before the end of the quarter. This explains in large measure why NHTC's clients complain that they receive insufficient notice to nominate and release their staffs for training.

It is difficult to see how NHTC can address this constraint whilst it remains a government entity, since it depends upon clients in the bureaucracy and financial management practices which are slow and cumbersome. Autonomy would offer a solution if this can be justified on other grounds.

New training technologies

Recent developments in training technology worldwide represent an opportunity for NHTC to capitalise upon. NHTC typically offers classroom based training where participants are taken away from their jobs, sometimes for long periods of time. The establishment of Regional Health Training Centres was intended to bring this form of training closer to the districts and health units where staffs work. However, the advent of e-learning in which participants learn using computer, networked and web-based technology now means that much training does not need to be delivered "face to face." People can learn at their workplaces or at home, and access help from their networked learning community or an online tutor. For clinical training for example, the theory components may be delivered through e-learning, even though the practical elements must be conducted on site in "face to face" sessions where there are patients. In this way, e-learning can therefore supplement classroom-based training. Clearly, the availability of computers and internet access in remote areas will restrict the spread of this technology in the short-term, but it is likely to be a more cost-effective method for meeting some training objectives at least in the long-term in a health system, such as Nepal's, where the staffs are widely dispersed geographically.

3.3 Mandate and Functions of NHTC

Now we turn to the internal capacity of NHTC. But since capacity exists for a purpose, it is first necessary to ask what NHTC's mission is? This is not an easy question to answer. In the Introduction, we described how the responsibilities of NHTC have evolved over time. The role has been enlarged: responsibilities have been added (though without any explicit requirement to consider GESI issues), but none have been removed. As far as we are aware, there is no formal mission statement for NHTC. Certainly nothing can be found in the National Health Training Strategy.[7] Indeed, it is difficult to see how a short and compelling mission could possibly serve the diverse range of responsibilities which have been entrusted to NHTC.

In the presentation to the stakeholder meeting, a comprehensive set of training and development functions were identified as follow:-

- Policy development
- Training needs analysis
- Planning and budgeting
- Curriculum design

[7] The DoHS Annual Report of 2008/09 contains a mission statement to the effect that NHTC "…serves as a resource centre to facilitate and support partners in preparing and implementing training programmes and train service providers for successful implementation of health services."

- Contracting out training
- Delivering training
- Evaluation
- Follow-up and research
- Quality assurance

By comparing these nine functions with the responsibilities assigned at various times in different documents, it appears that NHTC has been explicitly entrusted with eight of them. The exception is the contracting out of training. This is an unreasonably long list of functions for a single training organisation to handle, especially one which cannot control the expertise of the staff deployed there. Unsurprisingly, NHTC is not presently carrying out all of these functions. However, it 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. Certainly, the NHTC has proven credentials in managing effective partnerships with external bodies and individuals.

Specifically, NHTC carries out planning and budgeting (for its own courses), curriculum design (with supporting partners) and some training delivery through the technical staffs at its RHTCs. It also contracts out a substantial amount of training delivery to qualified trainers employed within the government and non-government health systems (even though contracting is not explicitly listed as a responsibility!) It performs a limited amount of training needs analysis (only for individual programmes with supporting partners) and some brief evaluation (of trainee reaction and learning at the end of the training, but not behaviour change or impact.) Presently NHTC performs no policy development work or quality assurance. That said, it would be inappropriate for them to quality assure their own training, which is a function which should be carried by the professional councils. We found, however, that the professional councils neither accredit nor monitor NHTC courses.

In our assessment of internal capacity, we examine those functions that NHTC is currently performing, either fully or partially, as well as missing training and development functions. The findings are presented in accordance with the five capacity factors illustrated in Figure 1 above.

3.4 Capacity: Organisation Structures

“Structure” refers to the allocation of tasks, the coordination of work and the reporting relationships between work units. First, the allocation of work is examined. The only organisation chart we could find was in the Annual Report of the DoHS of 2007/08. This shows a heavy structure with six specialised training units designed to meet the training needs of the DoHS.[8] This is evidently a structure designed for a large training centre with specialised trainers, which bears little relation to the actual work of the NHTC presently and how it is allocated. And because the structure reflects specialism rather than the different

[8] The training units are: technical and specialised (e.g. ultra-sound, behaviour change); reproductive health and family planning; child and adolescent health, management information system; training programme conducting and strengthening; bio-medical equipment; medical nursing and volunteer training; and basic orientation and logistics management.

training and development tasks, it unsuited to the delivery of the nine functions set out above. Moreover, it is a structure on paper only. NHTC contracts out most of the training it finances, although it retains responsibility for logistics, administration and coordination of its delivery. Technical staffs at headquarters are allocated the responsibility for coordinating specific training programmes and technical staffs are given responsibility for administration at the point of delivery, as well as conducting a few courses where they have expertise. Beyond this, there is little structure in the way that NHTC operates.

Where does NHTC sit in the Ministry? The official organisation charts show that the NHTC reports to both the Ministry and the DoHS, which contradicts the unity of command principle. The Secretary has subsequently clarified that the NHTC reports to the DoHS, and is therefore answerable to the Director-General of Health Services. In our view, this seems a sensible structural arrangement. First, it provides an opportunity for the NHTC to be directly involved in the annual planning process of the Department and to respond to the training needs of its technical divisions and centres. Secondly, it should help the technical divisions to see the NHTC as a partner on a day to day basis. Unfortunately, in practice, with the exception of the Family Health Division, the divisions and centres of the DoHS do not accept NHTC’s responsibilities and they express major reservations about its capacity. This explains why they do not presently coordinate their in-service training (for which they have their own budgets) through NHTC. And NHTC no longer makes an effort to coordinate its programmes with the divisions; it has long since given up. Instead, it simply develops its own annual training plan, which includes the programmes it conducts every year and new programmes which are developed with the help of its supporting partners, such as JHPIEGO, NSI and PSI.

To run training programmes, the NHTC must communicate with its regional centres and with the RHDs and DHO/DPHOs to organise the venues, commission trainers and to select participants. Discussions during our field visit revealed that information does not always flow smoothly, resulting in frantic last minute preparations. This occurs in large measure because most official communication originating from the NHTC, for instance to solicit nominations of participants from DHO/DPHOs, is paper-based. This form of communication is slow and inefficient, especially in an information age where electronic media are available.

3.5 Capacity: Staffing

Table 1 analyses the current staffing situation at the NHTC and the RHTCs. There is one vacant post at the NHTC and 16 vacancies in the five RHTCs.

Table 1: Current Staffing at NHTC and RHTCs

Category	NHTC		RHTCs		Total	
	No.	%	No.	%	No.	%
Medical officer	3	10%	0	0%	3	3%
Technical officers (grade 6 & above)	5	17%	16	23%	21	21%
Technical staff (grade 5 & below)	2	7%	13	19%	25	25%
Administrative support staff	7	23%	16	23%	23	23%
Peons & others	13	43%	25	36%	38	38%
Total	30	100%	70	101%	100	100%

There are 100 staffs engaged in the NHTC and the RHTCs, 70% of which are deployed in the RHTCs. The staffing structure is a pyramid with a very limited number of technical officer staffs at the top of the pyramid capable of conducting training and a large number of semi-skilled and unskilled staffs at the bottom. There are only three Medical Officers in Kathmandu (two allopathic and one integrated medicine.) At the other extreme, over 60% of staffs are engaged in supporting roles, in the main office helpers (peons or equivalent.) Less than half of the staffs in the RHTCs (42%) have technical training, which is a small proportion for a dedicated training centre. Of these 29 staffs, 13 staffs are below grade 5 level, leaving only 16 experienced technical officers to conduct training at the regional level, an average of three persons in each centre. Even so, these technical officers lack the skills, knowledge and experience to conduct professional training. They specialise in conducting upgrading courses for paramedics, which are too few to keep them fully occupied. All professional level training financed by NHTC is contracted out.

