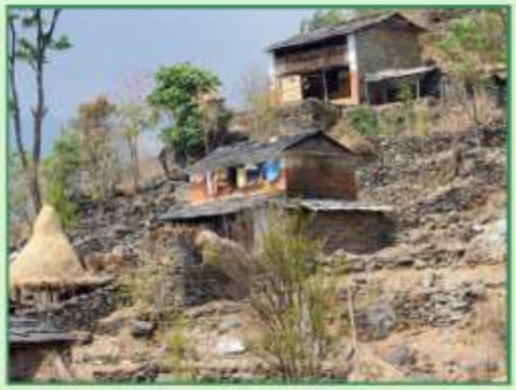
NHSSP

August 2011

Training Capacity Assessment and Strategy Development


Lynne Elliott (LATH Consultant)

with

Bill James (NHSSP International HR Advisor)

Liverpool Associates
in Tropical Health
Anson House
25 Anson Street
Liverpool L3 5NY
United Kingdom
www.lath.com

Tel: +44 (0) 151 705 3773
Fax: +44 (0) 151 705 3774
Email:info@lath.com

CONTENTS

ACRONYMS

AAC	Anaesthesia Assistant Course
ANMs	Auxiliary Nurse Midwives
APRO	UNFPA's Asia and the Pacific Regional Office
AWPB	Annual Work Plan and Budget
BEOC	Basic Emergency Obstetric Care
BHLT	Basic Health Logistics Training
BNMT	British Nepal Medical Trust
CCU	Critical Care Unit
CHD	Child Health Division
CME	Continuing Medical Education
COFP	Comprehensive family Planning
COPE PLA	Client Oriented Provider Efficiency Participatory Learning Approach
CPD	Continuing Professional Development
CTEVT	Council for Technical Education and Vocational Training
DoHS	Department of Health Services
FEP	Follow-up and Enhancement Programme
GAAP	General Approach and Action Plan
GBV	Gender Based Violence
GESI	Gender Equality and Social Inclusion
GoN	Government of Nepal
HRH	Human Resources for Health
HuRIS	Human Resource Information System
ICM	International Confederation of Midwives
ICT	Information and Communication Technologies
ICU	Intensive Care Unit
IMCI	Integrated Management of Childhood Illnesses
KIIs	Key Informant Interviews
LATH	Liverpool Associates in Tropical Health
MCHWs	Maternal and Child Health Workers
MLHW	Mid Level Healthcare Workers
MLP	Mid-level Practicum
MoHP	Ministry of Health and Population
MoGA	Ministry of General Administration
NAMS	National Academy of Medical Sciences
NHSSP	National Health Sector Support Programme
NHTC	National Health Training centre
NFHP	Nepal Family Health Programme
NRs	Nepali Rupees
NSI	Nick Simons Institute
NTP	National Training Programme
PAHS	Patan Academy of Health Sciences
PAC	Post Abortion Care
PBL	Problem Based Learning
PHCCs	Primary Healthcare Centres
RHDP	Rural Health development Programme
RHTC	Regional Health Training
SBA	Skilled Birth Attendant
TQM	Total Quality Management
UNFPA	United Nations Population Fund

EXECUTIVE SUMMARY

The overall objective of the Training Capacity Assessment and Strategy Development is to support the training and development component of the Human Resources for Health (HRH) strategic plan. The specific outcomes are to provide recommendations on a strategic framework for continual professional development (CPD), review the capacity and ability to deliver CPD, including regulatory mechanisms within Nepal.

This TA assignment took place between 18th July and 05th August 2011. Lynne Elliott, a consultant from Liverpool Associates in Tropical Health (LATH) worked on the assessment with the International HR Advisor for the National Health Sector Support Programme (NHSSP) in Kathmandu, Nepal.

The focus of the assessment was in-service training and specifically CPD for the health sector. CPD goes beyond training; it is an on-going, developmental and often cyclical process. This type of training is not just intended for clinical service providers but for all staff.

A great deal of training in the health sector is provided by government, I/NGOs and to some extent the private sector.[1] The strengths and achievements of the system to date include:

- The government is committed to training with allocation of financial and human resources for training interventions
- There is contracting of private sector providers
- There are examples of best practice in training currently in Nepal, these include practical work-place-based training approaches
- Some follow-up of training does take place.

However, our findings suggest much of the training is 'supply driven' and not based on evidence of the type of training required. There are gaps in training provision with topics such as management, human resources (HR), data management and analysis, finance, planned preventative maintenance, procurement, M&E, leadership and team working being largely overlooked. Innovative training approaches are being used[2]. However, there was a general consensus that approaches seem to focus on 'class-based theory but not practical skills which staff can use' and selection procedures for in-service training do not appear to be needs-based or transparent. The quality of training providers seems variable and current regulatory mechanisms through the professional councils are not yet functioning effectively. The councils were said to 'lack capacity' and 'effective governance'. Overall there seemed to be a fragmented approach to in-service training rather than a **systematic approach**.

A model framework for in-service training and CPD has been developed as part of this assignment. It is designed to respond to the current challenges, including providing a more coordinated and systematic approach to training and CPD.

The model framework uses mechanisms such as **national and local training committees** to improve coordination, as well as **local Learning Coordinators** to link at regional and district levels to develop a bottom-up approach to training and CPD, which is firmly rooted at the local level.

[1] Private sector currently focussed more on pre-service training

[2] These are described in more detail in this report but include : courses run through the National Health Training Centre (NHTC) such as Postabortion Care developed by the USAID funded Nepal Family Health Programme and NHTC and Nick Simons Institute (NSI) practical training approaches e.g. Mid-level practicum for Mid-level Health Workers (MLHWs)

As a result of the model framework a number of recommendations have been developed.

SUMMARY RECOMMENDATIONS

Immediate recommendations include:

- **Establish a National Health Training Coordination Committee Chaired by the Secretary** to drive training strategy and planning as part of the wider HRH Strategy.
- **Produce a training strategy and plans** with milestones agreed by stakeholders. This should be developed as part of the wider Human Resources for Health (HRH) strategy.

  The following recommendations should be included in the training strategy and plans with short, medium and longer term goals and milestones set for each recommendation.

- Ensure in-service training in topics such as management, human resources (HR), data management and analysis, finance, planned preventative maintenance, procurement, M&E and leadership are included in training plans.
- Use an affirmative action approach to selection to address inequalities. For example, MoHP could take a strategic decision to prioritise in-service training in leadership and management for women and other socially excluded groups.
- **Build on existing, and developing new, good practice approaches and models used to deliver training and CPD.** There has to be a shift from one-off interventions to viewing in-service training and CPD as a continual process, related to the trainee's job, whilst ensuring that training and CPD is valued by organisations to develop and motivate their staff. We recommend the use of innovative information and communication technologies (ITC), as well as implementation of systems and structures to ensure effective follow-up and supervision. Focus on:
  - training effective teams
  - 'learning by doing' with work-place based practical training
  - providing staff with on-going support from managers, mentors or "learning buddies". These could be provided at district level, such as public health nurses and others (see learning coordinators below).
- Develop the role of **Learning Coordinators** to link at regional and district levels to partners across the sector.
- **Establish regional and district coordination committees** for training and CPD to foster collaboration, improve coordination and address training and CPD at regional and district levels.
- **Review all current training materials to ensure they are in line with Gender Equality and Social Inclusion (GESI) principles, thus helping to ensure Ministry of Health and Population and Department of Health Services staff are well placed to deliver equitable health services.** In future all training initiatives will be aligned with GESI principles as part of standard training practice and procedures.

A complete set of recommendations is provided at the end of the report.

INTRODUCTION

The overall objective of this assessment as outlined in the TOR[3] was 'to support the training and development component of the HRH strategic plan and other organisation and development initiatives' aimed at improving 'the effectiveness' of the 'health workforce across the health sector'. More specifically the objectives were to:

1. **'**develop a strategic framework for ensuring continual professional development ….through the provision of appropriate training and development activities'.
2. 'review the capacity and ability of the National Health Training Centre….together with its regional counterparts and private sector providers to deliver the estimated training and development activities required'
3. 'review the capacity and ability of current regulatory mechanisms to ensure adequate quality and training and development from eligible providers
4. 'recommend a broad set of steps for MoHP and NHSSP staff to further develop and implement a strategic framework for training and development through to 2014'.

This initial assignment took place over a period of three weeks between the 18th July and 05th August 2011. This comprised 15 working days conducting interviews with 55 interviewees,[4] undertaking a 3-day field visit, collating and summarizing results and a participatory stakeholders meeting with 19 participants in Kathmandu.[5] The LATH consultant worked with the International HR Advisor for the National Health Sector Support Programme (NHSSP) programme in Kathmandu.

Information was collected using a short interview guide.[6] The assessment also involved an extensive literature review.[7] The focus of the assessment was on in-service training and Continuing Professional Development (CPD).

The Findings and Analysis section has been subdivided as follows:

Section 1 provides a review of existing and proposed plans for training and development for the Ministry of Health and Population and (MoHP) and the Department of Health Services (DoHS) workforce; its medical and professional employees.

Section 2 presents a review of the current approaches used for training and development by a range of providers and identifies the potential for improved approaches and methods of delivering appropriate CPD.

Section 3 provides an assessment of the institutional capacity of current MoHP and private providers of training and development activities and the effectiveness of current contracting mechanisms to enable greater use of the private sector. It also identifies institutional capacity development requirements.

[3] See Annex 1:TORs
[4] See Annex2: List of Interviewees
[5] See Annex 3: List of Participants who Attended Stakeholders Meeting
[6] See Annex 4: Interview Guide
[7] See Annex 5: List of Materials Used

Section 4 presents a review of the current regulatory mechanisms and their ability to ensure quality of training and development and identifies needs for strengthening these mechanisms.

Section 5 provides a model framework designed to address the challenges raised during the training assessment and a comprehensive framework to enhancing training and CPD across all levels.

Finally we present recommendations, conclusions and a set of broad steps for MoHP and NHSSP.

A series of **Annexes 1-8** provide information to support the main report document. Annexes 7 and 8 have been designed and developed to support the Findings and Recommendations sections of the report.

Annex 7 provides a table summarizing some of the principle organisations involved in training in the health sector in Nepal which have relevance for in-service training and CPD. **The table identifies special programmes, projects or features form the organisations involved in training and CPD which could be used as 'link points'[8] or useful models to develop/consider in the next steps and action plans for training and CPD.**

Annex 8 is designed to provide an overview of the findings of the needs assessment and **identifies approaches for addressing these**. The key findings from this summary have been described in more detail in the main sections of the report.

[8] **'link-points'** – These highlight areas where organisations are involved in an activity which could be included or considered in the next steps/ action plans or training strategy

BACKGROUND

In Nepal there is a large disparity in health measures. Life expectancy in Kathmandu is about 74 while it is as low as 37 in some other areas. There is a similar disparity in the quality of healthcare access offered in urban and rural areas. For example, two-thirds of doctors are in the Kathmandu valley or in other cities.[9]

The Government of Nepal (GoN) has given priority to extending the health care system to the poor, rural, marginalized and most vulnerable in the population and in particular providing maternal-child health, infectious diseases and outpatient care.

Accurate and up-to-date data on staffing is not always available or complete. However, data for 2007/2008 is available (see Table 1).

TABLE 1: HUMAN RESOURCES FOR HEALTH UNDER MOHP IN 2007/ 2008

Position	Sanctioned	Filled	Vacant	% Filled Positions	% Share
	2007/ 2008				
Medical doctor	1,062	816	246	77	4
Nursing staff including ANMs	5,935	5,307	628	89	24
Paramedics	10,642	9,212	1,430	87	43
Other	6,838	6,394	444	97	28
Total	**24,477**	**21,729**	**2,748**	**89**	**100**

Source: Based on data from Annual report, DOHS, 2007/08[10] and table cited in NHSP-2 and table in capacity assessment for health systems strengthening 2010[11]

More recent, but unpublished, data on sanctioned posts has been obtained from the Human Resource Information System (HURIS) at the MoHP. According to this data the total number of sanctioned posts is 27,316. This comprises: 1092 doctors, 6540 nurses, 7588 paramedics/allied health professionals, 7063 administrative and support staff, 4251 public health staff and 782 indigenous medicine health practitioners. However, there is no corresponding data for the levels of vacant and filled posts.

These latest figures show that there are still a high number of paramedics/allied health professionals (27.8%) and support staff (25.8%) whilst the percentage of doctors (4%) and nurses (23.9%) largely unchanged from 2007/ 2008. The shortage of skilled staff such as doctors and nurses working for government is due to the inability to attract and retain them rather than overall supply.[12]

In a study which examined the influences which encourage doctors to stay and work in rural areas, researchers found that there were a number of interlinking factors and one of these was the desire for Continuing Medical Education (CME).[13,14] This is supported by other

[9] Nick Simons Institute Website. www.nsi.edu.np
[10] MoHP. 2010. Nepal Health Sector Programme Implementation Plan II (NHSP-2) 2010-2015. March 2010
[11] Martineau T. and Subedi H.N. 2010. Human Resources for Health. Capacity Assessment for Health Systems strengthening.
[12] MoHP. 2010. Nepal Health Sector Programme Implementation Plan II (NHSP-2) 2010-2015. March 2010.
[13] The term CME is a similar concept to CPD although it is more commonly associated with doctors and can be linked to registration with professional councils for doctors
[14] Butterworth K., Hayes, B. and Bhusan, N. 2008. Retention of General Practitioners in Rural Nepal – A qualitative Study. Australian Journal of Rural Health, Volume 16.

research which included interviews with a wide cross section of health sector staff in Nepal including: doctors, nurses and Auxiliary Nurse Midwives (ANMs).[15] Amongst this group training and opportunities for further study were consistently ranked as either the first or second most important motivating factor for staff. On-going training (or CME) has also been shown to be key to maintaining good care and has been identified as a priority in many countries.[16] Therefore investment in effective in-service training and CPD would have the double benefit of increasing staffing (through better attraction and retention) and improving quality of services particularly in rural areas where the government finds it particularly difficult to fill posts.

SUMMARY OF ACTIVITIES

The Training Assessment and Strategy Development took place over a three week period from the 18th July to 05th August 2011 in Nepal.

