

**JHPIEGO Technical Report**



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FOR INTERNATIONAL EDUCATION  
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NEPAL REPRODUCTIVE HEALTH  
TRAINING SECTOR ASSESSMENT  
AND  
FIVE-YEAR ACTION PLAN (1993-1998)

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<sup>1</sup>Assistance in preparing this technical report was provided by the following members of the Nepal Priority Country Strategy Team (Training and Service Delivery Component): From AID/WASH (Irene Koek and Roy Jacobstein), from AVSC/ARD (Nancy Piet-Pelon and John Neponick) and from USAID/Nepal (David Oot, Molly Gingerich and Matt Friedman).

## PREFACE

The information on which this technical report is based was obtained during a two-week period, from February 16 to 28, 1993. As members of the Nepal Priority Country Strategy (NEP-COST) team, Dr. Roy Jacobstein (R&D/POP/CMT) and I were asked by the USAID/Nepal Mission to assist in developing the pre-service training component of the strategy. In addition, we were asked to assist the other members of the training and service delivery component of the NEP-COST team (Nancy Piet-Pelon and Dr. John Naponick) in developing an action plan for revising IUD training for nurses and ANMs and in converting the so-called one-week "Depo" course for paramedics (HAs, AHWs and ANMs) into a basic family planning (FP) course covering all clinical contraceptive methods.

In collecting the data used to develop the NEP-COST draft paper, *Nepal Priority Country Strategy: Pre-Service Training Component*, considerable additional information was obtained. Subsequently, this material was used to expand the scope of the original draft paper to encompass an overall assessment of reproductive health, including FP, training needs. By using the supplemental information, and having the luxury of additional time, it was possible to write a more comprehensive action plan, develop a more accurate time frame for conducting the proposed activities and interventions, and construct the technical assistance package<sup>1</sup>.

In preparing this report, I benefitted from the work of many writers, including GON, NGO and donor staff as well as international and local consultants. The most important of these documents are listed in the **REFERENCES**. I also received support and assistance from the following individuals: the FP/MCH Unit (Drs. K.R. Pandey, H. Shrestha and J. Bhattarai); faculty and representatives of the IOM/Kathmandu including: Drs. P.C. Karmacharya (Dean) and Rita Manandhar (Acting Chair, Ob/Gyn), Dr. Uma D. Das (Director, Nursing Education) and Mrs. D. Lohani (IOM/Kathmandu Nursing Campus Chief); other MOH senior staff, especially Ms. Rukmani Shrestha (National Training Coordinator) and the Director of the Maternity Hospital, Dr. Laxmi N. Shrestha.

Others who provided much valuable information and insight included: Omer Ertur, Country Director (UNFPA); Drs. Tikamon Vaidya (Executive Director, NFCC), Pramila Sharma (Medical Advisor, FPAN) and T.B. Khatri; Dr. James D. Andersen, Consultant (UNICEF); Marta Levitt (Advisor/Project Director, National TBA Training Program (Redd Barna) and Sham Thapa (FHI).

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<sup>1</sup>The terms of reference did not include evaluation of the pre-service education of paramedics, auxiliaries and community Health Workers; therefore, this report does not include detailed information about the training needs of these cadres of FP service providers.

In addition, I wish to thank the USAID/Nepal mission (David Oot, Molly Gingerich, Matt Friedmar, and Health and Population Office support staff) for providing superb guidance as well as logistical and other support throughout the assignment; also Dr. Paul MacKenzie (the JSI/Nepal team) who prepared much of the background information on the status of IUD training and service delivery in Nepal (**Annexes 8-10**).

Finally, it was a pleasure meeting and working (for the first time) with Nancy Piet-Pelon and Dr. John Naponick from AVSC/ARO.