The overall ratio of female to male employees is 1:5 in NHTC as shown in Figure 3. It is worse at the officer level, where the ratio is 1:6.5. None of the Regional Training Centres are currently headed by a woman. The staff diversity profile at Figure 4 shows a dominance of Hill Brahmin Chhetri (HBC) at all levels. After HBC, the next major group is the Madhesi Brahmin Chhetri, and Terai Janajati. Other backward classes are represented but the numbers are small. Amongst women, some originate from Hill Brahmin Chhetri (HBC), but the representation of women from other social groups is minimal at all levels.

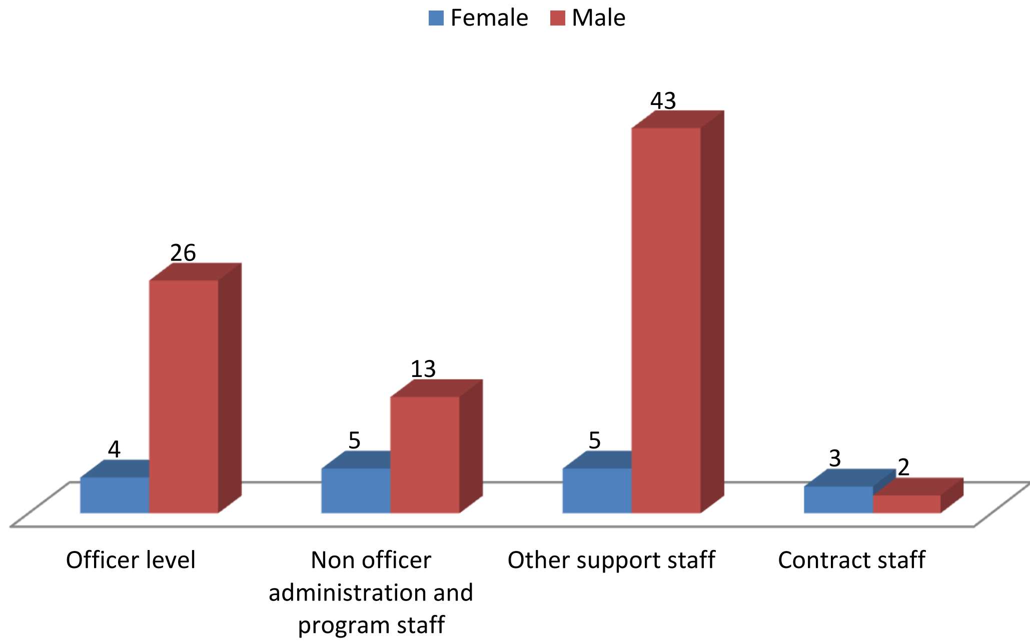
Figure 3: Proportion of Female & Male Staff in NHTC
Female
Male
4
26
5
13
5
43
3
2
Officer level
Non officer administration and program staff
Other support staff
Contract staff

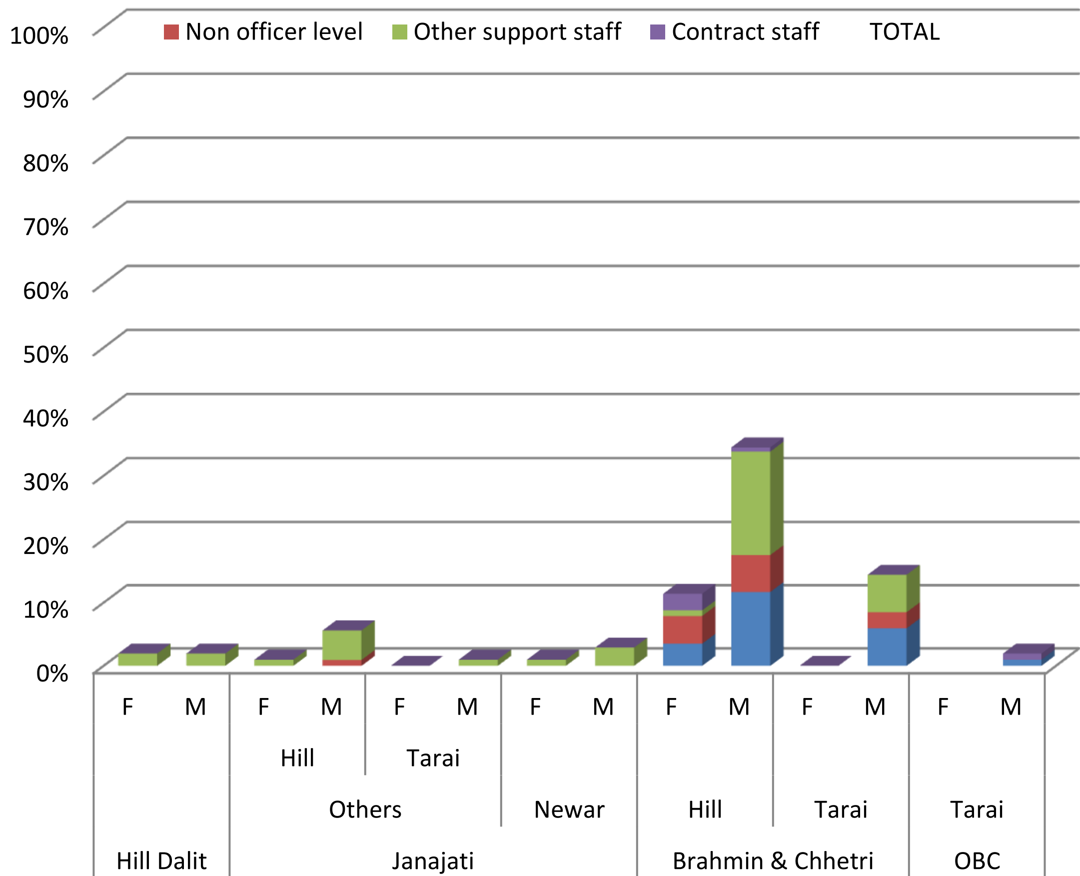
Figure 4: NHTC Staff Diversity Profile
Non officer level
Other support staff
Contract staff
TOTAL
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
F
M
Hill
Tarai
Others
Newar
Hill
Tarai
Tarai
Hill Dalit
Janajati
Brahmin & Chhetri
OBC

3.6 Capacity: Skills

A questionnaire was administered to collect information on the qualifications and skills of training professionals in NHTC and RHTC. The response rate was extremely poor; the consultants only received six completed questionnaires, two from headquarters staffs and four from RHTC Dhankuta. Assuming that this regional centre is representative, all the training professionals have worked as either health education officers or health assistants before joining the RHTC. They are qualified to either certificate or diploma-level. Three of the four said they did not possess any relevant skills for their jobs. Yet they were all expected to organise and conduct training.

In addition, we assessed the depth of skills present in NHTC generally to carry out each of the stages in the training cycle. The assessment represents the consultants' judgement based on the evidence from relevant documentation (e.g. evaluations, curricula) and discussions with NHTC's senior management. The findings are summarised in Table 2 below.

The table shows that NHTC currently lacks any meaningful skills in two of the eight skill areas assessed. In five other areas staffs have acquired skills on the job and by working with competent partners, but these skills need to be strengthened. Only one skill area (evaluation) was assessed as satisfactory. Of the eight skills areas, curriculum design and training delivery are essential skills for a training institute. Both of these require considerable improvement.