The assessment comprised key informant interviews (KIIs), a 3-day visit to the field, an extensive literature review and stakeholders meeting to obtain feedback on initial findings. Meetings and visits were conducted in Kathmandu and in one region outside of the Kathmandu valley namely Western Region.

In Kathmandu visits were made to training institutions such as National Health Training Centre (NHTC); Nepal Administrative Staff College; government departments and divisions, eg HR and Child Health; NGOS; UN agencies; and nursing and health professional councils. In Western region visits were made to Lumle, Naudada, Parbat and Pokhara. These included visits to a government and private training college, the Regional Health Training Centre and a Training Health Post, the District Health Offices and the Regional Hospital.[17]

A short interview guide was developed to gather information during key informant interviews (KIIs). Interviews were conducted with a total of 55 respondents. These included interviews with: the Director of NHTC; Joint and Under Secretaries of Personnel Administration, HR and Financial Management; the UNFPA Country Representative; heads of large NGOs; and training institutes focussed on training for the health workforce in Nepal.[18]

Limitations

- Necessary limits to participation in the assessment could potentially result in similarly limited ownership of results and recommendations.
- Fieldwork was limited to one region (Western region) with visits to only 3 districts within this region.
- Quality of some documentation was deficient which makes supporting of anecdotal evidence challenging and makes estimates difficult to determine.

Despite the limitations of fieldwork many of the findings have been supported by other studies/work and these have been referenced throughout the report.

[15] Riitta-Liisa Kolehmainen-Aitken and Prof. Ishwar Bahadur Shrestha. January 2009. Human Resource Strategy Options for Safe Delivery. Ministry of Health and Population.
[16] Peck, C. et al. 2000. Continuing medical education and continuing professional development: international comparisons, British medical Journal, 320, pp432-435
[17] See Annex 2: List of Interviewees
[18] See Annex 2: List of Interviewees

FINDINGS AND ANALYSIS

SECTION 1: REVIEW OF EXISTING AND PROPOSED PLANS FOR TRAINING AND DEVELOPMENT

Two dimensions of in-service training were considered:

1. Review of existing and proposed plans for in-service training
2. The relevance of this for the MoHP, staff and ultimately their clients

In addition, we considered:

3. How this training was planned and coordinated.

1.1 Types of training and training plans

In-service training for MoHP and DoHS takes place through a variety of short and longer term programmes. Training takes place both in and out-of-country. Accurate and up-to-date data on the numbers and types of staff receiving in-service training across the health workforce was not available and we understand is not routinely recorded, for example in individual HR files.[19] Broad data for total numbers trained through NHTC is available through Annual Reports and is provided below (see Table 2).

A more detailed breakdown of numbers, types and gender of staff trained was requested from NHTC but not provided.[20] The lack of availability of complete and accurate data has been highlighted as a constraint in other reports[21] and has been a challenge while gathering evidence to support findings of this report.

[19] The exact figures were requested from HR and NHTC but data was not provided. HR did respond and we understand that HR records, for example, are incomplete and do not routinely record the in-service training which an employee has received. Information on in-country and out-of-country training is also held in two separate divisions: Human Resources and Financial Management Division and the Policy, Planning and International Cooperation Division. The total figure for out of country training is understood to be incomplete. The reasons provided by MoHP was that a great deal of this training is funded through scholarships/ other funding from donors not MoHP funds and training is not recorded in individual HR files. There was no response from NHTC on numbers of staff trained and in-service training courses run through NHTC but some figures for planned and actual training were obtained from the Department Of Health Services. 2011. Annual Report 2066/67 (2009/ 2010).

[20] A complete list of planned and actual numbers trained was requested from NHTC. See Annex 6 for the information requested and which should be completed as part of the next steps.

[21] Riitta-Liisa Kolehmainen-Aitken and Prof. Ishwar Bahadur Shrestha. January 2009. Human Resource Strategy Opitons for Safe Delivery. Ministry Of Health and Population.

TABLE 2: CENTRAL-LEVEL TRAINING ACTIVITIES ANNUAL TARGET AND ACHIEVEMENT FOR FY 2066/67 (2009/2010)

Programme Component/Activities	Unit	Annual		
		Target	Achievement	(%) Achieved
Trainers capacity building activities e.g. Training of trainers	Person	300	182	61
Training on Reproductive health services (SBA)	Person	835	787	94
SAS Training Doctors, Nurses	Person	230	201	91
Family Planning Training	Person	300	298	99
Minimum Initial service package (MISP/ RH)	Person	20	20	100
OTT Management Training				
OT T Management/ AA/ CTS	Person	46	34	74
Medical/Nursing care Management Training e.g. ICU/ CCU Nursing Care Management training for MO/NS	Person	76	76	100
Infection Prevention Training Training to service providers	Person	400	360	90
Bio Medical Equipment Training	Person	32	52	100
ASRH Training	Person	100	57	57
Behaviour change communication training	Person	40	40	100
COPE/PLA training for HF Staff /HFOMC members	Person	60	66	100
FCHV Training ,TOT for District programme Assistants	Person	20	12	60
Training Information Management System (TIMS) package development	Person	20	20	100
Gender Based Violence and Conflict Management Training (GBV) training	Person	100	84	84
Logistics training for store keepers of HFs	Person	280	37	13
Monitoring/ supervision Training monitoring/ supervision by Training officers	Times	300	300	100
Annual Training Programme review planning workshop	Times	300	300	100
Total		3159	2626	83

Source: Data extracted from MoHP. Budget Analysis 2010/2011. MoHP. January 2011. Final Draft

Training also took place at district level which was provided through NHTC but held at local District Training Facilities. These are listed in Table 3 below.

TABLE 3: TRAINING ACHIEVEMENT, DISTRICT LEVEL 2066/67 (2009/2010)

SN	Programme Component/Activities	Unit	Annual		
			Target	Achievement	% Achieved
1 FCHV Training Programme					
1.1	TOT for District Assistants /In-charges	Person	30	30	100
1.2	FCHV kit bag procurement	Bag	8845	4645	53
1.3	Mothers Group Orientation	Person	4,855	3912	81
1.4	Basic Training	Person	4855	3990	82
2 PHC /Out Reach Training					
2.1	Training for district assistant/ Facility In-charges	Person	3810	2911	76
3 Adolescent Sexual Reproductive Health (ASRH) Training					
3.1	ASRH training to district assistants / HF In charges	Person	1100	1086	99
4. Gender and Health					
4.1	Training for Service Providers	Person	250	191	76
5	AAT Training	Person	16	4	25
Total			14916	12124	82

Source: Data extracted from MoHP. Budget Analysis 2010/2011. MoHP. January 2011. Final Draft

NHTC (including regional training sites) and district level training centres performed well against targets set for the year 2009/2010. They achieved 83% and 82% of targets respectively. From these basic figures, extracted from the Annual Report, a total 2626 staff received training at the regional and national level. This represents 12% of the workforce (as per the figure for total workforce in Table 1). The data has been adapted slightly from the Annual Report to try to capture in-service training interventions since that is the focus of this assessment. We would assume that, for training at the national and regional levels, a large part of this would be off-site.

In order to assist future planning it would be useful to capture this type of information.

It is not easy to determine the total expenditure on training since training is conducted within individual divisions as well as under more obvious stand-alone programmes such as the NHTC.

The budget for training provided through NHTC at district level is presented in Table 4. The data was sourced from budget analysis papers produced by MoHP[22]. In these, training conducted by NHTC and the regional training centres is described as the National Health Training Programme (NHTP); training provided through NHTC at district level is described as the National Training Programme (NTP). The budget is given directly to the districts to control and allocate.

Table 4 presents the budget and actual expenditure for these two programmes during 2009/2010 (178.6 million Nepali Rupees (NRs)) and the total planned budget for 2010/2011

[22] Summary of data from: MoHP 2011. Budget Analysis 2010/ 2011 MoHP January 2011 Final Draft.

(210.5 million NRs). For both NHTC and the NTP actual expenditure was less than the budget allocated in 2009/ 2010. The reason for underspend in some cases may have been due to late release of funds[23]. The NHTC underspent by 33.8%, whilst the NTP underspent by 24.9%. The NHTP budget was reduced by 14% for 2010/ 2011, whilst that for the NTP has been reduced by 31%.

TABLE 4: TRAINING PROGRAMMES WITH BUDGET IN NRS (MILLION) FINANCIAL YEAR 2010/ 2011

Programme	Budget 2009/ 2010	Actual Expenditure 2009/ 2010	% Underspent	Budget 2010/ 2011
National Health Training Programme (including NHTC and regional training sites)	180.0	119.1	33.8%	155.5
	(2.4)	(1.6)		(2.1)
National Training Programme	79.2	59.5	24.9%	55.0
(includes training programme activities at district level)	(1.1)	(0.8)		(0.7)
Total	**259.2**	**178.6**	**31.1%**	**210.5**
	(3.5)	**(2.4)**		**(2.8)**

Source: Summary of data from: MoHP 2011. Budget Analysis 2010/ 2011 MoHP January 2011 Final Draft. Exchange rate used 1 USD = 71.5715 Nepalese Rupee[24]
[a]USD (Million) equivalent shown in brackets

A list of proposed training courses for NHTC for 2010/2011 are shown on the page opposite, these comprise of mostly clinical trainings but there are some more general topics. Most of the training is provided as a mix of class-based and practical clinical sessions. All training courses are provided for Ministry staff but some private sector providers are also trained.

[23] Department Of Health Services. 2011. Annual Report 2066/ 67 (2009/ 2010).
[24] http://www.oanda.com/currency/converter/. Accessed 15th August 2011

TABLE 5: TYPE OF TRAINING PLANNED AND PROPOSED 2010/11

Integrated Training Action Plan for 2011-2012 (2068/69)	
Type of training	**No to be Trained**
Anesthesia	30
Specialized MLP	30
Biomedical Equipment Technician	32
Postabortion Care. *On-the-Job-Training*	50
Ultrasound training	58
Biomedical Equipment Assistant Technician	77
Clinical Training Skills	172
Mid-level Practicum (MLP)	260
Comprehensive Abortion Care	400
Family Planning	1430
Skilled Birth Attendant (SBA)	1699
Total Clinical Training	4238
Other General training: Comprehensive Family Planning (COFP)/ RH Counseling (orientation to trainers) Basic Health Logistics Training Distance Learning approach (Based on CD-ROM) MCHW/ VHW basic logistics District Level Procurement District Level BHLT MCHW to ANM upgrading training (this is the last year this is continued) Basic ANM and Sr. ANM training (this is the last year this is continued) Management of Mental Health training Medico Legal training Health Facility Operation Management Committee (HFOMC) Intensive Care Unit (ICU)/ Critical Care Unit (CCU) Management Emergency service management training (District Hospital) Infection prevention (IP) (for service providers of Health Posts / hospital Operation theatre training (for nurses) Sr. AHW (180 days) COPE PA. LA. for SP (7 dist) Community mobilization training for Behavior change to District supervisors International Training Conduction TOT for: COFP/Counseling Training; Hospital and HF management Training (Central and regional level); Information and Technology; FCHV (District); IP; TOT: Basic for District level trainers; for RH service during emergency situation and FCHV GBV RHTC trainers (5 RHTCs) Medical Abortion	4062
Grand Total	**8300**

Source: NHSSP August 2011

Training courses are developed by NHTC or, more usually, by NHTC with one or more partners. These partners include: DFID/ NHSSP, Nick Simons Institute (NSI), USAID Nepal Family Health Programme II or the Family Planning Association Nepal. A summary of some of the key organisations involved in health related training activities with relevance for in-service training and CPD is provided in Annex 7.[25]

1.2 Strategic fit or relevance of training for MoHP staff and service users

Our findings indicate that there is not always a good fit between the training provided and the needs of the health sector with much of the training being 'supply driven rather than responding to needs'. Some topics such as management and HR are largely overlooked. Evidence to support this includes:

- Research conducted by NSI which focussed on Mid-Level Healthcare Workers (MLHWs) and found 'performance gaps' of between 1.28 - 31.75% in both clinical and management skills.[26] A total of 93.9% of MLHWs reported that management and administration formed a large part of their job yet they scored well below average for these skills (mean score 45.68%). Similarly for clinical skills respondents said that 'they were expected to treat disease', but did not have adequate exposure to this in either pre-service or in-service training (skills gaps for clinical skills ranged from 1.28 - 31.75%).

Further evidence to support the claim that much of the in-service training is supply-driven and lacks responsiveness to training needs came from interviews with several senior government staff.

- One senior government respondent said 'we are delivering courses based on previous years' experiences. NHTC provided this training last year so it continues to provide the same programme this year'. NHTC themselves recognise the need for more detailed training needs assessment but say that they lack the resources and capacity to conduct these.

Perhaps this repetition of previous years training is also linked to the need to be more innovative in training responses.

- There was also a view that training is developed centrally, with staff at regional and district levels reporting a lack of control over the type of training which could be provided locally. This lack of bottom-up approach to training has been taken into account in the recommendations provided at the end of this section and in the model framework for training described in Section 5.

> 'training is designed centrally and passed to' local levels for implementation.
>
> *One respondent from the district*

- The lack of management and administration skills highlighted in the NSI study reflect our finding from KIIs, who reported that key topics are overlooked, including: management, HR, finance, data management and analysis, planned preventative maintenance,

[25] This list is by no means comprehensive but is designed to highlight some of the key players. This can be used as a starting point in the next steps to build a more comprehensive list

[26] NSI. August 2007. Measuring the Quality of Rural Based Government Mid-Level Health Care Workers. A clinical Skills Assessment.

procurement, M&E, leadership and team working. Hospital management and the need for in-service training in this area were mentioned more specifically.[27] In future, a specific cadre of management staff can be trained and developed to undertake hospital management. These staff can include clinical and non-clinical staff.

The gaps in these general management and administrative topics may be linked to previous vertical programming approaches which focussed on specific disease areas such as TB, IMCI or HIV/ AIDS. With disease specific training it is easy to see how more general topics such as management, procurement or HR, could be missed.

