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HEALTH TRAINING RESEARCH AND DEVELOPMENT PROJECT

PROJECT No. 497-0273

FINAL ASSESSMENT OF THE HTR&D
MANAGEMENT TRAINING COMPONENT
FINAL REPORT

Jakarta, Indonesia

February 11, 1986

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IQC Contract No. PDC-1406-1-00-1125-00

EXECUTIVE SUMMARY

During January and February, 1986, Dr. Gary Bergthold, a management training consultant, conducted the final assessment of the Health Training, Research and Development Project (No. 497-0273) Management Training Component. The assessment included a review of project documents and interviews with over forty individuals in the Ministry of Health (Jakarta) and in three HTR&D-assisted provinces (Central Java, West Java and West Sumatera).

The objectives of the assessment were:

1. To assess the major impacts of the HTR&D management training component on MOH training capacity and utilization of that capacity.
2. To determine which HTR&D training capacities are supportable by the MOH without USAID funding and to describe the obstacles to continuing support.
3. To recommend to USAID options for a close-out strategy consistent with the findings on HTR&D capacities.

The final report of the assessment describes the intended impacts of the project and the strategies followed in carrying it out. Impacts of the project are described including the numbers of individuals who have demonstrated competence in management training, task analysis, case study development and impact evaluation.

The HTR&D management training component has been largely successful in introducing modern management training methodologies (i.e. problem solving training) into five key provinces of Indonesia and into the Center for Education and Training of Health Personnel (Pusdiklat).

These methodologies, which have transformed in-service management training from a top-down, lecture-oriented, largely formalistic activity into a management-oriented tool for analyzing and solving operational problems, have been widely adopted in the participating provinces. These management training methods have been disseminated vertically into virtually all levels of the organization, from community health workers (Kadirs) to career training for mid-level employees. In the selected provinces these training methodologies have been disseminated horizontally as well, into technical and management training for family planning, immunization, community health as well as to some medical schools and public health institutions.

The management training methodologies introduced by HTR&D are a good example of "appropriate technology". They are only slightly more costly than the training methodologies they replaced and they fit well with prevailing cultural norms and practices. It is highly likely that these training techniques will endure in health training since they represent, in the words of a Puskesmas doctor, "Going back to nature--to "musyawarah"--decision by consensus." These methods are also likely to spread to other provinces through normal channels of dissemination, but more speedily through the large training expansion program about to begin with the World Bank funding. This program intends to rely heavily upon HTR&D-trained individuals to train the trainers for the new training centers (BLKMs) which will conduct much of the MOH in-service training in the future.

An often overlooked feature of the training systems in the provinces is that the "trainers" are, in fact, supervisors of operating programs who conduct training on a part-time basis. Generally, training is conducted by individuals at the next highest echelon (provincial supervisors train Kabupaten level, Kabupaten train Puskesmas, etc.). This integration of management training

within the supervision function, where training combines skill building, problem solving and planning, should be encouraged. Efforts to create full time positions for trainers and to isolate training from other management functions should be discouraged.

The other technical inputs introduced by HTR&D such as task analysis, case studies and impact evaluation are seen as useful by many Indonesian health authorities, but they are less appropriate technologies than the management training methodologies. All three technical inputs have created specific and useful impacts but their expense and technical difficulty makes them unlikely candidates for permanent adoption in the absence of external funding.

It seems possible, however, to adopt these technologies into less costly and difficult, but useful methodologies. Simpler methods of collecting data on organizational problems using some of the task analysis methodologies, short "vignettes" written by supervisors and health workers to illustrate field problems and simple follow-up and evaluation techniques such as collecting "critical incident" reports, might be introduced as part of the training methodologies.

Finally, progress has been made by the HTR&D project in encouraging the establishment of formal and informal policy and organizational mechanisms for supporting these in-service training methodologies. But more progress is needed. Training teams have been formed at Pusdiklat and the provinces to plan, design and monitor training, but none of these groups have been anchored formally into the system. Training and trainers have gained increased visibility but their role within the management system is still unclear.

What are the implications of these findings for USAID? What activities should receive further support? The following are four options for the final phase of USAID funding of the HTR&D management training component:

Option 1 - Small group training and intern development in TOT
and consultancy

Twelve to fifteen interns would be given intensive training in techniques for developing task-oriented, problem solving groups (L-group training). Following this training the interns, under direct supervision of HTR&D consultants, would:

- (a) design and deliver a one-month management TOT course for up to 40 "advanced training" candidates.
- (b) provide consultation to at least two DepKes programs (e.g. immunization and community health) in order to demonstrate a possible role for Pusdiklat in providing direct assistance in strengthening management systems.
- (c) strengthen Pusdiklat's ability to manage the trainer network and assist Pusdiklat to plan the utilization of HTR&D - developed training capabilities in the up-coming World Bank Project.
- (d) modify the methodologies of task analysis, case development and impact evaluation to make them more "accessible" to trainers and supervisors.
- (e) explore ways to integrate training into regular MOH supervisory activities.

Possible Costs (very rough estimates):

1. Small group training program	\$ 250,000
2. Internship costs (12 x 3 months)	\$ 150,000
3. Short-term consultants (9 man-months)	\$ 90,000
4. Costs of advanced training program (1 month x 40 participants)	\$ 100,000
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	\$ 590,000
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Option 2 - Intern development in TOT and consultancy

Provide up to three months of supervised development for 12-15 management consultancy interns. During this period, key intern candidates from Pusdiklat (high priority) and HTR&D assisted provinces would be supervised by LTC Rolf Lynton and short-term consultants. The interns would work on items (a) through (e) above.

Possible cost:

1. Internship costs* (12 x 3 months)	\$	150,000
2. Short-term consultants (9 man-months)	\$	90,000
3. Costs of advanced training (1 month x 40 participants)	\$	100,000
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	\$	340,000
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Option 3 - Internship development in consultancy

Three months of supervised consultancy for 8-10 management interns. Interns, under the supervision of LTC Lynton and two STCs would carry out items (b), (c), (d) and (e) above.

Possible Cost:

1. Internship Costs (10 x 3 months)	\$	125,000
2. short term Consultants (6 man-months)	\$	60,000
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	\$	185,000
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- * It is possible that some of the internship costs for consultants working with the immunization program could be paid by that program.

Option 4 - Internship development on Pusdiklat Management

Three months of supervised consultancy for 4-5 management interns, supervised by LTC Rolf Lynton. These consultants work on items (c) and (e) above.

Possible Cost:

1. Internship Costs (5 x 3 months)	\$ 63,000
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1.1 Introduction

In its current five year plan (Repelita IV), the Ministry of Health has given very high priority to developing manpower and strengthening management of health programs. During Repelita IV (1984-1989) the Ministry of Health plans to increase its health personnel by about seventy-five percent, from about 162,000 in 1984 to 284,000 in 1989.

To achieve this increase will require a doubling of graduate level physicians, from 12,713 to 24,094 in 1989, an increase of trained nurses from 44,651 to 76,238, and a tripling of other technical paramedicals (sanitarians, dental assistants, lab technicians, assistant nutritionists, etc.) from 12,011 to 38,455.

Much of the responsibility for the training required in this rapid manpower expansion was charged to the Center for Educational Training of Health Personnel (Pusdiklat). In 1983, Presidential Decree No. 64 reorganized Pusdiklat into two centers for training of health manpower: pre-service training was given to the Center for Education and Training for Health Manpower (Pusdiknakes) and in-service training was to be provided by the Center for Education and Training of Health Personnel (Pusdiklat).

During Repelita IV Pusdiklat is expected to provide or coordinate in service training for nearly 342,000 health workers in technical, operational and health management skills. The Center is also expected to supervise the pre-employment training of 150,000 new personnel which are produced by Pusdiknakes' pre-service training, and to conduct civil service "career" training in management for echelon III, IV, and V personnel. According to long-term projections in Repelita V and beyond to the year 2000, this huge in-service training load will continue to increase as Indonesia attempts to meet its long term health goals.

At the present time, Pusdiklat's capacity to meet these in-service training goals are clearly inadequate. Pusdiklat is staffed by less than twenty administrators and no fulltime trainers. In practice, eighty percent of inservice training, especially of technical skills, is provided by the operating units of the MOH. Pusdiklat plays a limited consultative role in that training at this time. Pusdiklat primarily provided management training and training of trainers and must rely upon part-time trainers who are otherwise employed as provincial administrators and other health professionals. Only a few of these part-time trainers are professionally prepared as trainers and training is primarily of the traditional lecture and question format based upon curricula prepared at Pusdiklat for all 27 provinces.