Table 2: Skills Assessment of NHTC/RHTC

Skill	Assessment	Comment
Training needs analysis	No skills	Not done by NHTC. The last TNA for the Ministry was carried out several years ago.
Planning training	Needs improvement	NHTC only prepares annual schedules for its own training, not plans for the Ministry as a whole.
Curriculum design	Needs improvement	Some staffs have gained some skills by attending training and working with supporting partners
Training administration	Needs improvement	Most staffs have acquired some skills through experience on the job; but there remain weaknesses in selecting trainees and obtaining nominations in time
Training delivery	Needs improvement	Although staffs are inexperienced, many staffs have undergone a training of trainers programme
Monitoring	Some skills	This is carried out on an ad hoc basis by NHTC staffs.
Evaluation	Satisfactory	Reactions level evaluations are carried out; plus some assessments of learning for programmes assisted by supporting partners. Evaluations are filed away and not used to initiate corrective measures.
Training Follow-up	No skills	This is done sporadically by NHTC staffs, but there is a plan to start systematically this year.

Interviews with officers revealed that the majority at the headquarters had not received any GESI related training; hence their skills and competencies for mainstreaming GESI were inadequate. The exceptions were one officer level male employee and one non-officer level female employee who recently participated in a GESI orientation training conducted by NASC. Yet, staff recognised that an understanding of GESI and its application was essential for both trainers and frontline health workers in order to address issues experienced by women, the poor and the excluded.

Of the eight responses received from the questionnaire, only five stated that they have clarity regarding gender equality and social inclusion concepts and three (all hill Brahmin Chhetri men) claimed to have the capacity to integrate gender/gender based violence into a curriculum and to conduct such training.

3.7 Capacity: Processes

The Ministry needs effective training processes to deliver effective training for its staff. These processes will cut across its management structures and those of the NHTC. The key issues identified are as follows:-

- *Training needs analysis:* There is no established process in place in the Ministry for analysing the training needs of the whole public sector health system (although there are tools used by supporting partners to identify skill gaps for specific training programmes.) We would expect a process which starts first with the analysis of performance gaps within the health service delivery system and then proceeds to examine what is causing these performance problems, isolating skill factors from other reasons;

- *Planning of training:* The training needs analysis should establish training priorities to inform the development of a single training plan for the whole Ministry (or a series of central, regional and district training plans designed to address performance gaps.) However, the planning process is fragmented; the NHTC and the divisions develop their own annual training plans independently based on their own perceptions of need. The divisions have their own training budgets and training staffs. These separate plans are not brought together or coordinated with each other when the annual budget is prepared. The second problem is that planning is largely a "top down" process in which most training carried out at district level is decided by either NHTC or the divisions of the DoHS. District health offices may propose specific training to meet their local needs but this must be approved centrally and included in the budget "red book." In practice, DPHOs/DHOs are only involved in training when NHTC asks them for training nominations, and they feel obliged to respond positively. They have little if any control over how much time their front-line service providers spend away from their workplaces;

- *Curriculum design:* In principle, curriculum design should be a process which involves both the selection of relevant content and the choice of appropriate methods to deliver it in an effective way. However, with the exception of the learning packages which have been developed with the assistance of supporting partners, NHTC's curriculum tends to focus on the content rather than the methods and other requirements. It tends to be assumed that training will be delivered off the job (in a classroom or at a training site.) On-job training methods, such as coaching by a skilled supervisor, which keep staffs at their place of work, are not considered. In addition,

we found an example of where the curriculum was clearly not matched with the job to be performed. The six-month AHW upgrading training, which is intended to enhance management capacity, contained only 10 days of supervisory/management training even though this was the only difference between the AHW and the senior AHW job. The long duration of this training is therefore hard to justify.

- *Quality assurance:* There is no established process in the Ministry for the quality assurance of training delivered by either the NHTC or the divisions/centres, including the formal accreditation of training programmes, trainers and trainees, curriculum review, resource materials, training sites and facilities, and the monitoring of the trainer's performance at the point of delivery. Professional Councils only perform a quality assurance role for pre-service health training carried out by private providers. The exceptions are the programmes which are designed and delivered with the assistance of supporting partners (e.g. the Skilled Birth Attendants (SBA) programme).

- *Evaluation:* Whilst NHTC evaluates training at the levels of participant reactions and learning (using pre-tests and post-tests), it rarely follows up trainees after they return to their jobs to assess whether they are adopting new practices, or whether their performance has improved. The ultimate test of whether training is effective is whether the Key Performance Indicators in the NHSP-2 are moving in the right direction, and beyond the historical trend.

GESI in key processes

The key issues identified are as follow:

- *Curriculum design.* A wide range of health sector personnel are consulted in the process of curriculum development at the central level. But the system of curriculum design is at present not informed by consultation with primary stakeholders, including people from different social groups or with the regional training centre coordinators. There is no policy for the participation of women and other people from excluded groups in the curriculum development process. There is a National Health Training Coordination Committee (NHTCC) at the centre chaired by the Secretary of MoHP which approves the revision of training curriculum. But there is no mandatory provision for the representation of women and other excluded groups in this committee;

- *Planning and programming:* Until this fiscal year, the annual work planning and budgeting process (AWPB) did not include any specific steps to address GESI issues. However, this year, because of the NHSP-2 requirements to deliver on GESI and governance related indicators, an additional effort was made across all divisions and centres, based on directives of PPICD, to ensure GESI aspects were identified and included in the AWPB and business plan prepared of NHTC. Many of the GESI related activities will be carried out jointly with technical assistance, indicating

that the centre is not yet skilled adequately to ensure GESI mainstreaming on its own;

- *Quality monitoring and reporting.* Except for the SBA training, none of the other programmes have a quality assessment tool. Interviews with trainers and senior doctors revealed that quality of training does not include GESI aspects. In addition, the reporting system does not embrace GESI issues as no information is provided on how gender and inclusion issues have been addressed in the training. Nor are participants disaggregated by social profiles because this has not been considered necessary.

Training Management Information System

The consultants were explicitly asked to examine the functioning of the Training Management Information System (TMIS) at NHTC. This is because of concerns that a few favoured staffs are benefitting disproportionately from the available training opportunities; in fact, some may be attending the same training course more than once. Discussions with NHTC's management revealed that this computer-based system is still not functioning. Participant names were entered into the database during a pilot phase, but it has never been possible for the system to generate any reports. NHTC's management acknowledged that many of their own coordinators are not providing information on participants.

NHTC recently engaged an IT consultant to identify and solve the problem. It is understand that his report will have been made available before this report has been circulated. It is questionable though whether a functioning TMIS will solve the attendance problem, since the TMIS will only capture data on staffs trained by NHTC. The long-term solution would be for training participation to be captured in the personal records of each employee in the Ministry's human resource information system (HURIS.)

3.8 Capacity: Facilities and Resources

NHTC has five regional centres at Dhankuta, Pathlaiya, Pokhara, Surkhet and Dhangadi. All of the regional centres have training rooms and residential accommodation for participants, as shown in Table 3 below. There is a total capacity for 570 trainees, with 50% in residence. In addition, NHTC has 30 district training facilities, over half of which have residential accommodation, and 14 classrooms located at health posts.

The consultants were only able to visit one RHTC (Dhankuta) and our findings are therefore generalised from the experience of this one field visit. The main disadvantage of the RHTCs is that they are not co-located with a clinical training site at a hospital and participants must be therefore transported to a nearby hospital for the practical element of a programme. At Dhankuta, the facilities are under-utilised because the courses are restricted to upgrading programmes and a few other courses which the trainers are qualified to conduct. This means the trainers are poorly utilised too. The training rooms are inadequately decorated and poorly equipped, and, in our view, are unsuitable and unattractive venues for quality training.