1.3 Planning a coordinated approach to training

In addition to the requirement for a good strategic fit between training provided and training needs, there was a view that a more coordinated and strategic approach to training was required. There was a consensus that training was uncoordinated and in some cases a 'silo activity' which was described as taking place without consideration of other issues such as equipment available to trainees once training was complete. There was evidence of lack of planning and coordination. These included reports of:

- Trainees being trained and then lacking the equipment or decision making power to use skills within their place of work.
- Instances where trainees had received the same training twice.

This uncoordinated approach has significant opportunity costs in taking staff away from their workplaces (if training is off-site) and the subsequent disruption to services. There are also financial implications with inefficient use of funds when staff are trained but are unable to utilise the skills gained to change practices due to lack of equipment, power or level of decision making within their place of work.

Some respondents suggested that the uncoordinated approach may be due in part to donors 'driving their own agendas' for training and providing resources accordingly. This may make coordination of training challenging. A National Training Coordination Committee as described in NHSSP-2 will provide the ideal forum for having open and transparent discussions about such challenges and deciding as a group on strategies to respond to these within the framework of a Training Strategy and Plan. These elements are described in more detail at the end of the section.

Despite these challenges there are examples that demonstrate that assessment and planning and coordination of training do in fact sometimes take place.

Examples of good practice in the use of needs assessment, coordination and planning of training

- Through NHSSP the Integrated Management of Childhood Illness (IMCI) Section of the Child Health Division (CHD) carried out a self-assessment of its institutional capacity, and used these results to shape Annual Work Plan and Budget (AWPB) and NHSSP work plans.
- The IMCI Section's planning process was streamlined to focus refresher training on poorly performing districts in the coming year[28].
- Needs analysis also identified gaps in anaesthesia skills, especially for Comprehensive Emergency Obstetric Care sites. This led to the development of Anaesthesia Assistant

[27] NSI have conducted research in the area of hospital management. The results of this work are due for release late 2011 and should be considered as part of the strategy development and planning process
[28] NHSSP Quarterly report to DFID. January-March 2011

training which is to be launched at the National Academy of Medical Sciences (NAMS) this year.

- A NHTC Training Working Group has been established to plan training activities at NHTC. This group comprises partners such as NHSSP advisors, Nepal Family Health Programme and NSI.
- The Ministry of General Administration is currently collating training requirements from across government, including the MoHP, under the 'Training for All' initiative. Each Ministry has been asked to collate their own list of training requirements. It is unclear who will make the strategic decision on which training will go ahead.

Recommendations

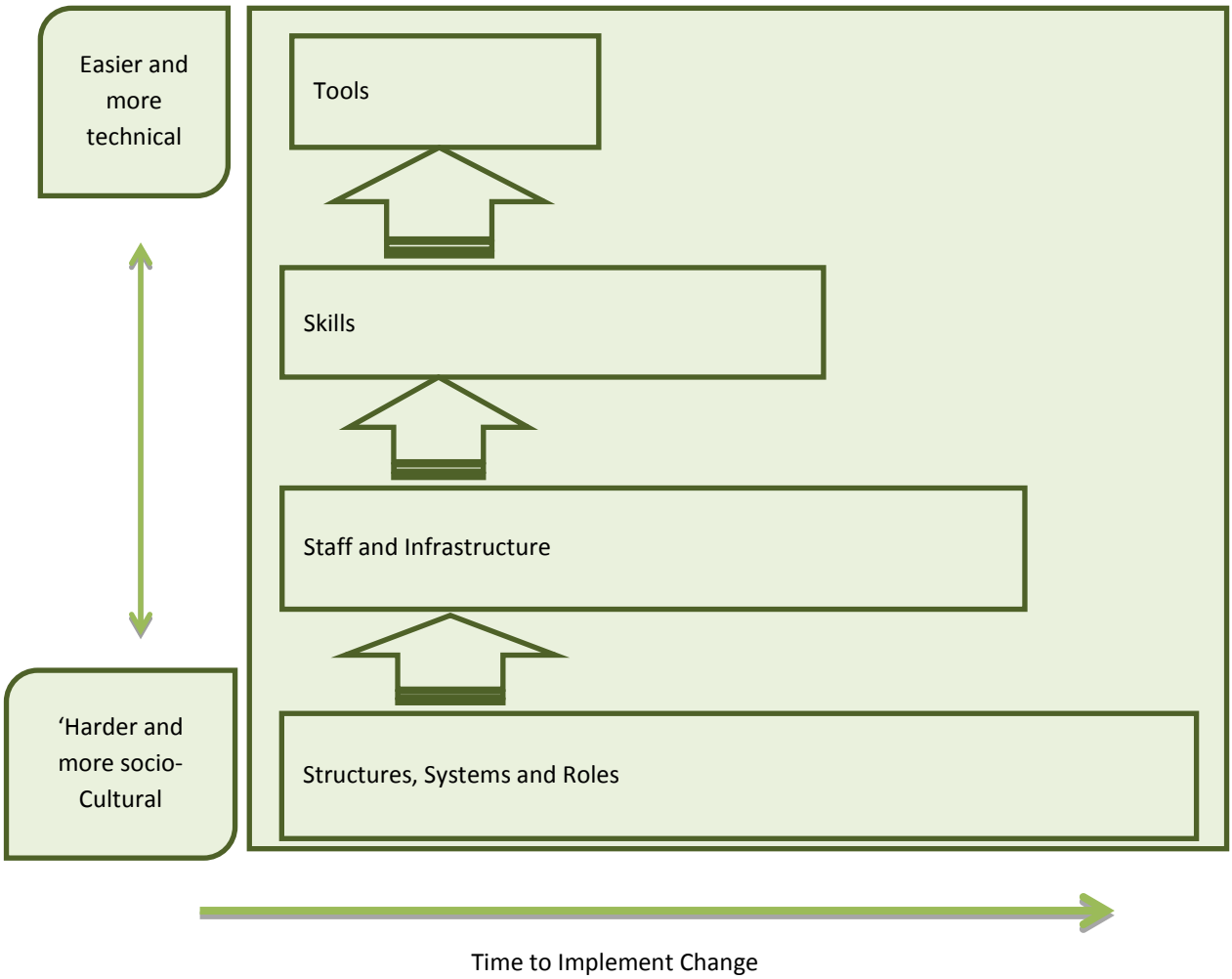
In the coming years focus has to be directed at developing a more **coordinated and systematic approach** to training and CPD.

This approach relies on developing systems and structural capacity for training and CPD at a number of levels, not just delivering training courses. Figure 1 helps illustrate this systematic approach[29]. The design of NHSSP has been based around this model.

Figure 1 provides a more comprehensive, sustainable and robust way to considering in-service training and CPD. Much of the emphasis to date has been focussed around 'easier and more technical areas' i.e. delivering training courses (see Skills level in Figure 1). The emphasis now needs to shift to some of the other levels for example structures, system and roles (see the first level at the bottom of Figure 1) to ensure a coordinated, well planned approach to providing needs-based in-service training and CPD.

[29] Potter C, and Brough R. 2004. Systematic Capacity Building: A Hierarchy of Needs. Health Policy and Planning 19(5): 336-345

FIGURE 1: COMPLEXITY / TIME DIMENSION OF CAPACITY BUILDING[30]



In practice this means developing training strategy and systems that can provide a coordinated approach.

Respondents believed that the MoHP needs to take a lead role in shaping a clear strategy for training. Developing a training strategy will allow a more comprehensive approach to training to be developed; one which is needs based and builds on good practices to develop innovative training solutions for the health workforce.

Key recommendations

- **Establish a National Health Training Coordination Committee** chaired by the Secretary as proposed in NHSP 2.

The **National Health Training Coordination Committee** will provide coordination at the national level. As set out in NHSP-2 this committee will be led by the Secretary and include members such as Division directors, Centre chiefs, and representatives from the National

[30] adapted from Potter C, and Brough R. 2004. Systematic Capacity Building: A Hierarchy of Needs. Health Policy and Planning 19(5): 336-345

Administrative staff college, Local Development Training Academy, central-level hospitals, private-sector training institutions, CTEVT, Ministry of Education affiliated training institutes and with the NHTC Director as member secretary.

- **Develop the role of Learning Coordinator** to link at regional and district levels to partners across the sector to develop a bottom-up approach to training and CPD which is firmly rooted at the local level, delivers based on local needs and is delivered in the main by local practitioners. At the same time these coordinators will be supported by central CPD leadership provided through the **National Health Training Coordination Committee**.

There are existing staff at regional and district levels who either undertake some of the activities of a Learning Coordinator or could potentially undertake these activities e.g. Safe Motherhood Regional Coordinators, district public health nurses, regional training directors (where these are in post), or the Health Education Supervisor[31] . As part of training plans a job description with agreed roles and responsibilities needs to be created and discussion on who might undertake these roles at each level. In the short-term the NHSSP regional specialists could also play a role in supporting linking and partnership across the sector.

Family Health programme are piloting an initiative to improve in-service training through the use of 'training cells' at district level. Two districts have been selected: Rolpa and Siraha. District Training Coordination Groups will be developed and will include focal persons for topics/areas such as IMCI and laboratory systems amongst others. The aim is to provide a mechanism which supports training more locally. There may be scope for this model to be used as the basis for local level coordination. There should be further discussion and agreement on approaches as part of the next steps and a commitment from government to scale-up these models nationwide.

New NGO arrangements which have just begun to emerge through a consortium of NGOs, including British Nepal Medical Trust (BNMT), Merlin and Save the Children, will also create excellent opportunities for partnership. These EC funded consortia are looking at NGO partnering in HR to support strengthening of the health workforce. They want to do this through working to up-skill and increase professional arrangements as part of a sector–wide approach, working at a local level and trying to implement this across the sector. The group have met twice with the MoHP which is leading this initiative for the Ministry and NHTC. Linking through these types of initiatives will further ensure more coordinated approaches to in-service training and CPD.

[31] Department Of Health Services. 2011. Annual Report 2066/ 67 (2009/ 2010). Recommendation for Health Education Supervisors described in Chapter 6a, P236

SECTION 2: REVIEW OF CURRENT APPROACHES FOR TRAINING AND DEVELOPMENT

The review of current approaches to training and development also included identification of the potential for improved approaches and methods for delivering appropriate CPD.

Several aspects of current approaches were examined: teaching and learning approaches used for in-service training and CPD; use of new information and communication technologies (ICT) in delivering training and CPD; follow-up and on-going support; inclusion of GESI principles in training materials; improving the perceived value of training; selection of candidates for training.

2.1 Teaching and learning approaches used for in-service training and CPD

Our findings suggested that a number of trainings focussed on class-based learning with 'theory but not the practical skills which staff can use'.

Yet we know that these didactic off-site approaches and one-off interventions have a poor track record for changing the actual practice[32] of health workforces. Research in Nepal has called for more practical in-service training to address skills gaps.[33]

> '**If performance change is the goal, exclusively didactic approaches, conferences and activities without any practice have little or no role to play**'
>
> **WHO Working Together for Health.**
>
> **World Health Report 2006**

There was a consensus view that a good deal of training is focussed on 'one-off' interventions, provided off-site. These training approaches have significant opportunity costs in taking staff away from their workplaces and the subsequent disruption to services. In fact several interviewees believed that this type of training was one of the biggest causes of absenteeism in the health sector in Nepal.

However, there are examples of good practice in training approaches being used in Nepal:

For example:

- Structured on the job training (OJT) for Postabortion Care (PAC) developed by the NHTC. The PAC OJT was first introduced in Nepal in 2002/2003 by the NHTC and the USAID funded Nepal Family Health Programme (NFHP) with technical support from JHPIEGO. The approach was introduced in an effort to scale-up and decentralize training. It has been used to train doctors, nurses and senior ANMs as skilled PAC service providers .The programme combines both individual and group learning based at the trainees place of work. The programme is supported by reference manuals, assessment tools audio-visual aids and implementation guidelines

[32] WHO. 2006. Working Together for Health. World Health Report

[33] NSI. August 2007. Measuring the Quality of Rural Based Government Mid-Level Health Care Workers. A clinical Skills Assessment.

- NSI training for MLHWs. In response to previous research[34] NSI designed, developed and piloted a Mid-Level Practicum (MLP) course.[35] The MLP is a three month clinical refresher for MLHWs which emphasises clinical decision making and practical exposure. They found that mid-levels were better able to diagnose illness, perform medical procedures, and manage their workplace after training[36]. The MoHP has adopted MLP as a national course for all Auxiliary Health Workers.
- Patan Academy of Health Sciences (PAHS) Problem Based Learning (PBL) approaches. Although Patan focuses on pre-service training its choice of problem-based learning approaches using case studies to teach students in its MBBS course is worthy of note. As it prepared its own curriculum, Patan called on international hosting workshops to support curriculum development and training in Problem Based Learning (PBL). This knowledge and experience of this type of approach is a resource which could be tapped for in-service training and CPD.

2.2 Use of new information and communication technologies

It is important when reviewing approaches to training provision to consider their relevance within the context of Nepal. Approaches such as distance education which rely on the availability and access to computers and internet can be used. There are current plans to make computers available at the district level. However, anecdotal evidence gathered during the assessment suggested that computers often 'sit in boxes and people don't know how to use them or so long since their training have forgotten how to use them'.

A needs assessment for CME provides some evidence of the availability of computers and internet access amongst doctors in Nepal as a means of supporting a CD-Rom based CME programme.[37] The study showed that almost 70% had access to a computer and half of the doctors interviewed had access to the internet. As a result of this research the NSI has launched a programme of CME on an interactive CD Rom format for doctors in Nepal. Although their target audience did have access to a computer some of these computers did not have a CD-ROM facility.

This research illustrates the need for more assessment to consider the most appropriate options for delivering training to staff across the workforce in Nepal. Other options for distance learning, including the use of radio, were suggested at the feedback meeting with key stakeholders.

Patan hospital works with government on the telemedicine programme currently operating between 27 sites and soon to be expanded to 57. They have indicated that this service has capacity to be used as part of training opportunities.

These and other options will need to be considered during the development of the training strategy and plans.