It is against the backdrop of this great need for increasing the amount and quality of in-service training that the Health Training, Research and Development (HTR&D) Management Training Component was developed. The overall HTR&D Project (USAID Project No. 497-02730) was begun in 1979 and contained four components: Planning/Manpower Development, Research, Management Information, and Diarrheal Disease Mortality/Morbidity Reduction. This large project, originally conceived as independent but highly related sub-projects, was designed to improve the Ministry of Health's planning abilities at both central and provincial levels and to assist in the extension of primary health care, particularly through improved services to mothers and children. Through the years the HTR&D project has undergone numerous changes in organization and purpose. The description of these changes is beyond the scope of this assessment, but they have resulted in the increasing independence of the Management Training Component from the other remaining components of the HTR&D. It is only the Management Training Component of the Project that is the subject of this Final Assessment.

The purpose of this final assessment, as stated in the authorizing PIO/T is to "assess progress of the Manpower Training Component of HTR&D. The assessment will focus on improvements in the capacity of the Pusdiklat in the MOH to conduct management training. The assessment is also intended to identify constraints affecting the institutionalization of the successful accomplishments of this component and recommend operations for addressing these constraints".

In keeping with this purpose, the strategy chosen for this assessment was to focus on training utilization, not the technical quality of the training. The latter, as implied in the PIO/T purposes, had been shown to be outstanding as evidenced by numerous course evaluation and reports by course participants and MOH officials. The specific objectives and questions that guided this assessment were as follows:

1.2. Objectives of the Assessment

- A. To assess the major impacts of the HTR&D management training component on MOH training capacity and utilization of that capacity.
1. What is the output of the project in numbers of trainers with different levels of capability ?
 2. What training methodologies and training materials (case studies, modules, etc.) were developed ?
 3. How are these training capacities being utilized by the MOH ? What are the plans for future utilization ?
 4. What has been the impact of HTR&D activities on the management capacity of the MOH at the provincial and central levels ?

- B. To determine which HTR&D training capacities are supportable by the MOH without USAID funding and to describe the obstacles to continuing support.
 - 1. What are the unmet demands in the MOH for the HTR&D developed capacities?
 - 2. Is the MOH committing sufficient resources and management systems to maintain and further develop this training capacity ?
 - 3. What are the financial and organizational obstacles to the survivability, growth and development of this capacity ?

- C. To recommend a strategy for USAID support for the HTR&D management training activities.
 - 1. What are the priority HTR&D activities that should receive further support ?
 - 2. What has been learned from this project that could be applied to future efforts to strengthen GOI training capabilities ?

1.3. Assessment Approach and Activities

This assessment was carried out by training and management consultant Gary Bergthold during a three week visit to Indonesia, from January 20 to February 11, 1986. Dr. Bergthold had earlier (May-June, 1985) served as a short term training consultant to the project and so was somewhat familiar with the design of the project and its field operations.

The two sources of data on which the assessment was based were interviews with forty individuals in Jakarta and three participating HTR&D provinces and numerous documents including quarterly and annual reports by the HTR&D consultants, USAID project documents, memoranda, MOH documents, and project evaluations (e.g. Mid-Project Evaluation, March 15, 1983). The first week of the assessment was devoted to interviewing key

USAID, HTR&D and Pusdiklat officials, and reviewing project documents in order to determine the objectives of the assessment and to design an appropriate methodology, including the preparation of interview schedules. It was decided that interviews should be conducted with officials responsible for managing training activities at Pusdiklat and in the provinces, with individuals who had received training provided under the HTR&D project, and with individuals who had utilized training in their programs (see Appendix A for a list of interviewees).

The three provinces chosen for field visits were West Java, Central Java and West Sumatera. In all three provinces the HTR&D long-term consultant had completed his six to eight month intensive intervention. This permitted observations to be made of how the MOH was implementing training activities without direct HTR&D consultant support. Central Java was chosen for study because it was the first HTR&D province (LTC left July, 1983). Intense activity during the LTC presence in Central Java was followed by a year-long dormant period as some the key trainers and administrators had been transferred, were away on other assignments or pre-occupied with other duties (National Health Week was held in Central Java in 1985). Reports indicated, however, that training activities had picked up in recent months, making this province a good place to study the longer term "survivability" of the HTR&D interventions. West Java had an HTR&D LTC until September, 1985 and was chosen because it afforded a view of a wide assortment of HTR&D-inspired activities in a broad range of settings. West Sumatera had its LTC from March to November 1984, and it provided an opportunity for observe an HTR&D project that worked symbiotically with another USAID-sponsored health project (CHIPPS).

During the second week, two-day visits were made to each of the three provinces. In each province I was given total access to the people I wished to interview and I was provided transportation for

visting individuals outside of the capital city. In all three province I was accompanied by a Pusdiklat staff member who decribed to local officials the purpose of the assessment and to help with logistics and arrangements.

During the third week of the assessment, interviews were held with officials at Pusdiklat and the Ministry of Health (DepKes). In addition, interviews were conducted with representatives of the World Bank and Ford Foundation about possible utilization of trainers in health projects sponsored by those agencies. The final part of the third week was devoted to preparing a draft report and attending debriefing meetings at USAID.

1.4 Format of the Report

This assessment report, as stated earlier will focus upon institutional impacts of the HTR&D project at both the provincial and Central MOH levels. Section 2 of the report will describe briefly the objectives and strategies followed by the project. This will be followed by brief case studies of the HTR&D project in the three provinces visited (Section 3). Section 4 will describe the assessment findings and conclusions as well as recommendations based upon these findings. The final section of the report will present general conclusions and observations that might be utilized to guide USAID strategies for future projects aimed at increasing GOI training capacities.

2.1 HTR&D objectives and strategy

I found it somewhat difficult to determine the precise objectives and strategy followed by the HTR&D project by reading the project documents and interviewing project personnel. This is due in part of the size and complexity of the project and to the fact that the strategy has shifted and moved continuously in response to opportunities and learning about what works in a given situation. This is not to say that the project was purposeless or unguided. On the contrary, I found that this flexibility, or "strategic" approach was much preferred to a static "blueprint" approach that surely would have been rejected by the health system.

Difficulties in communicating the essence of the project have created a certain amount of confusion in USAID and Pusdiklat about what the project is doing and why. It is with the hope that I can contribute to clarifying the project strategy that I offer my attempt at a description. The format I will utilize in this description is based upon the Logical Framework (Log Frame) which is a familiar USAID planning and evaluation tool.

The ultimate objective of the HTR&D project is to contribute to achieving the health goals of the Government of Indonesia, as stated in the present five year plan (Repelita IV). Specifically, these goals are:

- (a) strengthening health service delivery, including measures to support and expand primary health care activities at the community/village level;
- (b) Strengthening health manpower development;
- (c) expanding activities to improve nutrition, potable water supply, and environmental health;
- (d) establishing programs to strengthen the overall management of the health system; and
- (e) improving the supply, distribution and quality of drugs, medicines and medical equipment.

The HTR&D project is related to all five priorities but is especially relevant to goals (b) and (d). More precisely, the HTR&D sector goal has been stated as follows:

Improve MOH management capabilities to identify key problems, develop solution strategies, and implement effective solutions.

The project purpose (End of project Status) is somewhat more difficult to identify. Goal statements made years ago in early project documents do not totally reflect the reality of the project and more recent documents are not precise in their statements of objectives. The following is my attempt to clarify the project purpose from my observations and reading of recent documents.

2.2 Project Purpose (EOPS)

Pusdiklat has the capacity to provide specialized management training and technical assistance to planning offices of Provinces and Directorates General in accordance with needs identified by studies of actual problems and local field situations.

- Pusdiklat regularly assesses the management problems affecting performance in key service sectors.
- Pusdiklat regularly contributes to the formulation of MOH management improvement strategies, including training.
- Pusdiklat directly provides effective management training and technical assistance which contributes to the solution of identified problems.
- improved management training techniques and materials are adopted in health training institutions (e.g. BLKMs, medical schools).
- Pusdiklat has the capability to manage, enlarge and increase the quality of its training and technical assistance capabilities.

2.3. Outputs

As stated above, the specific aim of the HTR&D management training component has been to enhance the training and technical assistance capability of Pusdiklat and the MOH. The specific outputs that create this capacity are people with various levels of skills in training and technical assistance consultation, materials such as case studies and training modules, and task analysis studies. Section 4 will document the types and numbers of these outputs. This discussion will describe the strategy for creating them.