The clinical training site for the SBA programme at Koshi hospital was not well maintained for what is generally considered a “flagship” programme. The audio-visual equipment and clinical models originally provided by JHPIEGO were found to be in a poor state of repair. The consultants were informed that the faults had been reported to NHTC many times, but no action has been taken. Most important, there is no suitable residential accommodation at the hospital for the female participants, who are obliged to find their own accommodation in an unfamiliar town. The overall training environment therefore is not conductive to effective learning.

Table 3: Facilities at RHTCs

Regional centre	Training facilities	Training capacity (persons)	Residential capacity (persons)
Dhankuta	3 classrooms	90	60
Pathlaiya	3 classrooms	60	50
Pokhara	1 conference halls 3 classrooms	120	60
Surkhet	1 conference halls 3 classrooms	120	60
Dhangadi	2 conference halls 2 classrooms	180	60

Source: NHTC data

One key issue identified is the different “allowance” regimes which prevail depending upon the funding agency. By allowances, we include payments to both trainers and trainees. NHTC is obliged to pay the standard government allowances for all the trainees attending the training it administers. However, we found that the allowances provided to SBA participants are insufficient to cover the full costs of their accommodation and other living expenses. And the allowances provided to trainers are less than those offered by other agencies. If offered a choice, many of the SBA trainers would prefer to train for another agency. The National Centre for AIDS and STDs for instance, which is financed by the global fund, is able to offer more attractive financial incentives to both trainers and trainees.

The inferior government rates can cause significant emotional stress for the participants attending NHTC training, which undermines motivation and learning. This is because the daily allowances and lodging allowances are reduced by 50% and 75% respectively after the first seven days of a programme. As a result participants are often forced to move to cheaper accommodation. And they may be obliged to borrow money from friends, relatives, and even trainers, in order to sustain themselves to the end of the programme.

3.9 International Training

The consultants did not have time to visit Pokhara RHTC where international training has been carried out. Our findings are therefore based on discussions with NHTC’s management and previous work conducted by the national consultant. NHTC has conducted four courses for international participants in the mobilisation of women in health care, family planning,

post-abortion care and child health. These courses are not formally accredited outside Nepal. Specialised trainers (over 90% Nepali) were contracted to conduct the training. These courses attracted a total of 44 participants, all from Pakistan, an average of 11 persons per course. They were not marketed well. Only one customised brochure was developed, for the Child Health course.

It is evident that Nepal has some comparative advantages in the South and South East Asia region (for instance the community based health system, the SBA training programme.) And the purpose built facilities at Pokhara are not only superior to the other RHTCs, but they are located in a tourist paradise close to the regional hospital and other health facilities. The centre has two 30 person capacity classrooms, one 100 person capacity conference hall, a modest 30 bed hostel and a canteen. However, the facility is in need of intensive refurbishment and it lacks the adequate information technology and out of hours study facilities necessary to cater for international participants. The most significant weakness though is the lack of competent in-house trainers capable of delivering professional training to an international standard. Of course, outsourcing is a possible solution, but an international training institution cannot build its reputation solely on contracted trainers. It is very doubtful that high quality international training can be conducted by a government institution such as NHTC. If the Ministry wishes to invest seriously in international training, then it should consider the option of an autonomous institute which has personnel and financial flexibilities, modelled along the lines of the National Administrative Staff College.

4 OPTIONS

4.1 Future Role

Before we can determine where NHTC's capacity needs to be strengthened, we need to ask what its future role should be and, as part of this, which other training and development functions need to be performed within the health in-service training system. In the presentation to stakeholders three possible options were suggested: the current situation; a training institute; and a training and development division. In this report, the third option is referred to as "training management body." The functions relevant to each of these options are shown in Figure 5 below.

Figure 5: Options for Core Training and Development Functions

Core Functions	Present NHTC (Option 1)	Training Institute (Option 2)	Training Management Body (Option 3)
Policy development			√
Needs analysis	**Limited**	**Limited**	√
Planning & budgeting	**For its own courses only**		√
Curriculum design	√	√	√
Contracting	√	**Limited**	√
Delivery	**Limited**	√	**Limited to ToT**
Evaluation, follow up & research	**Some**	√	√
Quality assurance			√

√ indicates where the function is being carried out presently by NHTC (column 1) or where it should be carried out for options 2 and 3 (columns 2 & 3).

Option1 versus Option 2

It may seem strange to compare the present functions of NHTC with that of a training institute. After all, isn't the NHTC a training institute? In Figure 4, the six functions which NHTC is currently undertaking correspond closely to those of a conventional training institute. The differences are matters of degree, but they are nonetheless significant. The first difference is that a training institute will only wish to contract out a limited amount of its training[9] (in highly specialised non-core areas), because it will want to have a critical mass of competent trainers who are able to undertake its core training. Contracting out is the exception not the rule. The opposite is true of NHTC. Most of NHTC's specialised training is contracted out; only a few courses (such as upgrading programmes) are delivered by its own technical staffs with the narrow range of skills they collectively possess. The second difference is the function of planning and budgeting. NHTC has the mandate to plan all in-service training for the Ministry and the Department, even though it is unable to do so adequately because the divisions and centres do not cooperate with it. In contrast, a training institute does not have the responsibility to plan or budget for training for an entire health system or sector. Instead, it will respond to the needs identified in such plans by deciding on its comparative advantage and where it wishes to specialise. It cannot train in everything. The only plans it will make are for its core programmes where it is confident (based on prior experience and marketing) there will be sufficient demand from its clients. Space in the annual schedule will be left to meet the demands for customised programmes which it expects will be commissioned during the year. These two differences clearly demonstrate that the NHTC is not currently functioning as a conventional training institute.

Options 2 versus Option 3

The training institute role, option 2, diverges significantly from our third option, the training management body. The latter would be responsible for carrying out all of the training and development functions that have been identified except for training delivery. It would undertake two additional functions which cannot (or should not) be carried out by a training institute, namely training policy development and quality assurance, including accreditation. An institute should not be performing either of these functions because they constitute a conflict of interest. It cannot develop an impartial training policy for a Ministry[10], because it will be inclined to favour the types of training which it is qualified to deliver. And it cannot quality assure its own programmes since an independent view is needed. Because of its policy and quality assurance responsibilities, a training management body division should not generally carry out much training itself. But, to strengthen the quality assurance function, it may choose to have a core group of master trainers who are able to conduct training of trainer programmes. Generally, there should be a clear organisational separation between policy and quality assurance on the one hand, and training delivery on the other.

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[9] At NASC, more than 95% of the annual training for the GoN is designed and conducted by full-time professional staffs.

[10] In the case of NASC, the Ministry of General Administration (MoGA) formulates the training policy which NASC and other management training centres are required to follow.

The preferred option

The question is which option is the best solution for the Ministry and DoHS? Doubtless, most staffs of NHTC would choose to become a fully-fledged training institute (together with the financial and personnel autonomy that would accompany this.) But what is best for NHTC is not necessarily the right solution for the Ministry. 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. Incremental resources channelled through supporting partners can only influence the NHTC's annual plan at the margins.

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, this begs two questions: what training can be considered "core"? And which of this core training should be delivered in a classroom setting? Management training might be considered "core" and some will be classroom-based, but 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 organisation to perform either the policy development or, most important, the quality assurance role.