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3. **REPORT OF THE TASK FORCE ON THE ESTABLISHMENT OF THE NATIONAL TRAINING CENTER FOR STRENGTHENING HEALTH MANPOWER TRAINING**. Report submitted to HMG, MOH, 1992.
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6. Logical Frame/Prism Evaluation Indicators.
7. **CONSTRAINTS TO FAMILY PLANNING TRAINING AND SERVICE DELIVERY**. Prepared by Roy Jacobstein, MD/MPH, Chief CMT Division, AID/R&D/POP. February 1993.
8. **IUD SERVICES IN NEPAL**. Prepared by Paul MacKenzie, MD, Family Planning Resource Person, JSI/Nepal. February 1993.
9. Draft **IMPLEMENTATION PLAN FOR IUD SERVICES IN NEPAL: 2049-2050 (1992-1997)**.
10. List of IUD Insertions (Users) by District in Nepal.
11. Excerpt from the **FP/MCH Unit ANNUAL WORKPLAN: 2049-2050 (1992-1993)**.
12. Terms and Conditions for Conducting the Preliminary Assessment of the "Depo" Training Course.

## LIST OF ABBREVIATIONS

AHW	Auxiliary health worker
AID/W	Agency for International Development/Washington, DC
AIDS	Acquired immune deficiency syndrome
ANM	Auxiliary nurse midwife
ARI	Acute respiratory infection
AVSC/ARO	Association for Voluntary Surgical Contraception/Asia Regional Office
BFP	Basic family planning course
BN	Bachelor of Nursing degree
BNC	Basic nursing certificate
CA	Cooperating Agency
DDC	District Development Committee
DMPA	Depo medroxyprogesterone acetate (also referred to as "Depo")
DON	Division of Nursing
DPHO	District public health officer
EPI	Expanded Program for Immunization
FCA	Fourth Cooperative Agreement
F/CHV	Female/Community health volunteer
F/CHW	Female/Community health worker
FHI	Family Health International
FP	Family planning
FP/MCH	Family planning/Maternal and child health
FPAN	Family Planning Association of Nepal
FY	Fiscal year
GON	Government of Nepal
HA	Health assistant
HI	Health inspector
HIV	Human immunodeficiency virus
HMG/MOG	His Majesty's Government of Nepal
HP	Health post
HP/IC	Health post/In-charge
IEC	Information, education and communication
IN	Intern (medical)
IOM	Institute of Medicine
IUD	Intrauterine device
IUCD	Intrauterine contraceptive device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JSI	John Snow, Inc.
MBBS	Basic medical degree (in Nepal)
MCHW	Maternal-child health worker
MD	Doctor of Medicine
MOH	Ministry of Health
MPH	Master of Public Health degree

MIS	Management information system
MS	Medical student
NEP-COST	Nepal priority country strategy
NFCC	Nepal Fertility Care Center
NGO	Non-governmental organization
NPPR	Nepal Population Policy Report (1983)
NS	Nursing student
NTC	National Training Center
Ob/Gyn	Obstetrics and Gynecology
PHC	Primary health care
PHD	Public health division
PHN	Public health nurse
PRE-TAC	Pre-Service Training Advisory Committee
PY	Program year
R&D/POP/CMT	Research and Development/Population/Communication, Management and Training Division
RH	Reproductive health
RHD	Regional health director
RHS	Reproductive health specialist
RTC	Regional Training Center
SHP	Sub-health post
SLC	School Learning Certificate
SN	Staff nurse
SPHN	Senior public health nurse
STDs	Sexually transmitted diseases
TA/DA	Travel and daily allowance
TBA	Traditional birth attendant
TIS	Training information system
TOT	Training of trainers
UMN	United Missions of Nepal
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Voluntary District Committee
VHW	Village health worker
VS	Voluntary sterilization
VSC	Voluntary surgical contraception (e.g., IUDs, injectables, implants and voluntary sterilization)
WHO	World Health Organization

# EXECUTIVE SUMMARY

## ASSESSMENT OF FAMILY PLANNING TRAINING IN NEPAL

### Pre-Service Training

1. Over the years, numerous reports have documented that the pre-service education of health professionals (from physicians to paramedics) in family planning (FP) is not well coordinated and ranges from sporadic lectures and presentations on family planning topics to varying degrees of information on contraceptive technology.
2. Practical training in the provision of FP services is totally lacking in both physician (MBBS) and nurse (basic certificate and BN) undergraduate (pre-service) training and is provided in only limited, unpredictable amounts in the pre-service paramedic (HA, AHW and ANM) certificate programs.