The focus of the strategy has been province-based so that the bulk of the capacity building has occurred in five selected provinces. The intent was to strengthen provincial capabilities to analyze training needs, deliver and evaluate training, and to increase the provinces' ability to influence and to re-interpret guidelines and policies made at the central level. A great deal of effort has gone into direct work with Pusdiklat, however, primarily by the project coordinator, LTC Rolf Lynton. The work at Pusdiklat in the early years of the project seems to have centered on creating the favorable conditions that would enable the province-based work to go on without interference. In recent years, as the provincial work has become more securely established, the focus has shifted to capacity building at Pusdiklat, with staff members participating in more training courses and HTR&D consultation focusing on building the policies and management systems needed to support the training capacity.

The work of the HTR&D consultants, at both the provincial and central levels, has concentrated on capacity building, which can be defined as creating the organizational practices (norms), skills and policies necessary to create a viable national management training system. In the following I will describe the strategies followed in building this capacity.

2.4 Organizational Practices (Norms)

The change introduced into the MOH by the HTR&D project was intended to be normative, that is, create new patterns of behaviour and organizational practice consistent with project objectives. Specifically, the norms which the consultants intended to introduce were as follows (findings related to the implementation of these norms can be found in Section 4):

1. Pusklat personnel should participate in field training and other activities in order to learn about real problems and needs. Earlier, Pusklat saw itself as initiating all activities based upon central office priorities.
2. Pusklat guidelines should be seen as permissive; that is, stating direction and minimum requirements that can be adapted to local need rather than prescriptions for rigid implementation.
3. Training should be seen as a management problem solving tool which includes careful needs assessment to determine the problems to be solved, results-oriented training, and follow-up to monitor and assist participants to introduce the desired changes. Training budgets should include money for needs assessment and follow-up.
4. Training should be seen as part of a total management strategy, the development of which should be assisted by the trainers. Training should not be isolated from other management functions.
5. Training should be delivered by a team of individuals which shares responsibility for needs assessment, design, delivery and follow-up. Training based upon "canned" lectures from outside "experts" should be eliminated.

6. Training should be delivered in "modules" which allow participants to participate and practice the skills or behaviours expected of them. Emphasis should be on practical results and change rather than knowledge unrelated to practical application.
7. Training modules, cases and teaching methodologies should be continuously modified according to the results achieved. Training that becomes "formalized and routinized" should be eliminated.
8. When participants are paid for participation in an event, payment should be based upon production of quality products or results (judged against explicit criteria) rather than for mere participation in routine activities. For example, participants in case writing seminars should be paid per completed acceptable case produced.
9. Selection of participants for training should be made on the basis of agreed upon criteria related to program need rather than convenience or monetary incentives.
10. Selection of persons as trainers or participants for advanced levels of trainer training should be based upon explicit criteria and demonstrated competency.
11. Collaboration between province and region should be encouraged. Trainers developed in one province should be utilized to develop skills in other provinces, especially within the same region.

2.5 Skill Development

The HTR&D management training component has used a model of competency-based training in developing skill capacities. Rather than viewing the human resource outcome of this project as a

single set of skills, it must be viewed as a hierarchy of skills, with each person progressing up a ladder of skills development depending upon his or her demonstrated mastery of skills at the previous level. Each competency is further broken down into several capacities. Trainees who have participated in task analysis (TA), for example are further divided into three capacities: (1) knows about TA; (2) competence in applying TA for job holders and program units and, (3) competence to use TA for role clarification, planning supervision and management systems, and developing education and training curricula.

The HTR&D program has developed three levels of competencies that define distinct stages of trainees' capability, from ability to perform the skill adequately with minimum supervision (Level I) to the ability to train trainers and provide management consultation (level III). Individuals who have demonstrated competence at level III would be able to replace the HTR&D consultants in advising Pusklat in training system development, in developing new trainers and maintaining the trainer network.

Following are the three levels of trainer competency that the HTR&D project intends to create:

Level I - Can perform the technical skills with minimum supervision.

A. Technical Tasks

1. Task Analysis
2. Case Development
3. Impact Evaluation

B. General Training Skills Workshop (TOT)

Level II - Can provide management skill training with minimal supervision and train others in the use of technical tasks.

A. Advanced TOT Program

Level III - Can train trainers, train others in the technical skill areas and can provide organizational and management consultation.

A. Internship Program

1. Technical Tasks
2. System Development

The numbers of individuals who have attained each level of competency is presented in Section 4 of this report.

Specific criteria have been developed to select candidates for each level. For example, criteria for candidacy in the advanced program (Level II) are:

1. Completion of at least one HTR&D technical input and evidence of its successful application on the job (e.g. completion and use of a case, TA carried out and applied).
2. Evidence of capacity to profit from further HTR&D-type training (judgement of HTR&D consultants).
3. completion of general training skills workshop.
4. High motivation (evidence of participation in trainer network, program planning, professional development activities).
5. Kakanwil certifies that the candidate will be available for continued and regular work as a trainer.

Similar criteria are used to select the candidates for Level III interns. Criteria include measures of demonstrated performance as a trainer, high personal and interpersonal competence, development potential, and organizational support.

2.6 Policy and Organizational Supports

The strategy of the HTR&D project recognizes that the capacity of the MOH to provide quality management training depends not only

upon favorable norms and skills but also upon supporting policies and organizational structures. The MOH policies regarding incentives for trainers, the lack of clear career paths, the separation of technical and managerial training, and poor linkages between training institutions and user institutions have conspired to isolate training and make it into a ritualized activity rather than a management tool for solving important problems. Recognizing this, the HTR&D consultants have attempted to influence these policies and organizational issues. They have also been concerned about training sufficient numbers of people and selecting from strategically placed units so as to create a critical mass that would be less vulnerable to erosion from normal transfers and dropouts and from organizational attempts to limit their effectiveness. In Section 4 of this report, findings will be reported regarding these policy and organizational support for the program.

Comments on the Strategy

The stated targets for in-service training for which Pusdiklat has been given responsibilities is at least 200,000 trainees during FY 1984-1989 (Repelita IV - see page 1 of this report). If Pusdiklat hopes to actually train even a small percentage of that number it must consider changing its basic strategy. At this time Pusdiklat, with HTR&D support is pursuing a "train the trainers" approach with an apparent goal of developing a cadre of full time trainers attached to training centers throughout the country.

With even the most superficial analysis it becomes immediately apparent that Pusdiklat will need a small army of trainers to fulfill the need. Present plans are to develop at least 145 full time trainers over the next several years.

It seems to me that this approach will fail, both because it is extremely expensive, and because it sets training apart from

on-going managerial practice. Experience with such isolated training shows that training becomes increasingly irrelevant and ineffective in solving real problems.

Interestingly, the work of HTR&D can be seen as leading to a very different strategy. In actual practice, the training provided by HTR&D has been provided by part time trainers who are in fact often the supervisors or administrators of the people they train (Provincial trainer/administrators work with Kabupaten staff who in turn train Puskesmas staff). The content of the training tend to deal with identifying field problems, seeking solutions to the problems, and planning actions to solve the problems.

This approach to training is, in practice, hard to distinguish from good supervisory practice. Supervisors also work with their staffs in detecting problems, finding solutions, planning actions and developing skills that will be helpful in the work.

Unfortunately, calling these activities "training" brings into play a whole variety of unfortunate factors - fulltime trainers who don't understand the programs, difficulties in follow-up, and policies and traditions in the MOH that require honoraria for trainers and payments for participants.

Supervisors on the other hand, don't get paid extra for supervising nor do they need funding for follow-up.

3.1 Case Studies - Three Provinces

The HTR&D management training component has provided training and technical assistance in eight of the twenty-seven provinces of Indonesia plus the central education and training department (Pusdiklat). In only five of the provinces have the long-term consultants worked for a significant enough period (usually about six to eight months) that definite impacts could be expected. These provinces are West Java (Jawa Barat), Central Java (Jawa Tengah), West Sumatera (Sumatera Barat), East Java (Jawa Timur), and Aceh. A sixth province, South Sulawesi had a consultant for a few months but he left without being able to establish a viable program.

As part of this assessment, I visited three provinces (Central Java, West Java and West Sumatera) and interviewed several of the participants and users of HTR&D programs. I also interviewed the long-term consultant who worked in each province. The following are some brief observations of the program that developed in each province.