The advantage of the training management body option is that it could legitimately perform all of the core functions, with the exception of training delivery. There are major weaknesses with the current performance of most of these functions (training needs analysis, planning, curriculum design, and quality assurance) because of specific capacity gaps which were discussed above. A professional training management body would enable the necessary expertise to be pooled in a single unit serving the needs of the technical divisions and the district health offices. The main disadvantage is that the training management body option 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. Many are already experienced and competent trainers who have completed the clinical skills training module or other "Training of Trainer" courses. 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 build capacity for managing training than to develop permanent in-house capability to design and deliver training. It

needs to be emphasised, however, that if the NHTC is to become a training management body with a responsibility for quality assurance, it must cease conducting training since this represents a conflict of interest. The consequence of this decision is that all training would be conducted by the divisions/centres or contracted out to external providers. The Regional Training Centres (RTCs) could continue with their upgrading training programmes but the delivery of this training would no longer be the responsibility of NHTC. The regional directorates or the relevant MoHP/DoHS divisions could take responsibility for training in the RTCs.

4.2 Organisation structure

This discussion in this section has deliberately focused on the training functions which need to be carried out in the Ministry. No reference has been made to the organisation structures required to implement these functions or, in the case of the training institute, to the organisational form which is most appropriate. For instance, the Training Management body could be located in the Ministry or the DoHS, and it could be integrated with the HR function or separate from it. Since structures will depend upon the specific option which the Ministry chooses, recommendations will be made during the second phase of this assignment. The question of autonomy for NHTC is examined after a discussion of the options for international training.

4.3 International training

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, though it is arguable whether this is best done through formal training or a study tour. If formal training is deemed appropriate, the organisation responsible for delivering it would need to be run along business lines with substantial autonomy to guarantee high quality training responsive to the needs of overseas clients. A major marketing effort would be required to launch a viable training programme. The appropriate model for this organisation is NASC, which is elaborated upon below.

So far it has been assumed that this autonomous organisation would be NHTC itself; an alternative is to create a new organisation which is spawned out of NHTC, more specifically the regional centre at Pokhara. As discussed below, there is not a strong case for converting NHTC into an autonomous organisation (similar to NASC) because this is neither necessary nor desirable for delivering the national training function effectively. Further, 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. From its present base, NHTC will require a very long incubation period before such autonomy could be considered. Therefore, starting with a blank sheet of paper and spawning a completely new organisation is the preferred option for pursuing the market for international training. By separating national and international training, this option has the added advantage that it would not drain away the best people and resources from core training for the national public sector

health system towards the more attractive and lucrative international market. In principle, the NHTC should be able to manage this problem but, in practice, it would be difficult for management to keep competent trainers focused on the needs of the public sector when the financial incentives lie elsewhere.

4.4 Autonomy

Establishing the NHTC as an autonomous body is presently included as a proposal in the NHSP-2. A number of stakeholders have advocated for an autonomous institute, including the former Director. And many have suggested that the NASC model is the most appropriate for the NHTC.

The NASC is a legal entity established by an Act of Parliament. It has its own Board of Governors which acts as a policy body which has the authority to establish its own regulations, to approve new positions and to approve the annual programme and budget of the College. A government Minister (MoGA) chairs the Board and its members are all senior public officials (including the Chief Secretary, the Finance Secretary, the Vice Chairman of the National Planning Commission, the Chairman of the Public Service Commission and the Vice Chancellor of the Tribhuvan University. NASC has an executive committee chaired by the Executive Director which is responsible for implementing the programmes endorsed by the Board. The ED is appointed by Cabinet and enjoys tenure of five years.

To implement its programmes effectively, the College has developed its own training strategies, and HR and financial management regulations, which provide the kind of autonomy which many are seeking for NHTC. Specifically, NASC has its own recruitment regulation which enables it to advertise any vacancies and to fill these on merit through its own Recruitment Board. It can therefore recruit competent trainers/consultants from the open market; unlike, NHTC it is not dependent on the calibre of the officers which it receives on transfer from other parts of the public sector health system. NASC must follow the official GoN salary structure, but the Board has approved a 35% “allowance” for the organisation as a whole which the Executive Director allocates to trainers and other staffs based on their performance. Trainers may also receive additional remuneration (as set out in the consulting proposal) from the consulting revenue which they bring to the College.

NASC receives an annual block grant from the GoN, which it is able to carry forward into the next financial year if it is not fully spent. To supplement the block grant, NASC is able to raise and retain revenues from customised training, consultancies and research. Currently, around 25% of its expenditure is financed through its own revenues. The block grant is used to finance NASC’s regular training programmes which are approved by the Board at the beginning of the year. Because this grant is given as a lump sum, and not a line item budget, NASC has considerable discretion to decide exactly how it will be spent, and how resources need to be reallocated during the year, in order to deliver the programmes approved by the Board.

What organisation would not want this form of autonomy? Unfortunately, NHTC is not strictly comparable with NASC. NASC is a management training institute which provides

services for all Ministries and Departments of the GoN and it has the freedom to sell its services to external clients from the private, non-government and donor sectors. For this reason, it does not belong to or sit under any particular Ministry. In contrast, the NHTC exists primarily to serve the MoHP and the DoHS; international training is a side line which was recently introduced and it is not part of its core mandate. If the NHTC were to enjoy similar autonomy to NASC , it would have incentives to sell training not just to participants in other countries, but also to the private sector and donor agencies. If it were to succeed in doing this, it would inevitably undermine the training services it provides to its primary client, namely the Ministry, which in turn would adversely affect the delivery of health services at the district and community levels.

Should the GoN wish to retain the NHTC as a training institute (as proposed above) a more suitable organisational form would be a service agency that sits within the Ministry or the DoHS. Having HR and financial flexibilities for such a service agency would be highly desirable, as it provides more freedom to managers to deliver the training programmes which the Ministry requires. However, bestowing full independence through a Board of Directors is inappropriate since the agency should be directly accountable to the Ministry. Nor would such independence be necessarily desirable, since the NHTC may be exposed to political interference in its affairs, a situation which has afflicted the recently established Local Development Training Academy. Regrettably, under Nepali law, there does not appear to be an intermediate organisational form which offers the benefits of managerial autonomy without at the same time, creating a fully independent entity which would cease to be directly accountable to its primary client.[11] For this reason, in common with training centres in other Ministries, the NHTC must remain as a centre within the Ministry or DoHS.

4.5 Options for Developing Capacity

It has been argued in this report that the Ministry needs a training management body. In this section, we take a broad view and discuss what needs to be done to strengthen training and development generally in the MoHP/DoHS without making any reference to a particular entity. The main options are as follow:-

- 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 social inclusion aspects into these functions. It is not essential that they are health specialists, though some may be;
- Second, to enable these training managers and professionals to be effective, the Ministry should establish processes, routines and methodologies for analysing training needs and preparing training plans. The plans should be aligned with the annual

[11] The service agency model is prevalent in the civil services of many developed countries, including the UK, and some developing countries in Africa, such as Tanzania. When established in the UK in the 1980s, these agencies were referred to as “executive agencies” which provided easily specified services (training is a good example) for Ministries, but which at the same time would benefit from some HR and financial autonomy in order to provide them more efficiently.

planning and budgeting process of the Ministry, and they should incorporate a bottom-up element which allows DPHO/DHOs to identify their local priorities. Central and local plans would be coordinated to avoid duplication and waste of resources, and to ensure the overall volume of training is realistic so as not to undermine service delivery;

- 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. These might include building learning into the emergent supervisory processes, establishing learning partnerships with the private and NGO sectors, district coaches and mentors, and e-learning;

- Fifth, a pool of accredited trainers, mentors and coaches should be created, comprising Ministry staffs and external consultants. They would be accredited by the master trainers in the training management body;

- Sixth, all classrooms and training sites in demand should be modernised and properly equipped. No additional infrastructure is needed at this stage.

5 CONCLUSIONS, RECOMMENDATIONS AND NEXT STEPS

The NHTC has very limited capacity to perform its current mandate. It is unable to conduct relevant in-service training except in a few limited areas and it relies heavily on contracting. In practice, NHTC operates largely as a coordinator, manager or administrator of in-service training. Even in this capacity, it is responsible for only a part of the Ministry's in-service training because the divisions and centres of the DoHS organise and conduct their own in-service training programmes. They say they do this because NHTC does not have qualified professionals, although the desire to retain control of their training budgets may be another reason.