### In-Service Training

1. With regard to the in-service training of health professionals, the current situation is equally discouraging. The 1991 *Training Needs Assessment Report*, which was prepared for the FP/MCH Unit (Training Section) with assistance from AVSC/ARO, amply documents the "... serious need to change from the (current) sporadic, ad-hoc training (approach) to a coordinated and systematic training plan."<sup>1</sup>
2. A major finding of this assessment was that, until recently, many physicians in Nepal have been trained in other countries and not to uniform medical standards. Furthermore, many have received only clinical training through abbreviated clinical apprenticeships, often in mobile voluntary sterilization (VS) units. As a consequence, generally, they are not skilled in all clinical FP methods. Often they have limited, or outdated, knowledge about: a) modern contraceptive methods; b) the importance of counseling, especially with regard to voluntarism and informed consent; and c) recommended and doable infection prevention practices and other quality assurance measures.

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<sup>1</sup>Minkler DH, Manandhar V and Bhattarai J: *Training Needs Assessment Report*. FP/MCH Division/MOH/GON and AVSC, 5-29 August 1991.

## Conclusions and Recommendations

1. There is a serious need to change the way the in-service training of physicians in surgical contraceptive methods (IUDs, injectables, Norplant® and VS) is provided.
2. To address the documented deficiencies in in-service FP training<sup>2</sup> there is an immediate need to:
  - ◆ Establish a working group (or task force) composed of key government, IOM and NGO representatives involved in FP to develop a comprehensive training and service delivery plan that will lead to the increased provision of quality clinical methods.
  - ◆ Establish a system for providing refresher training for VS surgical teams and support staff.
  - ◆ Develop a basic FP training course(s) for physicians, nurses and paramedics currently working in the public sector who, to date, have not been fully trained in all clinical contraceptive methods.
  - ◆ Develop a training information system (TIS) that links population information and projections with health manpower data in order to more accurately forecast FP training needs and requirements (numbers and types of workers needed).
  - ◆ Ultimately (3-5 years), if the proposed National Training Center (NTC) materializes, all in-service FP training, both classroom and clinical, should be coordinated by this body and, space permitting, be conducted at the NTC or the existing/proposed regional (satellite) training centers.
3. A major obstacle to increasing the use of IUDs in Nepal is the chronic lack of female service providers working in the FP service delivery system. Unless this problem is addressed and realistic solution(s) implemented, use of IUDs in Nepal will never be a significant component in the contraceptive method mix.
4. Developing and introducing a comprehensive reproductive health education and FP training component into the curricula of the medical and nursing schools at the IOM/Kathmandu would serve several important functions, including:

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<sup>2</sup>In-service recommendations were developed in collaboration with AVSC/ARO (Nancy Piet-Pelon and Dr. John Naponick).

- ◆ Provision of a partial solution to the immediate and long-term training needs of the country
  - ◆ Establishment of a potentially sustainable, coordinated and systematic training system for physicians and nurses
  - ◆ Potential for establishing and maintaining national training and service delivery standards for all contraceptive methods
5. At present in Nepal, many of the strongest promoters and supporters of family planning are retiring or are nearing retirement age. In order to attract a new group of younger physicians (not more than eight to ten) into the family planning and population arena, it is recommended that a one-year diploma program in reproductive health be established in the Ob/Gyn department of the medical school at the IOM. (A similar program for nurses also should be considered.)