3.2 Central Java

Central Java was the first province to receive concentrated consultation from the HTR&D project. LTC Udai Pareek went to Central Java in February, 1983, and remained until July. Pareek was met with initial resistance and skepticism from top Kanwil staff when the project was described. The attitude, as reported by the planning director at the time was, "Oh no, not another consultant sent from Jakarta!" This resistance largely disappeared, however, as a result of a management course conducted by Pareek with most of the Kanwil staff. During that course it was decided that the HTR&D project had something useful to offer. The best strategy for gaining acceptance was to show results on key problems in the province and to involve all levels of the organization, from the Kakanwil to the community health centers.

During 1983, during Pareek's residence, six of the original participants in the management course formed a team to provide management training for program chiefs at the Kabupaten (Regency) level. Pareek served as lead trainer and consultant to the team as they carried out much of the training. During this period another management training course was conducted for doctors at the Puskesmas level, again trained by the team of six with Pareek's assistance.

Another significant event during the introduction of HTR&D to the province was a training program in task analysis involving the original trainers and hospital staff. This course was conducted by STC T.V. Rao and Pareek. The site used for field experience was the pediatric ward of the Kariadi Hospital in Semarang. The response to this course was enthusiastic and resulted in the utilization of TA in various other settings.

After Pareek left in mid-1983, the program continued at a fairly high level of activity with only occasional consultation from HTR&D. During 1983 and 1984 additional management training was provided for Puskesmas doctors and a TA was conducted with Kabupaten staff. Trainers also conducted TOT courses at the Kabupaten level, for family planning staff and for volunteer workers in community health centers. Technical training was also provided for malaria workers, using training techniques adopted from HTR&D.

During 1985 the level of activities dropped off markedly. The training coordinator (Lufti) was away for much of the year, the Kakanwil resigned and was replaced and several other key trainers were transferred or were away on temporary assignments. Those who remained were preoccupied with setting up the annual "National Health Day" activities which were held in Central Java in 1985.

A good test of the viability of the HTR&D approach is whether training activities resumed after this nearly year-long hiatus.

As of my visit in late January, the signs were quite positive. In early January a two week TOT course was given by the training team and two visiting HTR&D interns from West Sumatera with the supervision of Pareek. Thirty three participants have been selected for a three week course on hospital management scheduled for the end of February. In early February a task analysis project is scheduled to begin in a local hospital. All of these activities are being funded by local and central (DIP) funding.

A variety of plans have been developed for training and T.A. for later in 1986 but there is some uncertainty about how budget reductions for FY 86-87 will affect these plans. At this time, final budget decisions have not been made. The new fiscal year starts in April. Plans for next year include more training for hospital staff and health center staff, and TOT for family planning staff at the Kabupaten level (these programs are in the DIP budget). There have been requests for more TA at the hospital, TA for administrative positions at the Kanwil (to improve supervisions and control systems) and for TA at the Kabupaten level to improve management of the immunization program. These latter programs have not been included in budget plans.

What has been the impact of these training activities? Twenty-seven people in the province have directly received HTR&D training in TOT, case development, consultantion and TA. They in turn have trained thirty-five trainers at the Kabupaten level (three in each) plus many trainers for family planning. Only one Central Java trainer has gone through the advance training program and is eligible for the internship program although several are now eligible for advanced training.

Dr. Nardho Gunawan, Chief health officer (Kakanwil) reports that as a result of the HTR&D project, training has become much more results-oriented, with participants working on real field problems and finding solutions to these problems.

He said training methods have become more participative with greater emphasis on group discussion, skill development and problem solving. He reported that more time and effort is going into needs assessment and course design and that training is more systematic and focused on solving real problems. The Kakanwil also suggested that training given in the province in response to DepKes (Department of Health) initiatives is now being modified, both in content to make it more relevant to local needs and in methodology to make it more participative.

No formal evaluation or follow-up of training is being done to determine whether this more "results-oriented" training is in fact resulting in concrete changes. Informal anecdotal evidence is cited (Puskesmas doctors keeping better records and writing more realistic annual plans, health center volunteers taking greater responsibility and broadening their role) but more systematic follow-up is definitely needed.

Although several people in Central Java had received case development training and several cases have been developed and used (in the medical school and Puskesmas training), little further development of the case study technology has occurred. Most trainers reported that case writing is "too difficult" and time consuming and they predicted that no further cases would be developed unless special funding were obtained for that purpose.

Task analysis has been more strongly adopted in Central Java. I met with some of the people who had conducted the TA in the Kariadi Hospital in 1983. They reported that TA had been done to solve the problem of heavy work loads of nurses in the pediatric ward. They remained quite enthusiastic about the potential of TA but frustrated at the lack of implementation. Their TA study had indicated that nurses aides could be trained to take many of the tasks presently done by nurses. The TA also resulted in a curriculum for training aides and nurses. As of

now, however, no aides have been hired and no training has occurred. The only concrete result was that job descriptions were written for nurses. The reason these recommendations have not been implemented, according to the group, was that the hospital director had not been involved properly in the study. The hospital had been used as a training site and the director had not initiated or asked for the study. He has received the report but says he has no budget to implement the main findings.

In spite of these poor results the group feels that TA, if properly introduced, could be a useful technique. They advocate that TA be done in many hospitals nation-wide to give national attention to the problems and to be able to compare results and develop more standard staffing practices and work procedures. They recognize that this broad application is unlikely because of the time required to do TA (20 days by a team of 10 at Kariadi), the high cost and resistance by decision makers.

During my visit to Central Java I also explored the issues involved in the management of the network of trainers. In Central Java no official structure exists for managing training. An unofficial "coordinator" meets regularly with 8-10 people in a "training team" to plan training activities and to design specific courses. The coordinator feels a permanent training office should be established to plan, carry out and monitor training. He believes that training has received much more visibility and attention as a result of HTR&D involvement but that the pressures of other duties make it difficult to focus the resources and time necessary to maintain a quality program.

3.3 West Java

The province of West Java had its resident HTR&D LTC Michael Merrill, from August, 1984 to September, 1985. When Merrill arrived he found little enthusiasm for involvement with HTR&D.

By mid-November, 1984, little had been accomplished and Merrill seriously questioned whether the province was "ready" for HTR&D or whether "Jakarta" had pushed it on an unwilling province. In late November Merrill set up a meeting with the Kakanwil and his key staff but no one attended - only two counterparts assigned to Merrill. At this, Merrill cancelled the meeting and confronted the Kakanwil about whether he wanted the project. At the threat of withdrawal the Kakanwil set up a training team, gave his support, and the project got underway.

Since January, 1985, things have developed rapidly in West Java. Trainer training was carried out in a three tier approach. Merrill first trained a group of thirteen "key trainers". The Kakanwil was included in this course, further strengthening his support. These key trainers in turn trained forty five (of seventy total) "provincial trainers", with Merrill as consultant to the trainers. The training was for one month, twenty four days in theory and techniques of modern training and design of a TOT course for the next tier regency (Kabupaten) trainers. During the final six days of the course the provincial trainers trained one hundred twenty regency trainers, backstopped by the provincial trainers who were in turn assisted by the original key trainers and Merrill.

Since this initial training, the trainers' competencies have been put to very good use. Courses have been given by trained trainers for midwives, immunization workers, regency health educators, hospital management, diarrheal project, family planning and school health administrators.

In addition, trainers have been involved in HTR&D case development, TA and impact evaluation courses. Cases have reportedly been used widely in the training conducted in the province but there is no evidence of continuing case development. Task analysis has been used to a limited extent and one program was being out during my visit (see below).

Impact evaluation is being utilized by the evaluation unit but no systematic evaluation of training is being conducted.

An evaluation of participant reaction to training in hospitals indicated that participants liked the case method approach, the interchange about problems in the hospital, and the "human" approach taken by the trainers. The only suggestion was that more cases are needed on problems in hospital management. No follow-up or evaluation of post training impact or application was attempted. Several of the trainers emphasized the need to develop ways to determine whether trainees are applying what they have learned on their jobs.

There seems to be a large demand for training and TA in West Java. There are presently plans in the budget to extend TOT to all 70 provincial trainers and to complete the training of Puskesmas doctors. Specially funded programs such as family planning, diarrheal control and immunization are planning to conduct training programs.

In West Java, the LTC paid particular attention to the creation of a well functioning training team, "key trainers" who could plan, execute and monitor training. This group continues to function well, often meeting a day or two a week to plan their activities, evaluate past courses and design new ones. The Kakanwil has appointed a team leader and is seeking approval to appoint him to a full time position next year. He will do this by setting up an unofficial training center (BLKM). The Kakanwil's intention is to eventually fold the core team of trainers into the provincial BLKM, thereby giving them the institutional anchoring they need to function more effectively.