That said, we would not expect the NHTC to be fully capable of performing such a wide mandate. The organisation and management role is not a legitimate function for a training institute or training centre; it is a role which would normally be carried out by a training management body embedded within the organisation structure of the Ministry. And such an entity would also carry out additional professional functions (such as training needs analysis) which have been incorrectly assigned to NHTC. As a training institute, the NHTC need only be capable of designing and delivering training.

Looking ahead, therefore, the Ministry should be thinking broadly about the different training roles for which it requires capacity, not just the NHTC. In the short-term, the Ministry definitely requires a training management body. Our recommendations should be viewed in this broader context.

5.1 Recommendations

Our key recommendations are as follows:-

- The NHTC should become a training management body responsible for managing and quality assuring all training carried out for the Ministry and its departments. 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;
- The NHTC should be staffed by socially diverse professional training managers and a few master trainers, some of whom would have skills on mainstreaming GESI. The precise numbers and skills would be determined in Phase 2;
- Improved processes for analysing training needs and developing training plans should be designed, incorporating a bottom-up element to allow DPHO/DHOs to identify local priorities;
- 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.
- The Ministry should make efforts to introduce alternative approaches and methods of training development, with a focus on on-job methods, to avoid taking staffs away from their workplaces for long periods;
- All training sites and classrooms in demand should be modernised and properly equipped. They would be available for use by the divisions/centres and contracted trainers and training organisations.

5.2 Next Steps

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 change the NHTC to a training management body, which, in our view, is the priority at the present time. The key tasks proposed for Phase 2 are:-

- *Step 1:* Agree the change management arrangements, which will includethe appointment of a change sponsor, establishment of a change team, and communications and consultations on the impact of the proposed change;
- *Step 2:* Determine the structure, staffing, skills, financing and reporting arrangements necessary for the NHTC to perform the functions of a training management body effectively;
- *Step 3:* Prepare an implementation plan which identifies the key milestones in the "road map" and who will be responsible for delivering them;
- *Step 4:* Carry out stakeholder consultations on the proposals and plan;
- *Step 5:* Finalise the implementation plan.

The consultants acknowledge that the objectives and scope of Phase 2 differ from what some stakeholders envisaged when the TORs were originally developed. The TORs referred to the need to update of the National Health Training Strategy of 2004. When the consultants reviewed this document, it became apparent that the contents reflected a business plan for the NHTC rather than a training strategy for the Ministry as a whole. Based on the findings of this study, the development of a business plan is no longer relevant, nor would it be possible in the absence of a full understanding of the training needs of the Ministry. However, 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.

ANNEX 1: TERMS OF REFERENCE

TERMS OF REFERENCE FOR AN

INSTITUTIONAL CAPACITY ASSESSMENT OF THE NATIONAL HEALTH TRAINING CENTRE

AND REVISION OF THE NATIONAL HEALTH TRAINING STRATEGY

June to December, 2012

1. BACKGROUND

The Government of Nepal is committed to improving the health status of Nepali citizens and has made impressive health gains despite conflict and other difficulties. The Nepal Health Sector Programme-1 (NHSP-1), the first health Sector-Wide Approach (SWAp), began in July 2004, and ended in mid-July 2010. NHSP-1 was a highly successful programme in achieving improvements in health outcomes. Building on its successes, the Ministry of Health and Population (MoHP) along with External Development Partners (EDPs) designed a second phase of the Nepal Health Sector Programme called the NHSP-2 (2010-2015), a five-year programme, to be implemented from mid-July 2010. The goal of the NHSP-2 is to improve the health status of the people of Nepal and the purpose is to improve the utilisation of essential health care and other services, especially by women, the poor and excluded.

Technical assistance to NHSP-2 is being provided through pooled EDP (DFID, World Bank, AusAID, GAVI) support through the Nepal Health Sector Support Programme (NHSSP). The NHSSP is a three-year programme, funded by DFID and managed and implemented by Options Consultancy Services Ltd and partners. NHSSP is providing technical assistance and capacity building support to the MoHP in order to enable the Ministry to deliver against the NHSP-2 results framework within the programme timeframe.

The following are the key areas of NHSSP support:

1. Health Policy and Planning;
2. Health Systems and Governance;
3. Human Resources for Health;
4. Health Financing;
5. Gender Equality and Social Inclusion;
6. Essential Health Care Services;
7. Procurement and Infrastructure;
8. Monitoring and Evaluation, and
9. Aid Effectiveness.

2. SPECIFIC BACKGROUND

As stipulated in the National Health Training Strategy (2004), the **purpose of the National Health Training Centre (NHTC)** is to oversee, coordinate and provide all in-service training required by the MoHP, including the Department of Health Services, Department of Drug Administration and Department of Ayurveda. The **overall goal of NHTC** is *"to provide/prepare efficient health service providers by means of training to contribute to deliver quality health services towards attainment of the highest level of health status by the people of Nepal"*[12].

The **objectives of NHTC** are to:

Assess training requirements of health workers and prepare training plans based on programmes' requirements;
Plan, implement and train health workers as demanded by various programmes;
Design, develop and refine teaching and learning materials to support implementation of the training programmes;
Develop/improve the capacity of trainers to deliver quality training at central, regional and district levels;
Support RHDs and DHOs in organising, implementing and evaluating training programmes;
Coordinate with all national and international, governmental and non-governmental organisations to avoid duplication of training and to improve the quality of training;
Orient newly recruited health workers on the various health programmes;
Supervise, monitor, follow-up and evaluate the training programmes; Conduct
operational studies to improve training efficiency and effectiveness; Organise
international training as per the needs;
Establish a Training Information Management System (TIMS) for the quality recording and reporting of all training programmes at central, regional, district, and community levels.

NHTC operationalises its training activities in line with the 2004 National Health Training Strategy. These can be broadly classified into two categories – namely in-service training and international training.

In-service training is delivered through a network of National Health Training Programmes (NHTPs), which provide technical as well as managerial training at national, regional, district and community levels. There are five regional, one sub-regional and 75 district training centres and 14 training health posts. In addition, there are six family planning/post-abortion care training points. The NHTPs are managed by the Director of NHTC and his/her staff, with support from a number of EDPs.

[12] Annual Report of DoHS (2063/64)

A Training Working Group comprising various supporting partners was formed under the leadership of NHTC with the purpose of ensuring the efficient running of NHTPs and improving the coordination of all training provided under NHTC.

3. RATIONALE

Although the scope of training provided by NHTC has been broadened, it is yet to function at the level expected by the 2004 National Health Training Strategy.

The **goal of the Strategy** is '*to expand, accelerate and improve the quality of the national training programmes in order to increase the coverage and quality, and broaden the scope of services provided at various levels of the health care delivery system'*. The **guiding principles** adopted in the strategy include: decentralisation of planning for training; acceleration of training by identifying additional training sites and trainers; expansion of the scope of services by upgrading the skills of selected categories of health workers; strengthening linkages, collaboration and integration; improving training programme management, implementation, responsiveness, flexibility, and building on the existing human resource base.