2.3 Follow-up and on-going support

There were reports of limited follow-up or continuing support for trainees. In a study conducted by NSI on skills assessment for MLHWs the study reported a lack of 'support' and

[34] NSI. August 2007. Measuring the Quality of Rural Based Government Mid-Level Health Care Workers. A clinical Skills Assessment
[35] NSI. 2009. Mid-Level Practicum. Pilot Course 2009.
[36] NSI. 2009. Mid-Level Practicum. Pilot Course 2009.
[37] Butterworth K., Zimmerman, M, Hayes, S, Knoble, S. 2010. Needs Assessment for Continuing Medical Education Amongst Doctors Working in Rural Nepal. Volume. 4 No. 1.

this was evident even from the outset with 'no orientation on job responsibilities' for some staff. This research supports the views of several respondents. This lack of support has led to the design and development of programmes such as the follow-up programme for MLHW (see below for details of good practice).

Examples of good practice in follow-up of training

- Safe Motherhood (SM) regional coordinators have been contracted by Family Health Division. These coordinators are key for improving the quality of the programmes through their supervisory, supportive and information-gathering activities.
- Merlin has developed follow-up training for disaster management which involves putting into practice systems and plans through simulated practical exercises.
- NSI have developed a MLP training and follow-up and enhancement programme (FEP). The follow-up programme evaluates the MLP participants skills and provides support and coaching as an extension to the MLP course. It takes place at the participants place of work. It also provides feedback to the immediate supervisor, the district hospital and other key government stakeholders.
- The network of 50,000 unpaid female community health volunteers is acknowledged to work effectively and to be well supervised and supported.

Lessons learned from these approaches can be adapted and used to shape other training and effective approaches scaled-up nationwide in future.

2.4 Inclusion of GESI principles in training materials

At the same time as learning approaches are considered there should also be an alignment check of all materials to ensure that they are in line with Gender Equality and Social Inclusion (GESI) Principles. As far as we could ascertain no GESI analysis of materials has been carried out. This is included in NHSSP workplans for the GESI advisors. In August this year one of the Secretaries at MoHP[38] leant her support to this task by asking the head of NHTC to review all curricula from a GESI/ GBV perspective and wherever possible incorporate these. NHSSP GESI advisors plan to undertake this process with a core team in NHTC so that we can jointly review and identify how GESI can be practically mainstreamed. No date has been agreed to start this process.

The review of materials and inclusion of GESI principles will be important in training a health workforce that can deliver gender-sensitive and socially inclusive services.

As part of the improvement process for training materials a core team could be trained as Master trainers on GESI to help ensure that GESI principles are incorporated in training materials.

2.5 Improving the perceived value of training

Currently, training is not always valued as a commodity and until it is seen as having value it may not be having an impact. For example, incentives including allowances for travel and daily living allowances are currently linked with training. These allowances, rather than patient centred care, often seem to be one of the main drivers for attendance at training. In some cases staff can make savings from these allowances so, in effect, one could say they are 'paid' to undertake training.

> Overcome this incentive culture by 'harnessing staff' who have been on training and are already making a difference. Use them to build a critical mass of staff then others will begin to follow and 'say I need to be on that programme too'.

Effort should be made to continue to improve the quality of training so that staff want to be involved and view training as something of real value. Through implementation of quality training and CPD, the MoHP can begin to develop a cohort of staff who can become advocates, or **'bridge-builders'**, for a new system of training which focuses on quality and consistent delivery of good quality healthcare.

2.6 Selection of candidates for training

The selection of candidates for in-service training does not appear to be needs-based or transparent and this is impacting on the value of training. This was summed up by one respondent who said *'We are asked to select staff for training but somehow the names of candidates who attend training are not those we selected'.* There was also a perception that while 'some staff seem to be continually on training' other staff received no training.

The selection process currently detracts from the value of training and needs to be more transparent in future.

The Ministry also needs to use selection to address current gaps in trained staff and to use it as an incentive to help address staffing challenges in remote areas. For example in remote areas where posts are often more difficult to fill, the Ministry may want to incentivise these posts by giving priority for training to those from these remote areas.[39]

In future, an affirmative action approach to selection could be used to address inequalities. For example, MoHP may take a strategic decision to prioritise in-service training for future women leaders and senior experienced local staff as part of its training strategy and plans. Training in leadership and management in particular could be prioritised for women and other socially excluded groups. In future, data on those trained should be disaggregated in terms of gender.[40]

Summary of recommendations for improved approaches and methods for delivering CPD identified during the training needs assessment

- **Training approaches[41]:** Training needs to shift from one-off interventions provided off-site to more continuous approaches using: self-directed learning, feedback sessions with mentors, tutors, 'learning buddies[42], learning portfolios[43], total quality management[44]. Distance education approaches can be used including web-based training and access to literature e.g. Health Internet Work Access to Research Initiative, teleconferencing, collaborating workspaces, other web-based groupware. Factors common to all these approaches should include: after training support and follow-up and active learning opportunities based on real-life problems, 'learning by doing'.

[39] Care must be taken to use workplace based training where possible to ensure minimum disruption to services. Training approaches are dealt with in more detail in Section 2

[40] Data could be further disaggregation in terms of other social groupings. This can be agreed and planned as part of the next steps along with other data requirements and included in the training strategy.

[41] Information under this bullet has been collated from a mix of recommendations provided during the training assessment and best practice examples collated in the WHO report, Working Together for Health. World Health Report 2006

[42] 'Learning buddies' – an approach used where staff can be linked to encourage, motivate and support each other usually after more formal training interventions. Through these links staff can continue to gain knowledge and skills and share practical tips on putting their training into practice.

[43] The portfolio approach can provide a tool for collecting and managing multiple types of assessment evidence from multiple contexts and sources to document competence and promote reflective practice skills.

[44] Total quality management (TQM) is a management system for a client focused organization. It involves all employees in continual improvement of all aspects of the organization. TQM uses strategy, data, and effective communication to integrate the quality principles into the culture and activities of the organization. This approach has been used by the Ministry of Health in Uganda since 1994 to drive up the quality of service provision.

- Good quality work-place based placements (both clinical and non-clinical) need to be further developed in line with the need for more on-site training. Local learning coordinators, as recommended above, and district and regional training committees can be used to develop these opportunities with individual departments.

SECTION 3: ASSESSMENT OF INSTITUTIONAL CAPACITY, CONTRACTING MECHANISMS AND DEVELOPMENT REQUIREMENTS

A rapid assessment was made of institutional capacity of current MoHP and private providers of training and development activities and the effectiveness of the current contracting mechanisms to enable greater use of the private sector. The assessment was made specifically in relation to in-service training or CPD.

3.1.1 Institutional capacity

There are many training suppliers who provide a variety of training at different levels for Health and Health related Professionals in Nepal. The lack of a systematic database which records training provider details makes an inclusive assessment challenging. However, during this assessment we believe we have included some of the main stakeholders involved directly in providing in-service training services or who support in-service or CPD initiatives (See Annex 7[45]). One exception to this was The Council for Technical Education and Vocational Training (CTEVT) which we were unable to contact due to on-going industrial action. Nevertheless we have used available literature to provide some insight into the work of CTEVT.

In recent years there has been a rapid increase in the number of training institutions in Nepal. In 1978 there was one medical institute and this remained Nepal's only medical college until the 1990s. Today there are 13 medical colleges and the private sector trains over 90% of the doctors in Nepal. In addition, there are 103 Proficiency Certificate Level (PCL), 19 Bachelor of Nursing (BN), 25 Bachelor of Science (BSc) and 48 Auxiliary Nurse Midwife training colleges for nurses and MLHWs. However, in most cases the proliferation of the private training institutions has been in the larger towns and cities and not rural areas where the need is greatest.

Currently, the private sector focuses on providing pre-service training while in-service training is provided by government training centres and INGOs/NGOs with some private contractors. In future more private institutions could potentially be used to provide in-service training or CPD. Robust accreditation and regulation systems would need to be developed in line with this expansion. Accreditation is dealt with in more detail in Section 4.

Health-related in-service training is currently largely provided through NHTC. This is described in more detail below. We understand that some in-service training is also provided by CTEVT. The Staff Training College and Personnel Training Academy also provide some training services to the health workforce.

Since most health related training is organised by NHTC and delivered through the network of health training sites, more consideration in this section is given to the NHTC and training provided through its network of training centres and sites in the region.

Additional findings and comments related to the quality of in-service training provision and contracting are also provided under the heading General Findings.

3.1.2 National Health Training Centre (NHTC)

The National Health Training Centre (NHTC), under the MoHP and Department of Health Services in Kathmandu, is part of a network of government training facilities. The network

[45]Annex 7: Summary of Organisations Involved in In-service training and CPD In Nepal

comprises a total of five regional training centres, one sub-regional level centre thirty district level training facilities and 14 training health posts. Other facilities such as the Regional TB Training Centre in Pokhara and clinical training sites for family planning and safe motherhood are also used to deliver NHTC training. In terms of organisational structure, management and reporting, the regional centres link and report both to the NHTC and Regional Director of Health. The other district level facilities and posts are managed at district level. The director of NHTC in Kathmandu is the same rank as the Joint Secretaries responsible for HRH in the MoHP, therefore neither of the joint secretaries is in a position to set the agenda for NHTC.

The NHTC in Kathmandu has a total of 32 posts (31 of these are filled) and there are three or four staff who are said to have curriculum development skills and experience. At the regional level there is only one centre where the post of training director/chief is filled. Most trainers at this level are staff nurses or Health Assistants.

A strategic plan was developed for NHTC in 2004, with technical and financial support from UNFPA, which now needs to be up-dated. There is a National Health Training Centre Training Working Group comprising NHTC representatives, INGOs and NHSSP staff amongst others. This group is currently involved in annual work planning and budgeting with NHTC. In future there should be links between the more strategically focussed broader National Health Training Coordination Committee and the NHTC working group for example to share best practice.

Training run through NHTC is accredited by NHTC. Training is provided for government staff and some private sector providers. NHTC also provided training in 2009/ 2010 for two batches of district level managers from south and south East Asia countries.[46] This was provided at the regional training centre in Pokhara. NHTC is also responsible for accrediting institutions offering short non clinical competency based training. As part of the next steps this process of accreditation should be reviewed to determine its efficiency and effectiveness. In future, in line with driving up the quality of training consideration should be given to separating the two functions of NHTC as training provider and accrediting body. Courses could be accredited in future by a separate body or group of bodies for example the professional councils. An organisation for accreditation of courses for non-clinical staff would also need to be considered as part of the next steps.

3.1.3 Child Health Division of the Department of Health Services

The Child Health Division have opted to contract training services directly rather than running their training through the NHTC. They have developed a pool of trainers from across the sectors and have established a set of contracting procedures endorsed by the Director General of the DoHS. One of the reasons the CHD gives for contracting its own training rather than contracting through NHTC is that by contracting directly they believe they have more influence over the quality of training provided.

As part of the next steps the MoHP may wish to consider the effectiveness of this model to provide training for staff across the health sector (See Summary Recommendations at the end of this Section). If this were to be implemented there would be a need for a set of quality standards and contracting guidelines which would set basic standards for quality of training provided across the health sector.

[46]Department Of Health Services. 2011. Annual Report 2066/ 67 (2009/ 2010).

3.1.4 Council for Technical Education and Vocational Training (CTEVT)

The Council for Technical Education and Vocational Training develop policy and coordinates training for basic and MLHWs. It is a national autonomous body and accredits institutes to provide training mostly at pre-service level but also some in-service training. There are 125 CTEVT affiliated and managed mid-level healthcare training institutes in Nepal[47].

Research designed to assess pre-service training accredited by CTVET found that 'that the weakest aspects lay in central quality control and in the clinical experience that students are provided'. The study concluded an 'overhaul' of the training system was required to ensure that health-care providers were not 'under-qualified' for providing health services. Although this study assessed pre-service training the findings support anecdotal evidence gathered during this assessment on in-service training.

3.2 General findings and comments on institutional capacity, effectiveness of current contracting mechanisms and development requirements

This section provides a series of general findings which could not be linked to one particular training institute but were provided as general observations on the level and standard of training in Nepal but which have implications for in-service training and CPD.

- The quality of trainers is variable. In general staff involved in training at a range of government institutes which provide in-service training believed that there was a need for staff who had more general training and education experience. This has been supported by other research and reports.[48]

During the recent consultation on the HRH strategic plan the issue of the lack of capacity to deliver quality education and training was expressed[49]: There was a concern that those involved in providing education lacked necessary training and skills to deliver quality education.

Although some of these comments may relate to pre-service training provision rather than in-service training they do support findings of our interviews on in-service training provision.

- Basic organisation of data on training is weak. For example there is no record of individual staff training kept on HR files. At the same time more robust evaluation of the impact of training is deficient.
- In a new strategic approach UNICEF is focussing greater efforts on pre-service training to ensure that it prepares the health workforce with the right mix of skills from the outset. Perhaps the necessity for so much post basic training is one of the best indicators of the weakness of training provision in Nepal. One example of this is the need for ANMs to attend SBA training (provided as in-service training) before they can provide effective midwifery services. Although this helps illustrate the shortfalls in training capacity in Nepal it is still recognized that there is always a need for in-service training so that staff remain up-to-date with new and emerging diseases, technologies and improved approaches.

[47] Nick Simons Institute (NSI). 2006. A focussed study of CTEVT Mid-level pre-service health Training Programmes in Nepal.
[48] NSI. August 2007. Measuring the Quality of Rural Based Government Mid-Level Health Care Workers. A clinical Skills Assessment and MoHP. 2010. Report of the HRH consultative workshop – Country Coordination and Facilitation: 10th-11th November, 2010 – Kathmandu
[49] MoHP. 2010. Draft Report of HRH Consultation Nepal. Nov 2010

- The Logistics Management Division handles contracts on behalf of the MoHP. However, there are no current guidelines for contracting services such as training. These will need to be developed as part of the new strategic plan.

Summary of recommendations for institutional development requirements

In light of these findings and as part of the strategic planning process it may be worth re-vising some of the roles and responsibilities and structure of NHTC and the network of training sites to ensure a good fit with the new training strategy. Areas to consider include:

- The dual role of NHTC as training provider and an organisation who accredits training (Dealt with in more detail in section 4)
- Responding to training strategy and plans. Once the training strategy and plans have been developed it is important for all training providers including NHTC to consider how best to respond to training needs to ensure a good strategic fit. In terms of NHTC (which is currently one of the main providers of in-service training across the sector) this will present a good opportunity to review training requirements and review the organisational structure, roles and responsibilities of NHTC and the network of training centres.