During my visit to West Java I had the opportunity to visit a group of ten persons conducting a TA in a rural hospital that is changing from a class V to class IV designation. The group's concerns illustrate some general problems that should be addressed.

When I asked the group why they were conducting the TA they said, "To be trained in task analysis". On probing I discovered that the group had no clear understanding of its purpose. One person said, "We know what our objective is (training) but we are confused about our goal". They explained that they were documenting a severe shortage of nursing personnel in the hospital and a great deal of confusion about roles. This was not surprising to them but they felt TA had helped them understand the problems more clearly. The problem they voiced was that they did not know who wanted this information. The hospital administrator was involved and interested but they felt he could do nothing without high level support. They did not believe their report would be seen by the relevant decision makers, or even if it were seen, that they would act upon it.

This example illustrates how easily even a potentially useful management technique such as TA can become an empty ritual, further lowering the belief that "something can be done". If this TA is indeed an empty exercise it has clearly served no purpose, either as a management tool or as a training device.

3.4 West Sumatera

The HTR&D program in West Sumatera was introduced in March, 1984 by LTC Udai Pareek who remained until November, 1984. Although described as a "difficult" province in which to work, the program developed rapidly, largely because of the cooperation and support provided by the CHIPPS project and its coordinator Dr. Roger Feldman.

Pareek introduced the project by describing to provincial staff members the advantages of the "problem-solving" approach to training over the traditional "classroom" approach. An initial group of fifteen staff from the Kanwil, including the Kakanwil, volunteered for trainer training. This group designed TOT for the next batch of trainers (28 total) by developing training modules

on training process and strategy, training needs assessment, design, and evaluation and follow-up. Part of the training also dealt with planning to develop a training institution. This initial course was followed by an advanced seminar on consulting skills jointly sponsored by HTR&D and CHIPPS and co-trained by Pareek and Feldman. This group of twenty eight trainers have formed the back-bone of training capacity in West Sumatera and have rapidly expanded their training activities by linking training to the solution of recognized problems. There is a growing demand for training at all levels and money seems to be available, especially for community health, family planning, immunization and diarrheal control. The Kakanwil is highly supportive of the training approaches introduced by HTR&D.

Two examples of training approaches used in West Sumatera might illustrate some important issues. The first example is Puskesmas management training for 120 participants related to the development of integrated services. Training was conducted in four groups by the 28 health trainers. The training included the entire staff at each Puskesmas clinic (usually 3 - doctor, nurse/midwife and auxiliary). This was done to create a "team approach" and to see that the team "spoke the same language" about management. The course included theory and skills of management, leadership skills, SKN (National health policy), and epidemiology. The particular content was based on a task analysis study that had been carried out in several Puskesmas.

During my field visit I had an opportunity to meet with a Puskesmas doctor who had participated in this training. He described the training as "very active" and extremely different from courses he had previously received. " We were not just receiving training but thinking how to solve problems". As examples, he described how his training group planned a program to

manage an outbreak of diarrhea in a village, and also how they planned to involve community leaders in an immunization program.

Asked how he had utilized the training he showed me a detailed set of targets, plans and data on users that he had set up after the training. He had also changed his own methods of teaching, from a lecturing approach to involving participants in identifying and finding solutions to problems. He has provided training to community health volunteers and school teachers. He has even had school teachers ask his help in introducing "modern teaching" in their classrooms.

I asked the Puskesmas doctor why he felt these teaching methods had been accepted so readily. His reply was interesting. These participatory methods are much closer to the normal style used by village people to solve problems. He said, "With these methods we are going back to nature. We call this "musyawaran" -decision by consensus". "Furthermore," he said, "these people like to talk. Once they have been given the opportunity to participate they will never again accept someone coming to tell them what to do".

The second illustration of a program in South Sumatera involves training for the medical school field training program in community medicine. This program sends medical students out to villages to live with families and study health problems. In the past the faculty supervisors had not supervised the program well and students were not benefitting from the experience.

Again, a task analysis was done to determine what the problems were in supervision and to design appropriate training for the faculty. Three members of the faculty and health office personnel did the TA. Ten days of training based upon the TA findings was conducted for faculty members.

The results have been impressive. Faculty members are now spending more time in the field, supervision is much more focussed and there is evidence that teaching has become more closely related to community needs and problems.

The problem is that the Dean of the medical school would now like to do the same kind of thing with his faculty that teach medical and laboratory courses. But he has no funds, neither for TA nor training. The field supervision course was funded by CHIPPS.

The trainers in West Sumatera feel that they need a structure to more adequately manage training programs. The training group is very competent but has little internal cohesion. A temporary training officer has been appointed but he has no staff or clear mandate. He feels that a permanent training office should be set up in the province. The Kanwil will be proposing at the March national health conference that approval be given to a "health training officer" position and staff.

A BLKM, meanwhile, sits a few miles down the road from Padang. It has one full time trainer, an individual who has participated actively with the HTR&D program. It has a modern building with space to train and house over fifty people. It remains unclear what the role of the BLKM will be and how it will relate to the training officer and training team.

4.1 Findings, Conclusion and Recommendations

4.2 Outcomes

To obtain some idea of the magnitude of skilled persons developed by the HTR&D program, a summary was prepared of the number of people estimated by HTR&D consultants to have each of the competencies developed by the program. Table I presents this summary.

Table I
Number and Location of HTR&D Trained Individuals Possessing Each Training Competency*

Competency	Pus-diklat	JaTeng	SumBar	JaBar	JaTim	Acen	Total
A. Task Analysis							
1. T.A. of Job Holders	8	10	22	10	15	-	65
2. For role clarification	8	6	22	10	15	-	61
3. Identifying training needs	8	6	22	10	20	-	60
B. Case Development							
1. Case writing	-	2	1	3	2	2	10
2. Case teaching	1	2	9	5	3	-	20
C. Impact Evaluation							
1. Evaluate training	8	2	2	2	2	2	18
2. Program planning/monitoring	2	2	2	2	2	2	12
D. General Training Skills	11	7	18	12	7	7	62
E. Advanced Training Skills	6	5	12	9	7	5	44
F. Internship Program (candidates)***	5	1	8	5	4	1	24
G. Case Studies Completed	-	-	-	-	-	-	30

* Figures from HTR&D reports

** Since many individuals have obtained multiple skills many appear more than once in this table.

*** Have not completed the program.

As seen in Table I, the HTR&D has trained a significant number of people. It should be noted that these numbers represent only "first generation" training; that is, training provided by HTR&D consultants. These first generation consultants have, in turn, trained many others (second generation) there is some evidence (see Section 3.4) that some third generation training has occurred. It is difficult to make valid estimates of the total number of people trained directly or indirectly in HTR&D "technologies", but the number is probably well in the hundreds.

The competencies in which the most people have received training is task analysis (60+) and general training skills (62+) (It should be noted that many of the same people received both TA and training skills).

Perhaps the most important skills for the utilization and development of management training are the competencies of advanced training skills and the internship program. A total of forty-four individuals, distributed rather widely among the five provinces and Pusklat have received sufficient training to be able to provide management training with little supervision. Of these forty-four, twenty-four are candidates for the internship program but have not yet gained the competencies needed to provide trainer training to others and to consult on management problems. These are clearly key skills needed for the extension and maintenance of the pool of competent management trainers.

Fewer individuals have competencies in case writing (10) and impact evaluation (12). Project funding has not been sufficient to train more case writers or to enable anyone in the group to reach the intern level (able to teach others to write and teach cases). Impact evaluation is a rather recent addition to the HTR&D programs and relatively few people have taken that training. Significantly, eight of the eighteen participants in

impact evaluation training were from Pusdiklat where that competency might find the greatest utility. Only one impact evaluation trainee has reached the stage of being able to train others.

4.3. Part One - Findings, Conclusions and Recommendations Regarding the Technical and Training Capacities

This section of the final assessment of the HTR&D management training component will present overall findings and conclusions and general recommendations based upon these findings. The findings, conclusions and recommendation will be organized into three parts. Part one will deal with findings, conclusions and recommendations regarding the utilization and adoption of the technical and training capacities introduced by the HTR&D project (trainer training, task analysis, case development and impact evaluation). Part two will present findings, conclusion and recommendations regarding the institutional support for these activities.

A. Trainer Training

Findings and Conclusions

Recommendations

1. Modern methods of management training have been introduced into health programs in five provinces of Indonesia and into Pusklat.
2. At least sixty five individuals are capable of training others in modern management training methods and have utilized their skill to train other people
3. There is a great demand for management training using these methods in a wide variety of high priority health programs.