NHTC is expected to collaborate with the Ministry of Education in the standardisation of training curricula and the accreditation of training institutions and courses to assure the quality of training. The NHSP-2 indicates that the MoHP will support the NHTC to develop '*as an autonomous national health training centre to better enable the centre to design, develop, implement, monitor and evaluate national training programmes and conduct international training for participants from South and Southeast Asia meeting high professional standards with a minimum of bureaucratic hurdles.'* In order to strengthen the capacity of NHTC and expand its role and/or to develop it as an autonomous national health training centre, the NHTC and NHSSP have identified that the following activities should be undertaken:

1. Assess the institutional capacity of NHTC to manage and deliver training programmes;
2. Identify areas to strengthen and expand the role of NHTC, identify new opportunities aligned with MoHP's HRH Strategic Plan (2011-2015) and the HR projections to be developed in 2012, and make recommendations for its development as an autonomous training centre;
3. Facilitate stakeholder consultations and consensus meetings to present and review the findings and recommendations of the institutional capacity assessment;
4. Support the establishment of a stakeholders' thematic group to review the findings and develop strategies for those thematic areas;
5. Support revision of the National Health Training Strategy (2004) using the findings and recommendations of the assessment.

The following mechanisms and structures have been established to support and coordinate the institutional assessment and revision of the strategy:

a Steering Committee chaired by the Health Secretary, and
a Technical Working Group (TWG) chaired by the NHTC Director.

4. PURPOSE AND OBJECTIVES OF THE ASSIGNMENT

The purpose of this consultancy is to assess the institutional capacity of NHTC, recommend strategies and options for improving the management and delivery of its current mandate as well as its potential to expand its role, and to facilitate and support the revision of the 2004 National Health Training Strategy. The objectives of the assignment are as follows:

Objectives:

1. To assess the capacity of NHTC to oversee, coordinate and provide in-service training for MoHP as stipulated in the National Health Training Strategy (2004);
2. To assess the capacity of NHTC to meet the objectives stipulated by NHSP-2 with regard to national and international training and to achieve the milestones and targets set out in the NHSP-2 Results Framework;
3. To identify opportunities and options for improving the capacity of NHTC;
4. To identify specific improvement areas for the delivery of its current mandate and for an expanded role, including areas such as infrastructure, staffing, practicum/training sites, institutional approaches, information systems, HR systems and practices, financing and the use of ICT, etc.;
5. To use the findings of the institutional capacity assessment to support NHTC facilitate stakeholder inputs to the revision of the National Health Training Strategy (2004) and the development of a revised strategy.

5. TASKS

Specific tasks of the assignment will include:

Attend briefings with the NHTC director, staff and TWG to agree the scope and methodology for the assessment and the processes to be followed;

Review secondary documentation including NHSP-2, the National Health Training Strategy (2004), NHTC annual reports, training reports, evaluation reports, policies/strategies under revision or development relevant to the strategic direction of NHTC, and any other relevant documents;

Map NHTC's partners and other training stakeholders (EDPs, providers, trainees, etc.) and identify their roles, responsibilities and interests in coordinating and providing in-service training;

Prepare a brief background report on NHTC, including its establishment, mandate, current level of autonomy, governance and management systems and structures for presentation to, and validation by, the TWG;

Seek advice from and build consensus with NHTC's partners, including the TWG, throughout the assessment process on the scope of the assessment, the methodology and approach, as well as the findings and recommendations;

Develop data collection instruments including questionnaires, key informant interview schedules and focus group discussion guides;

Consult with representatives from DoHS, the Department of Drug Administration, the Department of Ayurveda and MoHP, and a small sample of private sector organisations and institutions that are providing in-service and pre-service training (limit of 3 institutions which should include the National Academy for Local Development);

Review the National Training Strategy (2004) and make recommendations for revisions and improvements based on international perspectives, approaches and good practice on institutional development and autonomy, and on training and development;
Review the functioning and quality of the NHTC training information management system;
Assess the current institutional capacity of NHTC against its current mandate and the recommendations and targets set out in the NHSP-2;
Visit one Regional Training Centre, identified in consultation with the TWG, to assess its capacity and identify areas for improvement;
Design and facilitate a one day national stakeholders' consultation meeting to present preliminary assessment findings, options and recommendations, and to identify short, medium and long term strategies and activities for inclusion in the revised National Health Training Strategy in order to address these findings and recommendations;
Based on the assessment findings and outcomes of the stakeholder consultations, make recommendations for improving NHTC's institutional capacity to oversee, coordinate and provide in-service training;
Facilitate a participatory stakeholder process to review the findings of the institutional capacity assessment, to identify thematic areas and establish thematic groups to develop strategies and activities to address these areas in the revised national training strategy;
Review the human resource projections of MoHP when developed, the assessment findings and recommendations, the strategies and activities identified during stakeholder consultations and use these to draft a revised National Health Training Strategy;
Facilitate a second one day stakeholders' consultation workshop to seek comments and feedback on the draft National Health Training Strategy;
Revise and produce a final draft of the National Health Training Strategy using stakeholder feedback.

Interviewees may include the following:

Government of Nepal (GoN)

* Secretary of MoHP;

* Director Generals (DGs) of all three departments;

* Division Directors, Planning, Policy and International Cooperation Division Director, Population Division Director;

* NHTC staff, and

* Staff of HR section of MoHP.

EDPs

* NFHP (JSI), PSI, NSI, JHPIEGO, USAID, DFID, and

* NHSSP staff.

Training Institutions

* IOM, Staff College, CTEVT, National Academy (Local development/tourism).

Private Sector Organisations And Institutions

* A sample as outlined above.

6. DELIVERABLES

There are 2 key Outputs as follows:

1. An Institutional Capacity Assessment including a review of the training strategy (Objectives 1-4), facilitation of a first national stakeholder workshop and finalisation of a capacity assessment report;
2. A Revised National Training Strategy including facilitation of the inputs of the thematic groups and the national consultation process in the review and drafting of the strategy (Objective 5).

The deliverables for the assignment are:

- A brief report and presentation on the background of NHTC;
- A brief draft report and PowerPoint presentation on the preliminary assessment findings, the review of the National Training Strategy (2004) with options and recommendations, including an analysis of internal (NHTC, DoHS, MoHP) and external stakeholders' expectations and perceptions of NHTC's capacity, for presentation at the first national stakeholders' consultation meeting;
- A brief report of the proceedings and outcomes of the first national stakeholders' consultation meeting including the thematic areas that short, medium and long term solutions have been identified for, for inclusion in the revised National Health Training Strategy
- A final report on the institutional capacity assessment including background, a review of the National Training Strategy (2004), assessment findings, options and recommendations and proposed thematic areas to be addressed in the revised National Health Training Strategy;
- Brief reports on the proceedings and outcomes of the thematic groups;
- A brief report on the proceedings and outcomes of the second national stakeholders' consultation meeting on the draft National Health Training Strategy, including presentations made by the thematic groups;
- A draft of the National Health Training Strategy and a PowerPoint presentation for the second national stakeholders' consultation;
- A final draft National Health Training Strategy.

All reports should be delivered in the following formats:

- Soft copies of both draft and final reports in word doc. file format;
- Three hard copies of the draft report;
- Three hard copies of the final report after comments have been received and incorporated.

7. TIMEFRAME

The assignment will be completed between June and December, 2012. The process will take place in two stages:

1. The institutional capacity assessment of NHTC led by the international consultant, and
2. The revision of the National Health Training Strategy led by the national consultant.