Although not required as part of this review, a few optional models for operating of NHTC have been provided for consideration.

1. The NHCT becomes more like a Technical Support facility/Unit (TSF or TSU) focussing on working with the Logistics Management Division (LMD), matching government requirements with service providers and commissioning training. This would require a small core team at NHTC with skills and experience in education and training combined with some expertise in commissioning and contracting (although this skill set could be provided in the main by LMD)
2. NHTC decides to focus on training which it is best placed to provide and develops a core team of technical staff well-placed to deliver this training. At the same time it could continue to source training for departments from the market which it does not deliver. Alternatively divisions of the DOHS could go themselves to the market to source training providers directly (as is the case currently with the Child Health Division).

These operational options can be considered as part of the strategic planning process:

- The role of NHTC and regional sites as international training centres. Regionally as well as internationally countries are striving to find more work-placed based solutions to training. Therefore the pursuit of the NHTC as an international training site seems out of step with current trends. It may be better to focus resources in the short-term at least on strengthening the training systems in Nepal and learning through good practices. Of course there can be a commitment to sharing these good practices internationally and therefore contributing to the international knowledge pool in that way.

Under a comprehensive training strategy for both pre and in-service training there is an opportunity to map overall standards which are expected for all training for MoHP and DoHS staff and develop contracting procedures for trainers which facilitate this.[50]

[50] Although we recommend a comprehensive training strategy be produced the focus of this report is of course in-service training and CPD and the findings and recommendations unless otherwise stated should always be viewed I this context.

SECTION 4: REVIEW OF CURRENT REGULATORY MECHANISMS AND NEED FOR STRENGTHENING THESE MECHANISMS

A review of current regulatory mechanisms and their ability to ensure quality training and development was undertaken and needs for strengthening the mechanisms identified

Accreditation is an essential mechanism not only for assuring institutional performance but for securing public trust in health professionals and health services. There are a number of regulatory councils in the health sector in Nepal including the Nepal: Nursing, Medical, Health Professional, Ayurvedic and Pharmacy council. These councils are responsible for accreditation and registration of training institutes.

4.1 Review of current regulatory bodies

There are now 20 medical schools registered with the medical council (although not all are functioning). There are approximately 232 institutions registered with the Nepal Nursing council. The Nepal Health Professional Council has more than 100 colleges registered with it. All Health Professionals other than doctors and nurses are eligible to register with the Nepal Health Professional Council.[51]

The Nursing Council have approximately 33,712[52] nurses registered to date and it has a total of 12 staff to oversee training facilities and nurses registered with the Council.

Given the numbers of nurses registered with the Nursing Council and the number of sanctioned and filled posts (Sanctioned posts approximately 6,935 and filled posts 5,307 as shown in Table 1) it is important for government to ask where all of these nurses are working and how they might be attracted to working under MoHP in government health facilities.

TABLE 6: REGISTRATION STATUS OF NURSES WITH NEPAL NURSING COUNCIL TO JULY 11

Cadre	Registration
Nurse	16015
ANM	17027
Foreign Nurse	670
Total	33712

Source: Nepal Nursing Council. July 2011

Nurses are required to re-register with the Council every six years. The Nursing Council are responsible for registration nursing training schools which teach bachelors level nursing and above; CTEVT are responsible for registration of institutions who teach nurses below this level.

4.2 Registration of health professionals and improving quality training

Currently doctors who register with the Medical Council are required to pass a registration exam. Currently there is no similar requirement to pass a national exam to register with the

[51] Requests were made to the council for data regarding number and types of persons registered with the council but consultants were unsuccessful in obtaining this information.
[52] Data provided by Nepal Nursing Council. July 2011

Nursing Council. However, from 2012 the Nursing Council plans to have a national examination which will be a prerequisite for registration with the Council.

Several respondents supported the idea of a national registration exam as a means of improving the quality of pre-service training. It was believed that those schools who consistently produce students who fail the exam will not flourish because students will simply go elsewhere. Support for national registration was also voiced during the feedback session with stakeholders at the end of the assignment. One consequence of improving pre-service training may be a reduction in the amount of in-service training required.

A record of CPD is not currently required by health professionals as a prerequisite for continuing their registration with the professional councils. In line with improving the quality and standards of health services we recommend that this be introduced in a phased approach in the coming years.

4.3 Capacity building of regulatory councils

A number of agencies including WHO, UNFPA and UNICEF have been working to strengthen the professional councils supporting them in their work of accreditation of pre-service training Schools, Universities and colleges, developing guidelines and registration of health and allied health professionals. UNICEF has supported both the medical and nursing council and WHO has supported both the Medical and Health Professional Council. UNFPA has been particularly focussed on supporting the Nursing Council and is keen to continue this support. They have been working in partnership to strengthen the capacity of staff at the Nursing Council. This has included support to attend workshops including:

1. UNFPA/ International Confederation of Midwives (ICM) South Asian Midwifery Strategy Planning Workshop in Dhaka Bangladesh. 2010
2. Training and Accreditation of Skilled Birth Attendants organized by UNFPA's Asia and the Pacific Regional Office (APRO) in Bangkok Thailand. 2010

and

3. An international conference organized by Women Deliver in Washington DC in 2010[53,54]

There have been further discussions more recently between the council and UNFPA on support for developing technical capacity of the Council in line with plans to develop a separate curriculum for a Bachelor in Midwifery in Nepal. If the Bachelor degree programme goes ahead there will great deal of work needed to amend the Nursing Council to Nepal Nursing and Midwifery Council, to create a midwifery board and develop a separate Act for midwifery. However, all of this is currently at the planning stage and very much under discussion with MoHP.

4.4 Effective regulation and transparency

Generally it was felt that there was a lack of effective and transparent regulation and enforcement of standards. Several respondents believed that the Councils were unable to properly regulate the quality of courses for a variety of reasons including: insufficient

[53] Women Deliver is a global advocacy organization bringing together voices from around the world to call for action against maternal death and the theme of the 2010 conference was 'Delivering Solutions for Girls and Women'

[54] UNFPA also provided support to one doctor from Nepal Medical Council to attend the Women Deliver Conference

number of staff, lack of capacity and financial resources, weak governance and lack real autonomy.

In general, inspection visits are compromised by 1) a lack of willingness to be critical of institutions and 2) the false impression given by institutions about learning resources.

Some specific examples which help illustrate the lack or effective and transparent regulation and enforcement of standards include:

- Private colleges/schools paying expenses of individuals undertaking annual site inspection visits, thus jeopardizing the independence of these visits. Lack of financial resources means that Councils are dependent on private schools to pay expenses during these inspection visits.
- One respondent suggested that some council members have their own colleges and '*did not want to be seen to upset other colleges by giving them a poor rating'.*
- During the stakeholders feedback meeting there was a very frank and open discussion about accreditation visits where they explained that:
  '*equipment such as microscopes and other learning resources are displayed for assessors but once these visits are over materials are stored away*'.

Summary recommendations

- A national exam becomes a pre-requisite for registration of all professional councils. There should be a phased approach to the introduction of CPD linked to registration. The phased approach will allow time for training suppliers e.g. NHTC and other colleges to meet training demands of registration and will also allow time to develop the capacity of the Councils to respond to the demands of accrediting training institutes who provide CPD and accrediting these courses. The Councils may wish to maintain registers of health professionals training records. Alternatively the onus could be put on the individual professional to maintain their own individual CPD record with spot checks only from the Councils as part of quality assurance processes

- In future there needs to be a focus on increasing transparency. There may be lessons which can be learned from other countries regionally and internationally for example Sri Lanka and the UK. Currently the UK government has committed £5 million to a programme which involves international partnerships between UK health institutions and countries working in resource constrained environments. There may be an opportunity to use this type of arrangement to support the development of the councils. Other INGO and NGO partners may also be able to tap into their own networks of supporters.

SECTION 5: TRAINING AND CPD MODEL FRAMEWORK

A **model framework** for training and CPD has been developed to address the challenges raised during the training assessment and described in Sections 1-4 of this report. See Figure 2 on the opposite page.

The model framework provides a **comprehensive** approach for addressing training and CPD requirements in a **systematic way and at every level:** District, Regional and National.

It achieves this by focussing on four key elements:

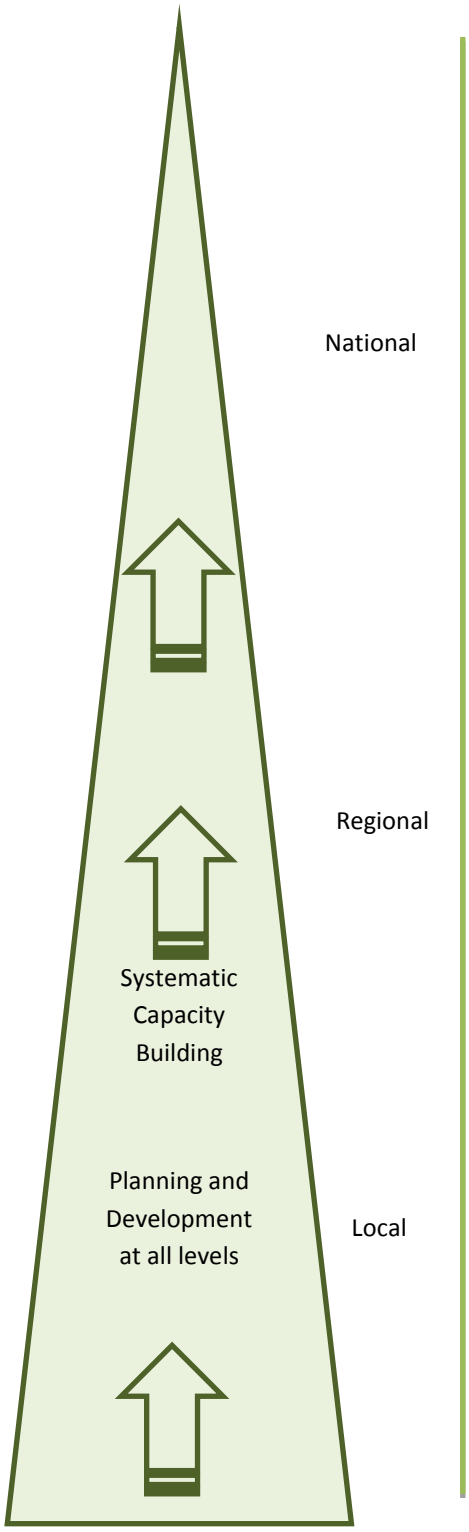
1. A National Health Training Coordination Committee at the central level
2. Coordinating mechanisms replicated at regional and district levels
3. New roles for Learning Coordinators to provide on-going support for training at local levels and help ensure training meets local training needs
4. Partnership working and the interconnectedness of actions at each level.

The model framework has partnership working as integral part of the model at each level and between levels to ensure the flow of information from grass roots upwards to shape policy and planning. The design of the model framework as one continuous block rather than separate individual boxes helps emphasise the interconnectedness of actions at each level. This helps stakeholders plan in a more holistic way.

At each level key recommendations for action are provided for: regulatory bodies, training providers, government and other key stakeholders (these are shown in the boxes on the right hand side of the Model Framework).

It will provide an excellent framework for the development of a training strategy and plans. Work on different levels of the model can be undertaken at the same time, but the detail of the sequencing where required can be further developed within action plans.

FIGURE 2: PLANNING AND DEVELOPMENT OF TRAINING / CPD FOR MOHP AND DOHS STAFF



MoHP and DOHS	Facilitates National Collaboration through National Training Coordination Committee Sets training / CPD standards for work force based on best practice and best value Commissions TA advice and research to inform improvement s Secures and allocates funding at national level Ensures legislative framework in place for regulating healthcare professionals/ or establishes this Establish robust contracting systems
Health profession regulators colleges and faculties	Set standards of professional practice and standards for education
Regional Level Health Offices	Facilitate regional collaboration through regional coordination committees Focus on long-term strategic issues for the region Work in partnership with training and CPD providers to ensure quality and best value which meets local needs Provide robust commissioning system at regional level to commission training
District Level Health offices	Foster collaboration through district coordination committees Focus on short-medium term strategic issues Produce training/ CPD plans that are integrated with financial and service plans Continually focus on driving up quality of health services by ensuring innovative and best practice in health care is including in training e.g. embedding GESI principles in all training while at the same time use best practice training approaches to continually improve the quality of training/CPD
Education/ Training/ CPD providers	Provide high quality education/ training/CPD which meets local needs . Providers should be involved in training committees

Conclusions and Recommendations

Throughout the report we have tried to emphasize where things are working for in-service training as well as highlighting the gaps and challenges.

A model framework for in-service training and CPD has been established to address the weaknesses such as lack of coordination and the need for practical needs based training. The model also allows for strengths and achievement such as good practices to be shared through scaling-up of these activities nationally.

Establishing a Coordinated and systematic approach to training and CPD

A model framework for training and CPD has been set out (see Figure 2 in Section 5). It includes systems and structures to **improve coordination of training at all levels** including establishing a **National Health Training Coordination Group which is already part of the NHSP-2 plans.** Similar health committees at regional and district levels will ensure a coordinated approach at these levels and will provide a forum and structure which encourages **partnership working and emphasises a coordinated approach.** These local coordination committees also **provide a bottom-up approach to training where needs and best practices from the districts and regions help shape training policy and practice**. New **Learning Coordinator** roles will help to coordinate training and CPD at local levels.

Topics for in-service Training

Topics such as management (including hospital management), human resources (HR), data management and analysis, finance, planned preventative maintenance, procurement, M&E, leadership need to be given more emphasis in the training strategy and plans.

Selection Criteria for training

Overall selection criteria need to be needs based and transparent. An affirmative action approach to selection could be used to address inequalities. For example, MoHP could take a strategic decision to prioritise in-service training in leadership and management for women and other socially excluded groups. Selection can also be used to address recruitment challenges for example the shortages of staff in remote areas.

Scaling up of Best practice Models

Examples of best practice training approaches for in-service training and CPD are provided in Section 2. For example work-place based approaches which focus on **'learning by doing'** and **a continuous approach to training rather than one-off interventions which are conducted off-site.** In future these best practice modes should be scaled up nationally.