4. In the five provinces where the HTR&D project has operated, 46 trainers have received "advanced training for management trainers". Another 50 candidates are eligible for advanced training. If trained, they would provide Pusdiklat and the 5 provinces sufficient training capacity to satisfy existing and immediately foreseeable demands.
4. Additional trainers (30-40) should be provided advanced training to provide a sufficient pool of skilled trainers in each province. At least 6-8 Pusdiklat staff members should also be given advanced training (high priority).
5. The expansion of training centers (BKLMS) on a national scale will require large numbers of trainers with modern training skills in all provinces of Indonesia. World Bank support for this program will rapidly accelerate this demand for trainers.
6. MOH traditionally has not budgeted funds for training of trainers. The World Bank loan will provide funding to train large numbers of trainers. This will increase the demand for TOT in provinces not now served by HTR&D.

7. The existing pool of experienced interns capable of training trainers for the training centers is now very limited but 8-15 individuals could gain the necessary skills with additional supervised training-experience.
8. Modern training methods as introduced by HTR&D do not greatly increase the costs of training over more traditional methods. They are also socially and culturally acceptable technologies. Therefore, these methods are very likely to be adopted and disseminated by health institutions
9. These training methods are designed to produce concrete results that impact the delivery of health services. Anecdotal evidence indicates that such impacts are occurring.
10. Trainers are weak in evaluation and follow-up methodologies.
2. Highest priority should be given to the development of training interns so that sufficient individuals are available to expand and extend the pool of skilled trainers as they are needed.
3. Simple and appropriate methods for following up training should be developed by the trainers. Training funds should include money for follow-up (see recommendation D-3,4,5 below)

11. Training budgets seldom contain money for follow-up and evaluation.
12. Little follow-up and evaluation of training is being done to determine whether management training is producing intended results. This creates the danger that training will become irrelevant.
13. Systematic evaluation has been conducted of the two advanced TOT programs as part of the impact evaluation training program. Reports of the results of these programs have been generally positive (see summary Appendix B).
14. Trainers are not strong in the "harder" aspects of management such as organization design, logistics, financial management, etc.
15. Program managers are reluctant to use trainers who lack intimate knowledge of program content and field realities or who lack credentials in the program specialities.
4. Advanced trainers should be given broad management training from a management training institution (this is being planned as part of the World Bank program).
5. Pusdikalt should assign interns to work with specific operating programs to demonstrate the role of consultant/trainer and create awareness of the value of these

16. Program managers in immunization and diarrhea control have requested that Pusdiklat provide HTR&D trainers to work closely with their programs in a consultation/training capacity resources.
(Note: The following is an example of how this collaboration might occur.
The Ford Foundation has a grant with the immunization program of CDC conduct field studies and use the information from these studies to make supervisory and management improvements. Both S. Gunawan, Director of the Immunization and representatives of the Ford Foundation have expressed an interest in including an HTR&D-trained consultant.trainer in the program possible using Ford Foundation funding).
17. Trainers do not have access to relevant literature on training methods and management concepts and techniques.
18. Interns would benefit from additional training in group skills important for training in Indonesia such as giving clear feedback, confrontation of problems, and developing goal-oriented behaviour.
6. The training team in each province should be provided a selected reference library, in Bahasa Indonesia when possible.
7. As part of the intern development program (see recommendation A-2), trainers should be given additional training in group skills.

4.4 Task Analysis

Findings and Conclusions

1. Task analysis has produced useful results when its purpose is clear (e.g. for determining training content or clarifying roles) and decision makers are committed to utilizing its results.
2. Task analysis is thought to be a highly useful technology by most who have utilized it.
3. There is a demand for task analysis in health training institutions, hospitals and in community health programs.
4. Task analysis is a costly technology as it is presently practiced (often requiring 10-15 man months of effort).
5. The GOI is unlikely to fund task analysis studies except for very high priority problems.
6. There is some resistance to task analysis from both

Recommendations

1. Evaluate and Document successful TA studies and show decision-makers how it can be used.
2. HTR&D consultants and interns should attempt to streamline and simplify TA for use in needs assessment and other purposes.
3. Demonstrate value of TA to decision makers especially for solving high priority management problems.
4. When task analysis is done it should be explained thoroughly

managers and employees who may feel that the clarity it produces may subject them to evaluation and stricter supervision.

to management and employees of the organizations being studied.

4.5 Case Development

Findings and Conclusions

1. About 10 individuals have received some training in case writing and 20 in case teaching sufficient to write and use cases with minimum supervision.
2. Thirty cases have been written and used extensively in training courses. They have been found to be an effective training tool.
3. There is a considerable demand for cases that deal with complex management and organizational issues and for cases that deal with settings such as hospitals, training institutions, etc.
4. No new cases have been written since the 30 produced and funded under HTR&D.
5. Trainers report that the case development technology is too difficult too and expensive to be utilized without external funding.

Recommendations

1. New cases should be written to deal with high demand problems such as hospital administration and more complex organizational issues.

6. No interns have been produced who are capable of teaching and supervising case writing and teaching.
7. _____
7. HTR&D requested funding for producing cases in high demand areas and for training case development teachers. USAID has not approved these requests.
8. No mechanism now exists for collecting, cataloguing and distributing existing case studies or other training materials.
2. Advanced intern-level training should be given to 3-4 case writers to enable them to continue developing and supervising case writers. (see recommendation A-2)
3. Effort should be made to develop simpler "case study" methodologies such as critical incident reports or short "vignettes" that would be useful in a specific training/supervision situation but would perhaps not qualify as a complete "case study" for widespread distribution.

Funds should be sought from other sources (World Bank loan?) for further development of the case method technology.
5. Pusdiklat should set up a case and training materials collection and distribution center. Eventually, this should be done through with the training center (BLKM) network.

4.6 Impact Evaluation

Findings and Conclusions

1. Two impact evaluations (I.E.) have been held, each combining training in evaluation with planning an evaluation of an advanced training courses for management trainers.
2. Eighteen participants have attended I.E. workshops. Eight of these are from Pusdiklat.
3. One trainer (at Pusdiklat) has the capacity to train others in I.E. methodology.
4. The most effective methodology for determining the impact of training is reported to be interviewing ex-participants for critical incidents that illustrate how they have applied their training on the job.
5. The cost of evaluation and follow-up are generally not funded in MOH (DIP) budgets.

Recommendations

1. Impact evaluation skills should be developed further, especially at Pusdiklat.
2. Evaluation should focus on how trainees apply their learning on the job.
3. Include training in the critical incident methodology in advanced training for management trainers.
4. Other inexpensive and simple to-use methodologies for workshop evaluation and follow-up should be developed by the intern group.
5. Pusdiklat should attempt to change the policy of the MOH to include evaluation costs as a standard part of training budgets.

4.7. Part Two - Institutionalization of the Training Capacity

This section of the final assessment of the HTR&D management component will deal with the capabilities of the MOH to sustain and further develop the training capacities developed by the HTR&D project. These findings and recommendations regarding institutionalization of the training capacity will be presented in four sections. Section 4.8 will deal with institutional capacities at Pusdiklat, section 4.9 with institutional capacities at the provincial level, section 4.10 with linkages between Pusdiklat and the provinces, and section 4.11 will describe findings and recommendations on the linkages between Pusdiklat and the operating divisions (Director General) of the MOH.

4.8 Institutional Capacities at Pusdiklat

Findings and Conclusions

Recommendations

1. Pusdiklat has a mandate to coordinate all in-service training in the MOH.
2. At present, Pusdiklat is understaffed and does not have the technical resources to fulfill its mandate. Presently, eighty per-cent of inservice training is done directly by the Directorates General with little involvement from Pusdiklat.
3. Pusdiklat was reorganized recently and in the past year has concentrated on internal organizational and personnel development.

While setting up its own organization and resources it has taken a rather passive stance vis-a-vis its supervision and consultation role.

4. Pusdiklat seems unclear about what its proper role should be and has no clear strategy for creating its role. At least some officials in DepKes would like to see Pusdiklat expand its role in manpower development to include planning, training and development (consultation).

5. Pusdiklat's own internal management is weak
 - The functions and objectives of the five operating divisions are not clear.
 - Pusdiklat personnel are regularly pulled off their normal duties by requests from D.G.s. who can demand the participation of specific individuals. Pusdiklat management has no effective way to resist this encroachment.
 - Planning, logistics, and

1. Pusdiklat should involve its top management in an organization development workshop to define its mission and strategy and to improve its internal management systems.

(Note: A one-month organization development workshop for Pusdiklat is being planned as part of the World Bank Expansion project.)