## PROPOSED FIVE-YEAR ACTION PLAN

In developing the five-year action plan for the FP training component, due consideration has been given to the fact that a number of other non-training, programmatic constraints must be addressed simultaneously to maximize the impact of the proposed training interventions. The most serious of these constraints are detailed in **Annex 7.**) Improving the capability of existing and future health professionals to provide FP services will have only limited impact if these constraints are not addressed. This is because training, although critically necessary, is not sufficient; it is the post-training service delivery environment that ultimately determines training impact.

The proposed five-year action plan will be twofold:

1. The **initial phase** will be to increase the capability of the FP/MCH Unit (Training Section) to manage and conduct the **in-service** training of physicians, nurses and other health care workers in the provision of clinical FP methods (injectables, IUDs, Norplant and VS). Priority for this is based on the immediate need to provide additional trained clinicians to meet the acknowledged unmet demand for these clinical methods, especially injectables (DMPA) and VS. Strengthening and expanding the in-service training system combined with linking it to a system for identifying the training needs (number, type and location of service providers to be trained as well as clinical skills requirements) should go a long way toward solving the "... fragmentation (of in-service

training activities) which has existed for some time, while (also) improving the quality of such training."<sup>3</sup>

2. The **second phase** of the action plan will be to introduce a comprehensive **pre-service** reproductive health education and FP training component into the curricula of the medical and nursing schools of the IOM in Kathmandu. This pre-service training activity, which will require four to five years to achieve, ultimately should be an important factor in assisting the GON expand the availability, quality, access to and use of family planning services in Nepal. In addition, it will serve as a cost-effective mechanism for providing basic reproductive health training through the indigenous educational system, thereby freeing up the FP/MCH Unit to focus their efforts on overseeing/providing refresher and/or continuing-education workshops and courses.

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<sup>3</sup>Minkler DH, Manandhar V and Bhattarai J: *Training Needs Assessment Report*. FP/MCH Division/MOH/GON and AVSC, 5-29 August 1991.

# NEPAL REPRODUCTIVE HEALTH TRAINING ASSESSMENT AND FIVE-YEAR ACTION PLAN (1993-1998)

## ***PART ONE***

### **BACKGROUND**

Over the past 20 or more years, attempts to develop and implement a comprehensive family planning (FP) training and service delivery system in Nepal have been largely unsuccessful. Numerous constraints, which have severely hampered this process, have been repeatedly identified. The most important of these still remain significant obstacles; they include:

- ◆ The demographic profile of Nepal is characterized by low literacy, large family size and low per capita income, based almost exclusively on a subsistence agricultural economy.
- ◆ The geography of Nepal — with its extremely limited road system, poor communication system and highly dispersed and largely inaccessible population — has impaired (almost defied) development of most, if not all, of the necessary components needed for regularizing training and implementing the effective delivery of FP services.
- ◆ The extremely limited human and financial resources of Nepal has led to the development of highly donor-dependent programs which, whether successful or not, have not been sustainable in the long run.

Added to this are the recent changes in the way health care, especially MCH and FP, is delivered — changes, which even now are not fully articulated and which most probably will impact significantly on the final form and content of this strategic planning process. For example, during the past few years the large and, to a varying degree, successful vertical projects have been folded into the MOH; as a result, many trained staff have been lost. The short-term impact of this has been devastating on all aspects of the FP training and service delivery system. Despite these problems, however, during the past 10-15 years, a number of excellent reports and other documents have been produced which, if taken as a whole, trace the beginnings of an approach to developing a comprehensive and potentially sustainable FP training and service delivery system.