Review materials to ensure they are in line with GESI principles

As part of ensuring a workforce who are able to provide fair and equitable health services there should be a review of current training materials to ensure they are in line with GESI principles**. In future GESI principles should be integrated at the design and development**

stages of all training interventions. Developing a **core group of Master trainers for GESI principles** will help ensure that this is achieved.

DEVELOP A COHORT OF 'BRIDGE-BUILDERS' WHO CAN ACT AS ADVOCATES FOR THE NEW TRAINING APPROACH

Currently training is not seen as a valued commodity and until it is seen as this may not be having an impact. Currently, one could say that staff are 'paid' to undertake training and the lack of transparency in the selection process often diminishes the value of training. Through implementation of quality training and CPD, begin to develop a cohort of staff who can become advocates or '**bridge-builders'** for the new system.

These key staff could play a role as Learning Coordinators or as valuable members of district, regional or national coordinating committees.

ENHANCING INSTITUTIONAL CAPACITY AND REGULATION MECHANISMS

Under a comprehensive training strategy for both pre and in-service training there is an opportunity to map overall standards which are expected for all training for MoHP and DoHS staff and develop contracting procedures for trainers which facilitate this.

Once the training strategy and plans have been developed it will be important for all training providers to assess how they can respond to meet training needs. As one of the main providers of in-service training NHTC should use this opportunity to re-visit some of its roles, responsibilities and mechanisms for operating to ensure a good fit between the new strategy and their organisational structure.

ENHANCING REGULATION MECHANISMS

In future there needs to be a focus on increasing transparency. There may be lessons which can be learned from other countries regionally and internationally for example Sri Lanka and the UK.

CPD linked to registration should be implemented as part of a phased approach.

As part of driving-up quality of training more generally a system of a national examination as a pre-requisite to membership of professional councils should be established. Again there should be a phased approach to this and the steps can be clearly articulated in an agreed action plan.

Recommendations for NHSSP

Options, through the NHSSP, can provide support in the form of TA/studies to support the development of more detailed plans for training and CPD. A great deal of support and momentum has been generated by the training assessment. The key will be to harness this energy and enthusiasm, establish a National Training Coordination Committee (as per NHSP-2 plans) and use principle members of this group to begin to complete key tasks and secure immediate results for training and CPD. One of the first key steps is to develop an action

plan[55] with clear priorities, milestones and responsibilities established from the out-set. In the medium to longer term the challenge will be having government counterparts who remain in post to allow progress to be made. Establishing key roles and responsibilities will help at least to set a framework for tasks and who takes lead responsibility (linked to a designation rather than an individual).

[55] A summary action plan highlighting key priority action areas is provided in Annex 9. This will need to be agreed and further developed as part of the next steps process (see the next steps section)

NEXT STEPS

A summary of the next key steps is provided below with more being provided in the summary action plan in Annex 9. These are recommended steps and a plan which can be used as a starting point for action. They will need to be further developed and agreed by National Health Training Coordination Committee members.

Immediate next steps

- Establish **a National Health Training Coordination Committee chaired by the Secretary** (as outlined in NHSP-2).
- Produce a training strategy and plans with milestones agreed by stakeholders. This should be developed as part of the wider HRH strategy.

Short term

- Further develop the summary Action Plan, provided in Annex 9, and agree this at the National Health Training Coordination Committee.
- Review and modify the model framework provided for training and CPD in Section 5 so that all key stakeholders are in agreement with the model.

Medium term

- Establish learning coordinators at district and regional levels. As a first step examine roles and responsibilities of staff currently working in the district such as district health nurses to see which staff might be best placed to take on the role of learning coordinators. As an interim measure NHSSP regional specialists can link at regional and district levels to help support this bottom-up approach to training and CPD.
- Review current training materials to ensure they are in line with GESI principles.
- Consider roles responsibilities and most effective operating systems for NHTC to ensure a good fit between the new training strategy and NHTC structure and operations.
- As part of learning lessons and developing stronger regulation mechanisms establish partnerships between professional councils in Nepal and regionally or internationally e.g. Sri Lanka or the UK.

Longer term

- CPD becomes a requirement for registration. This was discussed during assessment interviews as a way to improve quality of healthcare professionals but would require a phased approach to ensure that all mechanisms are in place to deliver this.
- Best practice training models are scaled-up nationally. Sharing of best practice and using it to inform policy and practice is built into the model framework for training and CPD developed in section 5. This provides systems and structures such as the Training Committees and roles such as the Learning Coordinators to ensure that best practices are shared and scaled up. Action plans can highlight models which are working well and develop a programme for national scale-up for each model.

ACKNOWLEDGEMENTS

We would like to thank the MoHP and DoHS for their overall support and guidance in particular to Mr Padam Raj Bhatta, Joint Secretary for leading the stakeholders meeting and to Mr Kabiraj Khanal both of whom are gratefully acknowledged.

The authors of this report want to thank NHSSP support staff for their support in organising field visits and coordinating meetings in Kathmandu

Special thanks to all staff who supported the completion of the assessment by not only taking part in interviews but for responding to questions afterwards

We would like to thank all those interviewed for their time and their full and frank responses. We also acknowledge the assistance of individual interviewees who suggested other key contacts for evaluation interviews and provided valuable additional reading materials.

ANNEX 1: TERMS OF REFERENCE

SECTION A: BACKGROUND INFORMATION

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 have designed the second phase of the Nepal Health Sector Programme. The 5-year programme, referred to as NHSP-2, was implemented from mid-July 2010.

SECTION B: THE PROGRAMME

The goal of NHSP-2 is to improve the health status of the people of Nepal, especially women, the poor and excluded. The purpose is to improve utilisation of essential health care and other services, especially by women, the poor and excluded. Options Consultancy Services Ltd (Options) and partners are providing technical support to the GoN to implement NHSP-2. LATH has specific responsibility for working with the MoHP to provide clear strategic direction on human resources for the health sector to support the implementation of NHSP-2.

SECTION C: JUSTIFICATION FOR CONSULTANCY

Continuing professional development (CPD) programmes are the cornerstone of a continuous improvement process. This is a major component of the HRH strategic plan (2011-2014) currently under development. The MoHP currently has no formal programme of CPD for its employees (health professionals, managers and support staff) at central or local levels and those of other health providers. The CPD programme needs to be supported by a training and development plan, based on a needs assessment linked to enabling health workers to deliver the content of NHSP-2.

The current institutional capacity will need to be strengthened in order to deliver the training and development plan across the sector. This will require a review of the current structures and provider mechanisms for delivering training and development, and the regulatory functions to ensure quality. In addition, coordination mechanisms are needed to ensure efficient use of resources, including staff time. The strengthening of institutional capacity and development of relevant systems need to be incorporated into a broader training and development strategy. The current strategy was developed in 2004 and is therefore due for revision. This provides an appropriate opportunity to incorporate an improved approach to delivering training and development for health workers across the sector.

SECTION D: OBJECTIVE OF CONSULTANCY

The overall objective of the consultancy is to support the training and development component of the HRH strategic plan and other Organisation and Development initiatives that aim to improve the effectiveness of the current health workforce across the health sector. The specific objectives of the consultancy are, working with MoHP counterparts and the NHSSP HR Adviser:

1. To develop a strategic framework for ensuring CPD of health staff across the sector through the provision of appropriate training and development activities. This will include the specification of the most suitable modalities for training and development as well as a crude modelling of the volume and types of these activities needed over the period of the HRH strategic plan[56] and a very broad estimate of resource requirements.

[56] There is not yet a complete data set on health workers in the sector, so this will be necessarily be an estimate based on available data and interviews with key informants.

2. To review the capacity and ability of National Health Training Centre (NHTC) and its status as a main training provider together with its regional counterparts and private sector providers to deliver the estimated training and development activities required (as identified in #1 above).

3. To review the ability of the current regulatory mechanisms to ensure adequate quality of training and development from eligible providers.

4. To recommend a broad set of steps for MoHP and NHSSP staff to further develop and implement the strategic framework for training and development through to 2014; identify appropriate resources; develop appropriate institutional capacity, within both the public and private sectors, to deliver the required training and development activities; and to implement mechanisms to assure quality of these training and development activities.

SECTION E: SCOPE OF WORK AND SPECIFIC ACTIVITIES

1. Review existing and proposed plans (including the draft HRH strategic plan) for training and development for the MoHP workforce, its medical and professional employees and partners.
2. Review the current approaches used for training and development by different providers to identify the potential for improved approaches and methods of delivering appropriate CPD.
3. Conduct a simple modelling exercise based on available data to identify the volume and types of training and development activities needed over the period of the HRH strategic plan. Estimate resource requirements based on the modelling.
4. Conduct an assessment of the institutional capacity of the current MOPH and private providers of training and development activities; and the effectiveness of the current contracting mechanisms to enable greater use of the private sector. Identify institutional capacity development requirements.
5. Review the current regulatory mechanisms and their ability to ensure quality of training and development. Identify needs for strengthening the mechanisms.
6. Present findings and a preliminary set of recommended steps to key stakeholders[57].
7. Finalise recommendations and prepare report.

SECTION F: DELIVERABLES

1. A brief presentation of findings and key proposal to HR stakeholders convened by the Director of Finance and Human Resources before leaving Nepal.

2. A report of no more than 20 pages, plus annexes, summarising the findings of the consultancy and the set of steps for MoHP and NHSSP staff to further develop and implement the strategic framework (and ancillary components – institutional capacity development, regulation and resourcing) for training and development through to 2014.

SECTION G: CONSULTANT REQUIRED

Minimum requirements:

- Will have the background and experience to work as a training and education assessment expert with the NHSSP team in Nepal.
- Experience in developing and reviewing health sector training and education strategies at national and regional levels.
- Strong working knowledge and experience in training and education assessment, planning and policy.
- Ability to prioritise issues and work with local counterparts productively with professionalism and discretion in differing in-country cultures.

[57] Including MoHP – others to be decided on the advice of the NHSSP HR adviser

- Good organization skills, flexible and working well under pressure.
- Post-graduate qualifications in a relevant field with a minimum of 10 years work experience in training and education.

SECTION H: TIMING

Indicative timing for this assignment is as follows:

- 16th July: travel to Nepal
- 18th – 28th July: 2 weeks in Kathmandu conducting assessment (9 days)
- 29th July-3rd Aug: visits to regions to view regional training centre and hospital training programmes [Pokhara/ Dolpa, weather permitting] (4 days)
- 4th - 5th August preparation and presentation to MoHP (2 days)
- 6th August: depart for UK
- 10th August (AM): submit draft report for internal review (3 days)
- 17th August: submit final report (2 days)
- Total days required, excluding travel days and weekends: 20 days

SECTION I: INDICATIVE MEETINGS REQUIRED

1. NHTC, Nepal Admin Staff College, Regional training centre, Medical colleges, Council for Technical Education and Vocational Training (CTEVT), Technical Working Group on performance management, selected UN agencies, NHSSP adviser team.
2. MoHP senior managers, a selection of private sector providers, NGOs involved in providing and commissioning training.

SECTION J: DOCUMENTATION AVAILABLE

All relevant NHSSP documentation[58] and MoHP published materials[59].

SECTION K: REPORTING REQUIREMENTS

Draft reports must be submitted to Bill James, the Technical Manager for this assignment and Roy Daley, Contract Manager at LATH, before being circulated to other stakeholders and MoH officials. Tim Martineau will have overall responsibility for approving the final report on behalf of LATH.

The report will be formatted by Anjie Holt, Programme Coordinator at LATH, before being submitted as final.

The report is the intellectual property of LATH and should not be circulated by the consultant without the permission of the Programme staff.

[58] E.g. HR capacity assessment; Milestone 7 report; inception report; latest draft of HRH strategy
[59] E.g. NHSP-2, previous strategic plan; Kohlemainen-Aitken report

ANNEX 2: LIST OF INTERVIEWEES

Name	Designation	Organisation
Gaurav Acharya	Administrator	Manipal College of Medical Sciences, Pokhara, Western Region
Surya Prassd Acharya	Joint Secretary, Chief Personnel Management Division, Administrative Division,	Ministry of Health and Population, Kathmandu
Dileep K Adhikary	Director, Centre for Development, Policy and Planning	Nepal Administrative Staff College, Kathmandu
Ramesh Adhikary	Senior Public health Administrator/ District Public Health Officer	Pokhara District, Department of Health Services, Western Region
Rajendra Bhadra	Specialist, Performance Improvement	Nepal Family Health Program-II
Bal Govinda Bista	Consultant HRH	NHSSP, Kathmandu
Sagar Raj Buandari	District Health Officer	Parbat District Health Office and Hospital, Parbat, Western Region
Ian Chadwell	Consultant, Partnership Programme Manager	International Nepal Fellowship. Consultant with Nick Simons Institute, Kathmandu
Maureen Darlang	Essential Health Care Service Advisor	NHSSP, Kathmandu
Nazayan Dhimal	Trainer and Administrator	Personnel Training Academy, Ministry of General Administration, Government of Nepal, Kathmandu
Nancy Gerein	International Team Lead	NHSSP Kathmandu
Ram Prasad Ghimire	Under Secretary, Organisational Development	Ministry of General Administration (MoGA), Government of Nepal
Matt Gordon	Health & HIV/AIDS Adviser - Human Development Team Leader	DFID Nepal, Kathmandu
David Hepburn	Senior Procurement Advisor, Department of Health Service Logistic Management Division	NHSSP Kathmandu
Chhaya Jha	GESI Advisor	NHSSP, Kathmandu
Bhagawati K.C.	Campus Chief	Nursing School, Tribhuvan University, Institute of Medicine, Pokhara Campus, Western Region
Binod K.C.	Joint secretary	Ministry of General Administration (MoGA), Government of Nepal
Naresh K.C.	Director, Family Health Division	Department of Health Services, Kathmandu
Mr. Kandel	Senior Assistant Health Worker	Naudanda Training Health Post, Western Region
Arjun Karki	Founding Vice Chancellor	Patan Academy of Health Sciences, Kathmandu
Madan Khadka	Medical Officer	Regional TB Centre, Pokhara, Western Region
Sunil Khadka	Infrastructure and Maintenance Adviser	NHSSP, Kathmandu
Bishwa Raj Khanal	Regional Director	Pokhara District, Department of Health Services, Western Region
Kabiraj Khanal	Undersecretary HR Development Section	Ministry of Health and Population, Kathmandu
Sudhir Khanal	Programme Specialist, Child Health and Survival, Health and Nutrition Section	UNICEF Nepal,Kathmandu
Steven J. Knobel	Training Consultant	Nick Simons Institute, Kathmandu
Bil Kumari Kumal	Senior Assistant Health Worker	Naudanda Training Health Post, Western Region
Sandhya Limbu	Programme Officer, Performance Improvement Team	Nepal Family Health Program-II, Kathmandu