2. It is clear that Pusdiklat will never fulfill its mandate if it sees itself as creating an army of full-time trainers. It must begin to conceive of training as an activity largely carried out by supervisors of their supervisees. This training/supervision would include detection of barriers to program implementation (needs assessment), problem solving, skill development and planning (training), and on the job

financial arrangements for provincial training programs is often carried out in a crisis, adhoc manner, although there is evidence that this is improving.

- morale of the staff is low because of the unclear mission
- and poor management of the institution.

coaching, follow-up and evaluation leading to new rounds of problem solving, etc. In this sense, training can take place in a training center or in a clinic or community setting and it can take place in groups or individually.

6. A training team has been formed to monitor and manage the trainer network in Pusklat.

This team is beginning to function effectively and will likely continue to function as it will have major responsibilities in coordinating the World Bank project.

7. The World Bank Project is a multi-million dollar loan aiming to expand Pusklat's capacity to fulfill its training mandate. The program, scheduled to begin in April, will expand the network of training centers (BLKM's) at the provincial, regional and national levels. The program also contains \$ 1 million for training of trainers, both and in-country and externally.

3. The BLKM's should not be staffed by full time trainers but by a few master trainer/consultants who would assist supervisors to integrate training as part of their supervisory function.

8. Although Pusdiklat's technical capabilities are still weak in relationship to its mandate, the HTR&D project has made a substantial contribution toward building its capacities.
9. The Pusdiklat training team has begun an inventory of the people and their capacities trained under the HTR&D program.
10. The GOI budget for 1986-87 is being reduced substantially. Pusdiklat is "only" being cut 13% since training is considered a priority activity. GOI funds for trainer training will be in short supply until the World Bank loan becomes active.
11. Although 1986-87 budgets are not yet clear, Pusdiklat director Pak Oyo feels that it is "unlikely" that Pusdiklat will have counterpart funds to pay for HTR&D local costs in FY 1986-87.
4. Give highest priority to training Pusdiklat personnel in remaining HTR&D programs.
5. Complete inventory of training capacities and disseminate to provinces and D.G.s.
6. Remaining HTR&D funds should be put into high priority areas such as intern development and advanced TOT to help Pusdiklat prepare to meet the demands for training anticipated in the World Bank training expansion project and to develop an internal consultancy capacity.
7. Pusdiklat should immediately develop its plans for the HTR&D project for FY 1986-87 and enter into negotiations with USAID regarding funding requirements.

12. The career development opportunities open to trainers and consultants.
13. A recent decree from Menpan has given official sanction to the BLKMS and for trainer positions with the BLKMS.
14. Pusdiklat expansion strategy (to new provinces) is based upon development of a BLKM network throughout the country. It is anticipated that the BLKM's will attract many of the HTR&D trainers as full time staff. Pusdiklat has had 68 applicants for 21 positions for the first group of BLKMs. Most of these applicants have participated in the HTR&D project.
15. At present, incentives for training are both the non-material (team membership and support, pride in contributing) and material (additional years of work as trainer after official retirement age, promotion points, direct
8. Pusdiklat should work with the Bureau for Personnel Affairs to develop a policy regarding the job classifications of trainers and consultants.
9. To avoid the problem of trainers become isolated from "real world" problems, the BLKMs should rely primarily upon part-time trainers who are also involved in program activities as supervisors and administrators. Training must be thought of as part of the supervisory/management function rather than as something done by "trainers".
10. MOH should review its entire incentive system to make sure it is motivating appropriate behaviour.

payment and allowances).
These incentives have often
fostered irrelevant and
excessive training.

4.9 Institutional Capacities at the Provincial Level

Findings and Conclusions

Recommendations

1. In most of the HTR&D provinces an informal network or "team" of supervisors/trainers is developing. In provinces where the project is more than one year old the team is working quite effectively in planning and guiding the training function.
 2. There have been some attempts to set up permanently staffed training offices (SumBar, JaTeng) but this has not received official sanction as yet.
 3. The trainer networks, although unofficial, have been effective at disseminating their skills and knowledge and beginning to change the conception of the role and purpose of training.
 4. The training networks involve and have the support of key individuals in the provincial health system, including the chief health officers (Kakanwils), medical schools, other training institutions, and hospitals.
1. The MOH should decide on a policy for "anchoring" trainer training organizationally. It seems to be moving toward making the BLKMs the training office in each province.

5. The training networks have provided considerable cross-province and regional support. Trainers have worked in other provinces and have been trained together. Most of this cross-provincial contact has been motivated and supported by HTR&D.
6. Most provinces do not have a clear training strategy and plan. Much training is still done in response to opportunities and agendas set by central authorities and special projects.
7. Trainers feel they would be more effective if their training competence were officially recognized by outside, preferably international degree or diploma granting institutions.
8. Trainers need a continuing program of professional and personal development and opportunities for sharing experience and learning.
2. Pusdiklat does not have the mechanisms and funds to continue this important regional interchange. The expansion project (World Bank) should further encourage the development of national and regional networking of trainers.
3. Provinces should be involved in manpower planning in coordination with plans at the central level.
4. Resist efforts to "professionalize" training into an isolated and elite activity. Training is best when it is done as part of an overall management approach by people who are the direct supervisors of the "trainee".
5. Pusdiklat should create mechanisms for up-grading the skills of trainers, providing forums for exchange (newsletters, conferences, etc.) and should enable trainers to tie into the

international network of
trainers (through
subscriptions to journals,
periodic attendance at
professional conferences,
etc.)

4.10 Linkages between Pusdiklat and the Provincial Trainers

Findings and Conclusions

Recommendations

1. HTR&D has greatly expanded the opportunities for Pusdiklat and provincial people to work and train together. This has created an effective informal network for planning and support.
 2. The provincial training teams have been "encouraged" (given informal verbal support) by Pusdiklat to modify and adapt training guidelines to fit local needs and conditions.
 3. Pusdiklat reports that it has received increased requests for technical assistance from the provinces (especially following a one-day conference in which new training approaches were described).
 4. Provinces have pressured Pusdiklat to respond more energetically to their needs, especially through providing technical guidance and assistance.
1. Pusdiklat should consider establishing a policy of issuing "permissive" guidelines that establish goals and minimum requirements but encourage local initiative in training design.
 2. Pusdiklat should communicate to the provinces the kind of technical assistance services it can provide.

5. By mixing Pusdiklat and provincial people from different organizational levels, and providing skills in giving feedback, high level people at Pusdiklat have heard suggestions and criticisms from lower levels which they had seldom heard before.
3. Trainer training should continue to mix levels and organizational units to encourage network building and informal channels of communication.

4.11 Linkages between Pusdiklat and the Directorates
General of the MOH

Findings and Conclusions

Recommendations

1. D.Gs do the bulk of in-service training (80%) with little Pusdiklat involvement.
 2. Factors which inhibit D.Gs from seeking help from Pusdiklat are:
 - a. limited staff at Pusdiklat
 - b. limited technical skills at Pusdiklat
 - c. concern that outsiders will interfere with program activities.
 - d. fear that programs now funded through DGs will be transferred to Pusdiklat if Pusdiklat becomes involved.
 - e. D.G.s feel that only people trained in their technical specialty are qualified to provide training.
 - f. perception in some places that Pusdiklat training methods (discussion, etc.) are not useful in teaching technical subjects.
 - g. Some DG staff make a sharp distinction between technical and management training.
1. Periodic meetings between DGs and Pusdiklat should be held to explore barriers to cooperation and to find ways to remove them.
 2. Demonstrate to DGs models of training specialists working with technical specialists to provide training.

3. At least two program directors (immunization and community health) have invited close collaboration with Pusdiklat. In both cases the director had worked with the HTR&D project (before being promoted to his present position) and is therefore knowledgeable about the program.
 4. Mechanisms are not now available for "loaning" personnel as consultants from one office to another in the MOH.
 5. No inventory or information system exists within the MOH to identify and locate people with specialized skills who might be available for consultation on specific problems. One D.G. said, "We don't know who are the experts. It's easier to find someone in Europe or the U.S."
 6. Some D.G.s have indicated that they would like Pusdiklat to play a more active role in helping with:
 - a. curriculum design
 - b. training assistance
 - c. planning of manpower development
3. Pusdiklat should respond to DG requests for collaboration by assigning consultant/trainers where feasible. Invite key DepKes officials and staff to participate in relevant Pusdiklat training.
 4. Mechanisms should be developed to make it possible to obtain consultation from resources within the MOH.
 5. Pusdiklat should consider expanding its role to identifying and inventoring skills brokering internal consultations.
 6. As Pusdiklat gains the necessary skills and experience it should actively "market" these services to the DGs (a one-day meeting with DGs is planned for FY 1986-87).