The proposed division of roles between the international and national consultants is as follows:

National Consultant

The national consultant will lead the strategy development process and facilitate the work of the proposed thematic groups in developing the strategy. The consultant's contract will be for up to 43 days between the months of June and December, 2012 and s/he will be responsible for the following tasks:

Task	Days
1. Familiarisation and literature review/documents review	3 days
2. Interviews with NHTC staff	1 day
3. Draft a background report and presentation for the NHTC TWG	2 days
4. Consensus building meetings with, and advice seeking from, the NHTC TWG	1 day
5. Support the development of methodology for assessment and tools and instruments	2 days
6. Conduct interviews with internal and external stakeholders, including a visit to RHTCs (excluding travel)	5 days
7. Support the analysis of findings and production of the report on preliminary assessment findings, options and recommendations	2 days
8. Support the facilitation of a one-day national stakeholders' consultation meeting to present preliminary findings and the preparation of a report on the meeting	2 days
9. Support the preparation of the final Institutional Capacity Assessment Report, incorporating feedback from the stakeholders' consultation meeting	2 days
10. Conduct interviews with stakeholders for strategy revision	2 days
11. Develop an approach and methodology to facilitate stakeholder engagement in the proposed thematic groups and facilitate the work of the groups	10+ days

12. Draft the National Health Training Strategy	4 days
13. Prepare and facilitate the second stakeholders consultation meeting to review the draft National Health Training Strategy	2 days
14. Produce the final draft strategy, incorporating feedback from the stakeholders' consultation meeting	2 days
TOTAL	40 days

International Consultant

The International consultant will lead the institutional capacity assessment including the strategy review process and preparation of the CA report. S/he will also provide inputs to the draft strategy. The international consultant's contract will be for **up to** 30 days between the months of June and December, 2012. The international consultant will be the lead consultant and conduct the assignment through a combination of remote desk based work and country visits. S/he will be responsible for the following tasks:

Tasks	No. of days	Location
1. Familiarisation and literature review/documents review, including background report and presentation prepared by the national consultant	2 days	Remotely/desk based
2. Develop methodology for assessment and tools with support from the national consultant	2 days	In country
3. Conduct interviews with internal and external stakeholders, including a visit to a RHTC	8 days	In country
4. Analyse findings and prepare a report on the preliminary assessment findings, options and recommendations, including a review of the 2004 National Training Strategy	3 days	In country
5. Facilitate a one-day national stakeholders' consultation meeting to present preliminary findings and produce a report on the meeting	2 days	In country
6. Produce the final Institutional Capacity Assessment report, incorporating feedback from the national stakeholders' consultation meeting	3 days	Remotely/desk based
7. Support the national consultant to develop an approach and facilitate stakeholder engagement in the proposed thematic groups	1 days	Remotely/desk based
8. Review and provide feedback on the draft National Health Training Strategy	2 days	Remotely/desk based

9. Support the preparation and facilitation of the second stakeholders' consultation meeting to review the draft National Health Training Strategy	3 days	In country
10. Support the production of the final draft strategy, incorporating feedback from the stakeholders' consultation meeting	2 days	In country
TOTAL	28 days	

8. REPORTING

The consultants will report to the NHTC director, the EHCS advisor of NHSSP and Margaret Caffrey from LATH. The consultants will work closely with NHSSP's advisors and the Technical Working Group.

9.QUALIFICATIONS, COMPETENCIES AND SKILLS REQUIRED

The national consultant and international expert should be training experts with experience of managing training institutions/departments and of assessing training needs and training institutions. Each should have at least:

- A Masters degree or PhD in public health or education;
- At least 8 years of experience in the Nepal health sector for the national consultant and in managing/evaluating training institutions for the international consultant;
- An understanding of the management of training institutions and issues affecting the quality of training;
- Excellent interpersonal communication and facilitation skills;
- Excellent spoken and written English;
- Previous experience in assessing training institutions and supporting training strategy development.

ANNEX 2: LIST OF PEOPLE INTERVIEWED

Name	Designation	Organisation
Prof. Pravin Misra	Secretary	Ministry of Health & Population (MoHP)
Dr. Mingma G. Sherpa	Director General (DG)	Department of Health Services (DOHS)
Padam B Chand	Joint Secretary Policy, Planning and International Relation Div	MoHP, Kathmandu
Surya Acharya	Joint Secretary, Human Resources and Finance Division	MoHP, Kathmandu
Ramchandra Man Singh	Health Sector Governance Advisor	NHSSP, Kathmandu
Dr. Laxmi Raj Pathak	National Team Lead	NHSSP, Kathmandu
Arjun Bahadur Singh	Former Director, National Health Training Centre (NHTC) and current Officiating ED	Nick Simon Institute (NSI), Lalitpur
Bal Govinda Bista	HRH Consultant	NHSSP, Kathmandu
Senendra Upreti.	Director, Family Health Division	Department of Health Services, Kathmandu
Naresh K.C.	Director, Logistic Management Division	Department of Health Services, Kathmandu
Shyam Raj Upreti	Director, Child Health Division	Department of Health Services, Kathmandu
Saroj Kumar	Director	Management Division, DoHS
Badri Bahadur Khadka	Director	National Health, Education, Information and Communication Centre
Krishna Kumar Rai	Director	NASC
Laxmi Narayan Deo	Acting Director	NHTC
Rajendra Bhadra	Team Leader, Specialist, Performance Improvement	JHPIEGO, Nepal Family Health Program-II
Margaret Caffrey	HR Lead Adviser (LATH)	NHSSP
Tim Martineau	HR Project Director (LATH)	NHSSP
Nancy Gerein	International Team Lead	NHSSP Kathmandu
Maureen Dariang	Essential Health Care Service Advisor	NHSSP, Kathmandu
Radha Raman Prasad	Director, Department of Drug Administration	Babar Mahal, Kathmandu
Ram Narayan Shah	DG	Department of Ayurveda, Teku, Kathmandu
Ganga Shakya	MNH Advisor	NHSSP, Kathmandu
Kabiraj Khanal	Under Secretary, Planning Development Section	Ministry of Health and Population, Kathmandu
Jaya Bahadur Tandon	Member Secretary	CTEVT
Ramu Sharma Poudel	Senior Integrated Medicine Officer	NHTC
Steven J. Knobel	Training Consultant	Nick Simon Institute (NSI), Lalitpur

Sandhya Limbu	Programme Officer, Performance Improvement Team	Nepal Family Health Program-II, Kathmandu
Udev Maharjan	Senior Programme Officer/ Training Coordinator, Performance Improvement Team	Nepal Family Health Program-II, Kathmandu
Chhaya Jha	GESI Advisor	NHSSP, Kathmandu
Rohit Pandey	Training Chief	Eastern Regional Health Training Centre, Dhankuta
Punya Prasad Neupane	Executive Director	Nepal Administrative Staff College
Krishna Kumari Paudel Subedi	Registrar and Administrator	Nepal Nursing Council, Kathmandu
Asha Pun	Programme Specialist	UNICEF Nepal
Amrit Bhandari	Consultant	DFID, Nepal
Norma Limbu		USAID, Nepal
Atul Dahal	Programme Specialist	WHO Nepal
Mangla Manandhar	Senior Public Health Admin.	FHD, DOHS
Ram Narayan P. Singh	Executive Director	Dhankuta Institute of Health Science, Dhankuta
Uma Kanta Jha	Medical Superintendent	Koshi Zonal Hospital, Biratnagar
Navraj Subba	DPHO	Morang DPHO Office
Vikas Shrestha	Programme Officer	Nick Simon Institute (NSI), Lalitpur
Khagendra Gelal	Senior Medical Officer	NHTC
Ramila Devkota	Medical Officer	NHTC
Dinesh Chapagain	Senior Public Health Officer	Management Division, DoHS
Krishna Jha	Accreditation Director	CTEVT
Shiva Shankar Ghimire	Director	Curriculum Development, CTEVT
Geeta Koirala	Training Coordinator	KZH Training site, Biratnagar
Anita Subba	PH Nurse	DPHO, Morang
Suresh Pradhan	Manager	FPAN, Morang office
Deepak Pradhan	Manager	MSI, Biratnagar
Suman C. Gurung	Programme Coordinator	NHSSP/ERHD
Suresh Dahal	Sector Officer	ERHD, Dhankuta
Mamta Shrestha	MSc SN	KZH Training site