Udev Maharjan	Senior Program Officer/ Training Coordinator, Performance Improvement Team	Nepal Family Health Program-II, Kathmandu
Bal Chandra Mishra	Executive Director	Personnel Training Academy, Ministry of General Administration, Government of Nepal, Kathmandu
Mukund Raj Panthee,	Clinical Professor of Radiology and Registrar	National Academy of Medical Sciences (NAMS), Bir Hospital, Kathmandu
Umesh Raj Parajuli	Senior Branch Manager	Family Planning Association, Pokhara, Western Region
Bishra Kanal Paudel	Ex Director Family Planning Association Nepal, now Planning Advisor	NHSSP, Kathmandu
Dhan Prasad Paudel	Registrar	Nepal Health Professional Council, Kathmandu
Raj Kumar Pokharel	Chief, Nutrition Section, Child Health Division	Department of Health Services, Kathmandu
Kamal Bihram Poudel	Ayurveda Health Assistant	Lumle Ayurveda Health Post, Kaski District, Western Region
Sitaram Prasai	GESI Advisor	NHSSP, Kathmandu
Geetha Rana	Assistant Representative	UNFPA, Kathmandu
Mira Maiya Singh Rana	Director	Educate the Children Nepal, Kathmandu
Bed Bahadur Rayamajhi	Radiologist	Regional TB Centre, Pokhara, Western Region
Gunawan Setiadi	Public Health Advisor	WHO Country Office, Nepal
Ganga Shakya	MNH Advisor	NHSSP, Kathmandu
Binod Bindu Sharma	Training Chief/ Senior Health Education Administrator	Western Regional Health Training Centre, Pokhara
Kiran R. Sharma	Undersecretary Training and HR Section	Ministry of Government Administration (MoGA) Government of Nepal, Kathmandu
Sabin Kumar Sharma	Programmer	HURIS, Ministry of Health and Population, Kathmandu
Ishwari Devi Shrestha	Chief hospital Administrator (Senior Nursing Officer)	MoHP, Kathmandu
Ram Bahadur Shrestha	Trainer and Finance Officer	Personnel Training Academy, Ministry of General Administration, Government of Nepal, Kathmandu
Arjun Bahadur Singh	Director, National Health Training Centre (NHTC)	Department of Health Services, Kathmandu
Hom Nath Subedi	Equity Access Advisor	NHSSP, Kathmandu
Krishna Kumari Paudel Subedi	Registrar and Administrator	Nepal Nursing Council, Kathmandu
Buddhi Bahadur Thapa	Medical Superintendent	Western Regional Hospital, Pokhara
Suresh Tiwari	Adviser, Health Financing	NHSSP, Kathmandu
Shyam Raj Upreti	Director, Child Health Division	Department of Health Services, Kathmandu
Catherine Brenda Whybrow	Country Director	MERLIN, Nepal
Mark Zimmerman	Executive Director	Nick Simons Institute, Kathmandu

ANNEX 3: PARTICIPANTS WHO ATTENDED STAKEHOLDERS MEETING 04TH AUG 2011

S. N.	NAME	DESIGNATION	ORGANIZATION
1	Bill James	HR Advisor	NHSSP, Kathmandu
2	Nancy Gerein	International Lead, Team Leader.	NHSSP, Kathmandu
3	Lynne Elliott	LATH Consultant	LATH
4	Ishwari Devi Shrestha	Chief Nurse	MoHP, Kathmandu
5	Udev M. Maharjan	Sr. Procurement	NFHP II, Kathmandu
6	Rabina Shakya	Executive Director's Personal Assistant	NSI, Kathmandu
7	Stephen J. Knoble	Training Consultant	NSI, Kathmandu
8	David Hepburn	Procurement Advisor	LMD, Kathmandu
9	Khagendra Rijal	Section Officer	MoHP, Kathmandu
10	Ron Marrocco	Procurement Advisor	LMS, Kathmandu
11	Padam Raj Bhatta	Joint Secretary	MoHP, Kathmandu
12	Ramchandra Man Singh	Health Sector Governance Advisor	NHSSP, Kathmandu
13	Bal Govinda Bista	HRH Consultant	NHSSP, Kathmandu
14	Dr. Babu Ram Marasini	Chief ,Health Reform Unit	MoHP, Kathmandu
15	Dr. Shambhu Upadhyay	Associate Professor	Patan Academy of Health Science, Kathmandu
16	Dr. Atul Dahal	National Planning Officer	WHO, Kathmandu
17	Dr. Nihal Singh	WHO-Ag. Representative	WHO, Kathmandu
18	Dr. Kishori Mahat	National Planning Officer	WHO, Kathmandu
19	Mr. Kabiraj Khanal	Under Secretary	MoHP, Kathmandu
20	Shankar Pandey	Chief	Kfw, Kathmandu

ANNEX 4: INTERVIEW GUIDE

Not all questions will be appropriate for all interviewees. The questions are designed to be used to guide interviews; the consultant may use all questions or select those appropriate to each interview situation.

What are your existing and proposed plans for training and development of MoHP workforce (its medical and professional employees and partners)? *Prompt for training strategies, plans, types of training topics e.g. management HIV/ AIDs)*

a) What training approaches do you use? (Prompt for use of practical approaches, case studies, distance, *classroom based*)

b) What plans (if any) do you have for improvements in training approaches (prompt for use of practical approaches, case studies, distance etc...?)

What types of training do you believe are most important for: health professionals, other professional staff based at the MoHP and other health professionals delivering health services (e.g. private sector staff). (P*rompt for top 3-5 areas of training need which is required). Prompt for numbers of staff to be trained*

a) How would you rate the capacity of training providers (private and MOPH) in Nepal to deliver training? Prompt can be given by providing a rating scale 1-5. One being very good and five being poor

b) What institutional capacity development, if any, is required

c) Can you describe your own experience of the contracting process either as a service provider contracted by government or someone who is contracting training services?

d) What improvements, if any, are required?

5. a) What are the current regulatory mechanisms for training

b) How might these be developed?

ANNEX 5: SOURCES CONSULTED

Annual Report - DOHS, Ministry of Health and Population, Nepal. http://www.xenomed.com/community/index.php?threads/annual-report-dohs-ministry-of-health-and-population-nepal.372/ accessed July and August 2011

Butterworth K., Hayes, B. and Bhusan, N. 2008. Retention of General Practitioners in Rural Nepal – A qualitative Study. Australian Journal of Rural Health, Volume 16.

Butterworth K., Zimmerman, M, Hayes, S, Knoble, S. 2010. Needs Assessment for Continuing Medical Education Amongst Doctors Working in Rural Nepal. Volume. 4 No. 1.

Community Action centre Nepal. http://www.cac-nepal.org.np/programmes/community/leader.php. Accessed August 2011

GIZ website. http://www.giz.de/en/profile.html. Accessed august 2011

GIZ website promoting the health sector in Nepal. http://www.gtz.de/en/weltweit/asien-pazifik/nepal/20542.htm. Accessed august 2011

Johns Hopkins centre for Global health research. http://www.hopkinsglobalhealth.org/projects/map/NP/1023 Accessed August 2011

Martineau T. and Subedi H.N. 2010. Human Resources for Health. Capacity Assessment for Health Systems strengthening.

MoHP. 2003. Strategic Plan for Human Resources for Health 2003 to 2017

MOHP. 2004. Training Course Management Guidelines. Family Planning and Postabortion Care

MoHP. 2010. Nepal Health Sector Programme Implementation Plan ii (NHSP-IP2). 2010 – 2015

MoHP. 2010. Report of the HRH consultative workshop – Country Coordination and Facilitation: 10th-11th November, 2010 – Kathmandu

MoHP. 2011. Budget Analysis 2010/2011. Ministry of Health and Population. January 2011. Final Draft

Nepal Health Professional Council http://www.nhpc.org.np/index.php?option=com_content&view=article&id=68&Itemid=55. Accessed July 2011

NHSSP. April. 2011. Milestone 7: Periodic Review on the Development of the HR Plan Ministry of Health and Population, Government of Nepal

NHSSP. April 2011. Quarterly Report. January-March 2011

NHSSP. January 2011. Inception Report

NHTC. 2004. National Health training Strategy.

NHTC. 2007. Implementation Guidelines of Structures On-the Job-Training (OJT) for Postabortion Care (PAC) in Nepal.

Nick Simons Institute (NSI). 2006. A focussed study of CTEVT Mid-level pre-service health Training Programmes in Nepal.

NSI. August 2007. Measuring the Quality of Rural Based Government Mid-Level Health Care Workers. A clinical Skills Assessment

NSI. 2009. Mid-Level Practicum. Pilot Course 2009.

NSI. 2010. Mid-Level Practicum Follow-Up and Enhancement Programme.

Nick Simons Institute Website. www.nsi.edu.np

Oanda Currency Exchange Site. http://www.oanda.com/currency/converter/. Accessed August 2011

Patan Academy of health Sciences. www.pahs.edu.np. Accessed July 2011

Peck, C. et al. 2000. Continuing medical education and continuing professional development: international comparisons, British Medical Journal, 320, pp432-435

Potter C, and Brough R. 2004. Systematic Capacity Building: A Hierarchy of Needs. Health Policy and Planning 19(5): 336-345

Riitta-Liisa Kolehmainen-Aitken and Prof. Ishwar Bahadur Shrestha. January 2009. Human Resource Strategy Options for Safe Delivery. Ministry of Health and Population.

Dr Olivier Weil. 2006. Support to Safe Motherhood Programme, Nepal. A part of GoN Nepal National Safe Motherhood Programme (NNSMP). Review of Situation within the Ministry of Health and Population with regard to Human Resources Policy and Management

WHO. 2006. Working Together for Health. World Health Report.

ANNEX 6: INFORMATION ON NHTC TRAINING PROGRAMMES

This table was designed and developed as part of the data collection process for the training needs assessment. The NHTC were asked to complete the table using data from the last five years, if this was available, or to complete using data from the most recent year. The table can be used as part of the data required for the next steps in developing a training strategy and plan

Staff Category	[60]Topic and Type of training Topic e.g. HIV/ AIDS Type e.g. pre-service, up-gradation, in-service training etc.)	Duration	Venue Kathmandu, Region or District	Who delivers the training	[61]Number of staff Trained 2005-2010		Budget 2005-2010
					Females	Males	

Source: NHTC Kathmandu August 2011

[60] Can you indicate if the curriculum was developed by NHTC, was a joint initiative or is designed and developed solely by an external provider. You may want to colour code this e.g. NHTC, Joint initiative and course designed and developed solely by external provider. Please indicate if the external provider is another government department, NGO or private provider.

ANNEX 7: ORGANISATIONS INVOLVED IN TRAINING IN NEPAL WHICH HAVE RELEVANCE TO IN-SERVICE TRAINING AND CPD

Organization	Brief Summary of Programme, List of Areas of Support/ Implementation Relating to In-Service Training and Any Special Programmes, Projects or Features which Can Act as Link Points in Next Steps
DFID/ NHSP-2	**Brief Summary of Programme** The Nepal Health Sector Programme-1 (NHSP-1), the first health Sector-Wide Approach (SWAp), operated from July 2004-July 2010. Building on the successes of NHSP-1, the Ministry of Health and Population (MOHP) along with External Development Partners have designed the second phase of the Nepal Health Sector Programme. The 5-year programme, referred to as NHSP-2, was implemented from July 2010. **List of Areas of Support/ Implementation Relating to In-Service Training and CPD** Includes Support to NHTC especially for maternal and neonatal health care training, SBA, infection prevention **Special Programmes, Projects or Features which Can Act as Link Points in Next Steps** Model on which NHSP-2 is built can be used to develop a systematic and coordinated approach to training and CPD
GIZ	**Brief Summary of Programme** GIZ has been active since 1994. Between 2001-2015 it has worked with MOHP on a programme -**Promoting the Health Sector between 2001 – 2015.** **List of Areas of Support/ Implementation Relating to In-Service Training and CPD** Training at health facilities- Medical services are being improved through training sessions for the staff at health centers. Particular focus is placed on reproductive health and HIV/ AIDS.
Merlin Nepal	**Brief Summary of Programme** Merlin has been working with Districts and regional health authorities on a number of areas from health camps to emergency preparedness **List of Areas of Support/ Implementation Relating to In-Service Training and CPD** • Emergency work – working with districts and regional health authorities as well as other international organisations to improve local capacity to prepare for and respond to emergencies • Training health workers and supporting local health authorities – training

	health workers in reproductive health, essential newborn care, community birth preparedness, and infection prevention. **Special Programmes, Projects or features which Can Act as Link Points in Next Steps** • **Support to Health Workforce through Civil Society Engagement** - This is a new programme and is a joint initiative between Merlin, Save the Children the Britain Nepal Medical Trust. The overall objective is to improve delivery of healthcare in Nepal through strengthened human resources for health
Jhpiego	**Brief Summary of Programme** Jhpiego is providing technical assistance under the Nepal Family Health Project (NHFP), funded by the U.S. Agency for International Development (USAID). Jhpiego's role under the NHFP is to lead efforts to improve the quality of family planning and maternal and child health services at thousands of health care facilities. **List of Areas of Support/ Implementation Relating to In-Service Training and CPD** Specifically, Jhpiego is: 1) strengthening and decentralizing in-service clinical training system capacity at the national, regional and district levels; 2) strengthening curricula, faculty and teaching sites for pre-service education of auxiliary nurse midwives; 3) applying a performance improvement approach to improving quality of services; and 4) supporting other training-related activities such as training site assessments and training materials updates.
Nepal Family Health Programme (NFHP-11) funded by USAID	**Brief Summary of Programme** The NFHP is a Bilateral project running 12007- 2012. The goal is to improve the provision and use of public sector Family Planning/ MNCH. One of key results is to strengthen capacity of MoHP systems. **List of Areas of Support/ Implementation Relating to In-Service Training and CPD** Works at central level on work including TA on development of polices, standards, guidelines, curricula, information systems and programme monitoring. **Special Programmes or Projects which Can Act as Link Points in Next Steps** • Trial of model for improved and more decentralized training using 'training cells' at the District level has just been developed with NHTC[62]. A District Training Coordination group is to be established with focal persons such as public health nurses for FH, IMCI, laboratory etc. Two districts Rolpa and Siraha have been selected as pilot sites.