APPENDIX A

Persons Interviewed:

A. Pusdiklat (Jakarta)

1. Pak Ojo Radiat, M.Sc.
Chief, Pusdiklat Personnel Affairs
2. Drs. Dachroni, MPH
Chief, Technical Functional Section (Department)
3. Sri Hartini, SKM, M.Sc.
Chief, evaluation & Reporting Dept.
4. dr. R.E. Laksmono, MPH
Chief, Program Dept.
5. Drs. Putu Lawa Udayana, MPH
Chief, Education and Training
6. Drs. Syaefudin
Chief, HTRD Team
7. dr. Gunawan Setiadi, MD
Chief, Sub-Division of Technical Functional

B. PUSAT (Ministry of Health)

1. dr. Surjanto Gunawan
Director, Epidemiologic & Immunization Dept.
2. dr. Borto Wasisto, MPH
Director, Planning Office
3. Drs. A.L. Pong Tengko
Chief, Health Source Planning
4. dr. Soejono Yahya
Director General Binkesmas
5. dr. A.M/ Adhyatma, MPH
Dir. Jen. PPM dan PLP

C. WEST JAVA

1. dr. Rustandi
Kakanwil
2. Drs. Omaj M. sutisnaputra, MPH
Chief, health Instructor
3. Dr. Joko H. Soetikno, MPH
Chief, K.I.A. (Mother Health Care)

4. Mr. Ayub
staff Bina diklat JaBar
5. Mr. suparman
Secretary for Administration
6. dr. Yahya
CDC
7. dr. H. Natjep Suryana
Planning, Program and Evaluation Division
8. Dra. Sumiati SH Sarjono
Nutrition Division
9. Dra. Ida Dawati
Chief, HTR&D Team Jabar & Family Planning Div.
10. Drs. Maneken Simanjuntak, BSc.
Provincial Trainer
11. Mr. Neni Roesmani
Provincial Trainer
12. Mr. Imam Sudrajat
Provincial Trainer
13. Ms. Ida Daswati
Provincial Trainer
14. Mr. Wekeng
Provincial Trainer
15. dr. Supardi Garnewa
Subang Regency Health Officer
16. dr. Rachmat Sentika
dokter Puskesmas Subang

Task Analysis Course Participants (12)

C. WEST SUMATERA

1. dr. H.M. Aslir Sahur, M.Sc.
Training Coordinator
2. dr. Anwar shah, MPH
Chief, BLKM Lubuk Alung
3. dr. Linda M. Thaufik
Chief, Mother Health Care Dept.

4. Mr. Asril Loeddin, SKM
Chief, TP. PPM Dept.
5. dr. Idrian Kahidir
Chief, Evaluation & Reports Dept.
6. Zr. Daltias Churchill
Director, Nursing School
7. dr. Henry Gunawan
Chief, P2D Dept.
8. dr. kamardi Taufik
Dean, Fakultas of Medicine
9. dr. H. Sabri Saaduddin, SKM
Vice Dean, Fakultas of Medicine
10. dr. Nadir Chan
Puskesmas Dr.
11. Mr. Syahbani
Health Educator
12. Dr. Roger Feldman
CHIPPS LTC

D. CENTRAL JAVA

1. dr. nardo Gunawan S. MPH
Kakanwil
2. Drs. M. Lufthi, MPH
Training Coordinator
3. Mrs. Harbandinah Tuti
Kariadi Hospital Lecturer in Public Health
4. Drs. W. Laksmono, SKM, MPH
Faculty of UNDIP
5. Sr. Ong
Coordination OPD, Kariadi Hospital
6. dr. Anwar
Kariadi Hospital
7. Mr. Hudiyono
Kariadi Hospital

8. Mr. Rachman
Health Education Unit
9. Mr. Bambang Darmawan
CDC
10. dr. Winarno Djojo Prayitno
Chief, BKLM Salaman
11. Drs. V. Sartono, SKM
Chief, Health Communication
12. Mr. R.H. Djam'an, BSC.
chief, BLKM Gombong

E. USAID

1. Dr. Emmanuel Volgaroupolos
Chief, Population & Health Office
2. Mr. John McEnaney
HTR&D Project Officer
3. Mr. Timothy mahoney
Program Officer
4. Dr. David Korten
AGR. Regional Advisor

F. HTR&D Consultants

1. Dr. Rolf Lynton, Project Coordinator
2. Dr. Udai Pareek, Province-based LTC
3. Dr. Michael Merrill, Province-based LTC
4. Mrs. Ronie Lynton, Consultant

G. OTHER ORGANIZATIONS

1. Mr. Jack Nelson, World Bank Consultant
2. Mr. Michael Dibley - Ford Foundation
3. Dr. Frances Korten - Ford Foundation

APPENDIX B

Summary of Impact evaluation of Advance Program for Management Trainers

This summary is based upon reports by Dr. Udai Pareek, LTC of evaluation studies reported in September, 1985 (Advance Program I) and January, 1986 (Advance Program II).

A. Evaluation of Advanced Program I (APM I)

Impact on Pusklat

1. Increased concern about training quality
2. Changed orientation to training as a systematic management problem solving tool rather than an activity providing source of additional income.
3. Increased awareness of the competency-based approach to training and selection.
4. Increased acceptance of the technical inputs (TA, cases, impact evaluation) as useful tools for solving management problems.

Impact on Trainer Teams

The training teams in the Provinces and Pusklat rated themselves as increasing in collaboration among team members and increased creativity and problem-solving orientation, and increased involvement in important decisions regarding training. These changes were rather small and it was recognized that much improvement was needed.

Impact on the Provincial Systems

1. Mutual Support - trainers reported increases in help-giving in regular work beyond training.

2. Change in norms - training is provided by teams rather than individual lecturers, training is planned more systematically, training is based upon needs assessments of real field problems.
3. Trainers are taking responsibility for training new trainers at the Kabupaten and Puskesmas levels (multiplier effect).

B. Evaluation of Advanced Program II (APM II)

This evaluation demonstrates a variety of positive results of the APM II on individual and professional competencies (increased initiative, collaboration, innovation, responsibility).

The evaluation also indicated a number of organizational and institutionalization impacts.

1. Organizational Impacts
 - a. increased team work of the training teams
 - b. more systematic planning by the training team
 - c. more output of training material
 - d. increase in problem solving
2. Institutionalization
 - a. Strengthening of the trainer network
 - b. Training network expanded
 - c. Training competencies invreased
 - d. working groups formed to deal with management problems
3. Diffusion and Multiplication
 - a. Interest in new (non HTR&D) provinces inreceiving TOT, especially in provinces containing CHIPPS projects.
 - b. Seven interns are being prepared with the capacities to train trainers and consult on the expanaion and diffusion of HTR&D training innovation.

The conclusion of the second impact evaluation study, written by Dr. Pareek, are interesting and worth quoting in full here:

Learning from Impact Evaluation

There are several lessons to be learned from this impact evaluation study. Regarding impact evaluation, we need to improve the methodology, refining the method of collecting more detailed and meaningful critical incidents. Indicators of the impact should be identified and measured. We recommend that Pusdiklat may undertake this work, and organize a workshop in which such indicators may be developed and impact evaluation may then be conducted. It may be sueful to do this for the whole HTR&D project, and its impact on health system functioning in Indonesia.

Data have shown that the impact increases with concentration (of training). The gains will be multiplied with some advanced training. We, therefore, recommend that at least three more APMT be planned (each one in 1986, 87 and 88).

The most significant factor in making tne impact (and in institutionalisation and multiplication) is the rigorous development of interns. Three types of interns are needed: general system development interns, specialist interns (case teaching, case writing, task analysis, impact evaluation etc.), and process facilitaors (L group interns). At least 10 - 15 interns in each area would help in consolodating and institutionalizing gains. If attention is is not paid to this aspect, and if concerted effort slackens, we are afraid that not only the institutionalization process may slow down, but may be greatly damaged. We therefore, recommend very urgent attention to the development of a minimum number of interns, and creating opportunities for their development and practising of the skills.

The analysis shows that there has been a significant impact of APMT-II on Pusdiklat. Pusdiklat is gaining enough competencies to function as an effective consulting organization. It may be useful if Pusdiklat staff, when assigned specific consulting responsibilities, are freed from other responsibilities, so that they can do justice to the consulting role.