[62] Booklet has just been developed but there has not been time yet to translate to English.

	• NFHP looking at training models such as delivering training in blocks of 5-6 days then six months later another 5-6 day block which builds on previous learning. They also recognize the huge overlap in training curricula and are undertaking mapping exercise of curricula with NHTC and wider DoHS. • They also have an interest in CPD as part of wider HR on which they focus and have one team member in Kathmandu who has focus on HR • NFHP is providing technical support in maintaining and using a training database
Nick Simons Institute	**Brief Summary of Programme** The Nick Simons Institute focuses on 3 main programme areas including**:** training, Rural staff support **and advocacy** **List of Areas of Support/ Implementation Relating to In-Service Training and CPD** **Training** – NSI works closely with NHTC and through a network of partner institutions. It has developed the following training programmes: • **Anesthesia Assistant course (AAC).** A one year training for nurses and health assistants. Anesthesia assistants can provide anesthesia for emergency operations such as orthopedics, caesarean sections and appendectomies. MoHP and NAMS adopted ACC as a national training for non-doctor anaesthetists, the first to lead to AA licence. • **Biomedical Equipment Technician**. A one year training for colleges graduates and 2 month training for support staff. Technicians and assistant technicians are able to repair hospital equipment and conduct preventative maintenance. MoHp has begun funding the courses, a first step in nationalization of these cadre. • **Continuing Medical Education (CME).** Distance education courses for doctors. Doctors are up-dated in their medical knowledge and case management across a range of subjects. Volume 1 of Nepal CME is complete and Volume 2 is in the last stages of production. • **Mid-level Practicum (MLP).** A three month clinical and management refresher for mid-level health workers. Mid-levels are better able to diagnose illness, perform medical procedures, and manage their workplace. The MoHP has adopted MLP as a national course for all Auxiliary Health Workers. NSI also pioneered the follow-up enhancement programme (FEP) for graduates of the Mid-level practicum. MoHP has called for widespread scaling up of FEP • **Skilled Birth Attendant (SBA).** A two month course for nurses. Nurses are able to conduct normal and complicated deliveries, including performing some life-saving procedures. • **Ultrasound training.** A three month basic course for doctors. Doctors are able to perform ultrasound to diagnose conditions in the abdomen and related to pregnancy **Special Programmes or Projects which Can Act as Link Points in Next Steps** • Best practices in training including: practical training approaches; monitoring and evaluation of training and follow-up and support, These models could be used to enhance future training. • NSI Rural Healthcare Workers Conference provides an excellent opportunity to share best practices and explore what's working, what's not and how programmes can be improved. • NSI newsletter to health workers provides an excellent opportunity to up-date staff

Patan Academy of Health Sciences (PAHS)	**Brief Summary of Programme** The Patan Academy consists currently of a medical school but in the future Patan aims to open Schools of: Public Health, Nursing, Allied Health Sciences and schools to train other health care professionals. **List of Areas of Support/ Implementation Relating to In-Service Training and CPD** Use Problem Based Learning (PBL) using case studies to train medical students **Special Programmes or Projects which Can Act as Link Points in Next Steps** • Expertise in PBL could be tapped • Innovative selection criteria - The entry and enrolment process combines an assessment of academic ability and aptitude. Potential entrants are required to undertake a short role play to assess the students suitability to communicate, listen and empathize with clients. These types of selection criteria could be used on a trial basis for some government training to assess suitability and improve selection • Patan also works with MoHP/ DoHS through the provision of telemedicine facilities. This site is currently linked to 27 districts and will be expanded soon to 57. The potential and willingness to use this facility for training and CPD has been strongly expressed by Patan.
Personnel Training Academy	**Brief Summary of Programme** The training academy was established in 2010. Previously the functions of the Personnel Training Academy were subsumed under the Staff Training College. **List of Areas of Support/ Implementation Relating to In-Service Training and CPD** Deliver in-service training for both government and non-government staff. Training includes: Public private partnerships, TOT courses, Late career, Pre-service and Refresher training, a Diploma in computer studies and other regular trainings
Population services International (PSI)	**Brief Summary of Programme** When PSI/ Nepal launched in 2002, it focused on HIV/ AIDS prevention, child survival and family planning. PSI/ Nepal programs have expanded to include: Malaria prevention and treatment, Safe water education, Pediatric zinc supplementation and fortified complementary food for Young children **List of Areas of Support/ Implementation Relating to In-Service Training and CPD** Works with NHTC on training including FP and medical abortion
Staff Government Training College	**Brief Summary of Programme** The Staff Government Training College provides training for senior government and non-government staff **List of Areas of Support/ Implementation Relating to In-Service Training and CPD** In-service training includes a 30-day management and leadership course for Secretaries and other senior staff funded by WHO

UNICEF	**Brief Summary of Programme** In 2010 UNICEF shifted its strategy for much more intensive support for pre-service rather than in-service training. The global world crisis has led to examination of strategies and approaches and it believes that a more effective approach is to pursue incorporation of training in topics such as IMCI into pre-service training. **List of Areas of Support/ Implementation Relating to In-Service Training and CPD** • Working with MoHP Family Health and Child Health Divisions to streamline curricula to avoid duplication of topics for in-service training. • Provides technical assistance to NHTC on programmes such as SBA training
UNFPA	**Brief Summary of Programme** **Some of the** Programme priorities in Nepal include assisting the government in: • achieving universal access to family planning for all citizens; • scaling-up HIV prevention efforts; • promoting legal and policy reforms to bring about women's empowerment. **List of Areas of Support/ Implementation Relating to In-Service Training and CPD** • UNFPA has been supporting the Nursing council in Nepal to develop capacity and wants to continue this support • Provides support to NHTC training including RH orientation, Gender Based Violence, behavior change and communication

ANNEX 8: APPROACHES AND OPPORTUNITIES FOR ADDRESSING FINDINGS OF THE NEEDS ASSESSMENT OF IN-SERVICE TRAINING & CPD

Strengths/ Achievements	Weaknesses
Government already undertaking a variety of training for health and health related professionals and administrative staff within the MoHP Government has asked staff within the MoHP to outline their training requirements (this process is being handled by the Ministry of General Administration). There are also excellent studies by organisations such as the Nick Simons Institute (NSI)[63] Government is already view training as just part of wider solution to improving healthcare (training/ CPD being considered as part of the Human Resources For Health (HRH) plan) Government already using some private sector providers to deliver training for Ministry of Health staff There is some follow-up of training at facility level (but not across the board and this is one of the weaknesses) There are examples of practical training approaches being used. Many of these are designed, developed and supported by NGOs/ INGOs and private sector	Training is 'supply driven' not based on demand There is lack of a strategic approach to training/ CPD The quality or impact of in-service training is largely unknown Training is linked with promotion rather than based on and ethos of continual improvements and creating a learning organisations Lack of coordinated approach to training e.g. staff may be trained but lack the equipment required or opportunities to practice their skills. In some cases the staff sent for training are not working in that areas (this was mentioned in particular in relation to international conferences and training) There is lack of coordination between training providers Training is considered by some as a principle cause of absence from health facilities because training is more likely to be conducted off-site rather than work-place-based. Follow-up of training is poor in general although there are examples of best practice Systems and processes to monitor training are lacking Councils charged with regulation of training lack capacity to regulate at a number of levels including: governance, lack of real autonomy, financial constraints and skills of staff CPD is not a prerequisite for maintaining registration and there is no requirement to pass an initial registration exam for nurses and other health professionals (excluding doctors) Much of the training delivered focuses on transfer of knowledge (theory) rather than developing practical skills which directly link to individuals jobs and their specific tasks Training focuses on training individuals not teams Topics such as management, practical clinical skills training, HR, planned preventative

[63] Various studies including assessment of CEVET to assess quality of training for Mid -Level Health Workers. Although this focuses on pre-service training many of the findings support our conclusions about the lack of quality training

	maintenance, procurement, M&E and IT skills training are largely ignored Healthcare workers face challenges that are not appreciated by central government People believe that rural healthcare workers are somehow inferior to their urban counterparts Many health care workers feel that they labour alone There is no lack of trained staff but there is an inability of government to attract and retain staff Incentives are currently linked with training these include allowances for travel and daily living allowances (TA/ DA). These allowances often seem to be one of the main drivers for attendance at training not patient centered care
Approaches and Opportunities to Address Key Findings	**Threats**
Government initiatives such as 'Training for All'. Build on these and advocate for strategic approach to training provided Training budget is available Re-focus efforts on serving patients, **delivering good quality healthcare and delivering consistently** Develop a training strategy which is designed to provide a framework for training requirements across the country. This can be used to address systematic capacity building and its implications at each level. The strategy and plan can be used as a tool to attract and secure donor funding (reversing the current trend where it is believed that training can be donor led) Examples of best practice in training are available in Nepal and these can be scaled-up and replicated e.g. PAHS providing scholarships for candidates from rural areas[64], NSI focus on training mid-level health workers, Merlin - practical participative training HRH plan and government commits to addressing the system of frequent transfers and promotes an environment which encourages continual improvement and learning. This	Lack of strategic and uncoordinated approach to training continues Training institutes resist regulation designed to improve quality and standards in training Training providers continue to provide supply driven training rather than training based on need NGOs and INGOs continue to develop training which meets donor requirements rather than country needs Donors continue to focus funds on out-dated modes of training which focus on out-dated modes of 'chalk and talk' approaches to training with a focus on numbers trained and facilities developed rather than developing systems capacity Topics for training remain highly focused on vertical programmes and continue to ignore broader more generic areas such as management, finance, procurement, planned preventative maintenance and M&E MoHP continues with system of 'irrational and frequent' transferring of staff

[64] Although this is for their Undergraduate MBBS programme the government may want to similarly use positive discrimination to select candidates from more rural populations or neglected groups.

also means that the organisation needs to be more open to mistakes Develop regulating bodies to ensure quality and standard of training Government records which staff are on training and the training they have received. Staff are awarded points/ credits for training and records of this are maintained UNFPA, WHO and UNICEF have all been working with the professional councils and are keen to continue this. Design and develop **practical training** which encourages 'learning by doing' and links directly to an individual's job/ tasks. For example, instead of management theory design and develop training around the annual planning process and use this as the training vehicle rather than brining staff to a course on planning theory. Similarly build HR skills by working for example with staff on a continuing basis using challenging HR cases for example as a learning opportunity. Through training staff work on and develop solutions to real live challenges they face. Also focus on **training teams** rather than individuals and ensure more **work-place based training** rather than centralized training in Kathmandu. There are already good practices in supporting and promoting rural health care workers. NSI has used a number of strategies including using conferences[65], awards recognizing the services of rural health workers and research studies Overcoming the incentive culture by '*harnessing staff who have been on training and are ready to making a difference. Use them to build a critical mass of staff then others will begin to follow and 'say I need to be on that programme too'. Continue to improve the quality of training so that staff want to be involved and view training as something of real value.*	

[65]NSI initiated an Annual Rural Healthcare Workers Conference. The 3rd annual conference took place over three days in March 2011 and was jointly organised by the Department of Health Services, National Health Training Centre and Nick Simons Institute

ANNEX 9: SUMMARY ACTION PLAN WITH PRIORITY AREAS FOR ACTION

Introduction

This summary action plan has been designed and developed as a result of the findings of this assessment. It provides an outline of **Priority Areas for Action.** These include:

1. Establishing a systematic and coordinated approach to in-service training and CPD
2. Ensuring continuous improvements in training approaches
3. Strengthen Institutions ability to provide training and CPD and strengthen contracting mechanisms
4. Improve current regulation mechanisms

Priority Areas for Action	Recommended Activities/ Action	Responsible	Yr 1 2011	Yr 2 2012	Yr 3 2013	Yr 2014	Yr 2015
Establish a systematic and coordinated approach to in-service training and CPD	Establish a National Health Training Coordination Group (NHTCG)	MoHP. Secretary	X By Sept				
	Agree summary action plan to develop training strategy and plans	NHTCG	X By Sept				
	Produce a training strategy and plans with milestones agreed by stakeholders. This should be developed as part of the wider Human Resources for Health (HRH) strategy	NHTCG Leads this process NHSSP TA support may be required	X By Oct				
	Review and modify the model framework provided for training and CPD in Section 5 so that all key stakeholders are in agreement with the model	NHTCG	X By Oct				
	Establish learning coordinators at district and regional levels.	NHSSP regional specialists with district health staff and selected members of NHTCG	X Dec				
Ensure continuous improvements in training approaches	Continually review good practices select which practices can be scaled-up nationally	At national level NHTCG and at local levels local training committees May require intermittent TA support provided by NHSSP	x	x	x	x	x

	Training materials are reviewed to ensure they are in line with GESI principles	NHSSP GESI Advisors working with NHTC staff May require TA support provided by NHSSP		X By March			
	Best practice training models are scaled-up nationwide.	Health training coordination committees at regional and district levels				X At least one good practice model scale-up nationally	X Second best practice model scaled up nationally
Strengthen Institutions ability to provide training and CPD and strengthen contracting mechanisms	Consider roles responsibilities and most effective operating systems for NHTC to ensure a good fit between the new training strategy and NHTC structure and operations.	NHTC With support from MoHP especially HR divisions and support May require TA support from NHSSP		X March			
	Guidelines for contracting training services developed	Logistics management Division		X Jan			
Improve current regulation mechanisms	Establish partnerships between professional councils in Nepal and regionally or internationally e.g. Sri Lanka or the UK	Individual professional councils		At least one link established by each council by June X			
	CPD becomes a requirement for registration with professional councils.	Individual professional councils May require TA support NHSSP					X