Beginning in the early 1980s, the comprehensive World Bank-sponsored *Nepal Health Sector Report (1982)* detailed a number of important issues that needed to be addressed if delivery of family planning services was to be improved and expanded. For example, in this 1982 report the need for increased government commitment to the population problem was clearly stated as well as the need for development of a national population policy. As a consequence, in 1983, the *National Population Policy Report (NPPR)* was produced. With this report the Government of Nepal (GON) now had a clearly articulated plan for addressing the high rate of population growth in Nepal. Most importantly, for the first time the NPPR documented the need to focus the country's limited human and financial resources on districts that had high population density and were readily accessible. Furthermore, in this report it was recommended that in order to decrease the dependence of the FP program on voluntary sterilization (VS), static (year-round) full-service FP clinics should be established in key districts of the terai and hill regions. Because these permanent clinics would require increased numbers of professional staff trained in the full range of clinical contraceptive methods — not just minilaparotomy or vasectomy — it was proposed that a National Training Center (NTC), as well as several regional satellite centers, be established to regularize service provider training. Thus, it has been recognized for over a decade that the way services are provided (and training of service providers conducted) needed to be changed if family planning was to have a significant impact on improving reproductive health and limiting population growth.

Since 1985, programmatic and financial issues and constraints have slowed the process of expanding and "institutionalizing" service delivery even in the 15 key districts as well as the country as a whole. And, as documented in the 1991 *Training Needs Assessment Report*,<sup>1</sup> training and FP services were interrupted frequently during this turbulent period of political transition. At present, however, the winds of change are much more favorable, and the GON is once again firmly committed to promoting FP. Furthermore, there is considerable evidence that much unmet demand for quality FP services exists; demand that will increase as the projected greater numbers of women reach reproductive age. As a consequence, the need to develop a systematic, cost-effective way of training service providers in the full range of clinical methods (i.e., injectables, IUDs, Norplant and VS), which is in accord with the recently published *National Medical Standards for Contraceptive Services*,<sup>2</sup> now is more important than ever.

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<sup>1</sup>Minkler DH, Manandhar V and Bhattarai J: *Training Needs Assessment Report*. FP/MCH Division/MOH/GON and AVSC, 5-29 August 1991.

<sup>2</sup>*National Medical Standards for Contraceptive Services*. His Majesty's Government, MOH, FP/MCH Division, November 1991.

## HEALTH MANPOWER DEVELOPMENT

Recently, UNICEF sponsored a comprehensive review of the MOH policy on health manpower development. The final report, which was released in September 1992, focuses specifically on the training, management, self-assessment and promotion of primary health care (PHC) workers.<sup>3</sup> This concise, well-written report consists of nine brief "discussion papers" that are based on the author's review of available training documents and discussions with UNICEF/UNFPA and GON staff. Each paper deals with a key aspect of PHC manpower development.<sup>4</sup> For example, the "Training Problems Identified" paper "... relates to the dissatisfaction of donor agencies with their inability to markedly change the unacceptably high morbidity and mortality in Nepal. This report classifies these problems into two categories: **Severe** (having a definite negative impact on the delivery of health services) and **Moderate** (making it difficult to work or sustain efforts by health workers)."

Most importantly, this report summarizes the nearly identical observations and recommendations a number of consultants have made over the years regarding training deficiencies and service delivery needs. Because of the clarity this report brings to the whole area of manpower development and service delivery, a brief summary of each of the nine discussion papers is provided in **Annex 1**. This report also contains a draft inventory (spreadsheet) of proposed PHC worker training for the GON's current Five-Year Plan: 1992-1997 (**Annex 2**). The information for the training inventory was obtained from the operating divisions and sections of the MOH. This inventory must be viewed as a wish list, given that currently thousands of GON employees have been asked to resign. For as the author notes, "... discussing training in (the present) atmosphere is like arranging the chairs on the Titanic - a bit difficult to get the facts."

Despite the number of GON employees already dispatched (those over 50 or those who have more than 30 years of experience), and with more resignations being called for, it is ironic that the new PHC plan calls for thousands of new workers to be trained. The proposed PHC infrastructure (from the district to the village level) in Nepal is presented in **Figure 1**. New to the system are the 205 primary health centers which are to be located at the electoral constituency level. As shown in this figure, the proposed staffing, if it can be provided, will enable these polyclinics to provide a wide range of services including maternity care (lying-in). (These sites also could be used as a base for static (reversible and permanent) surgical contraceptive services, including injectables, IUDs, Norplant and VS services.)

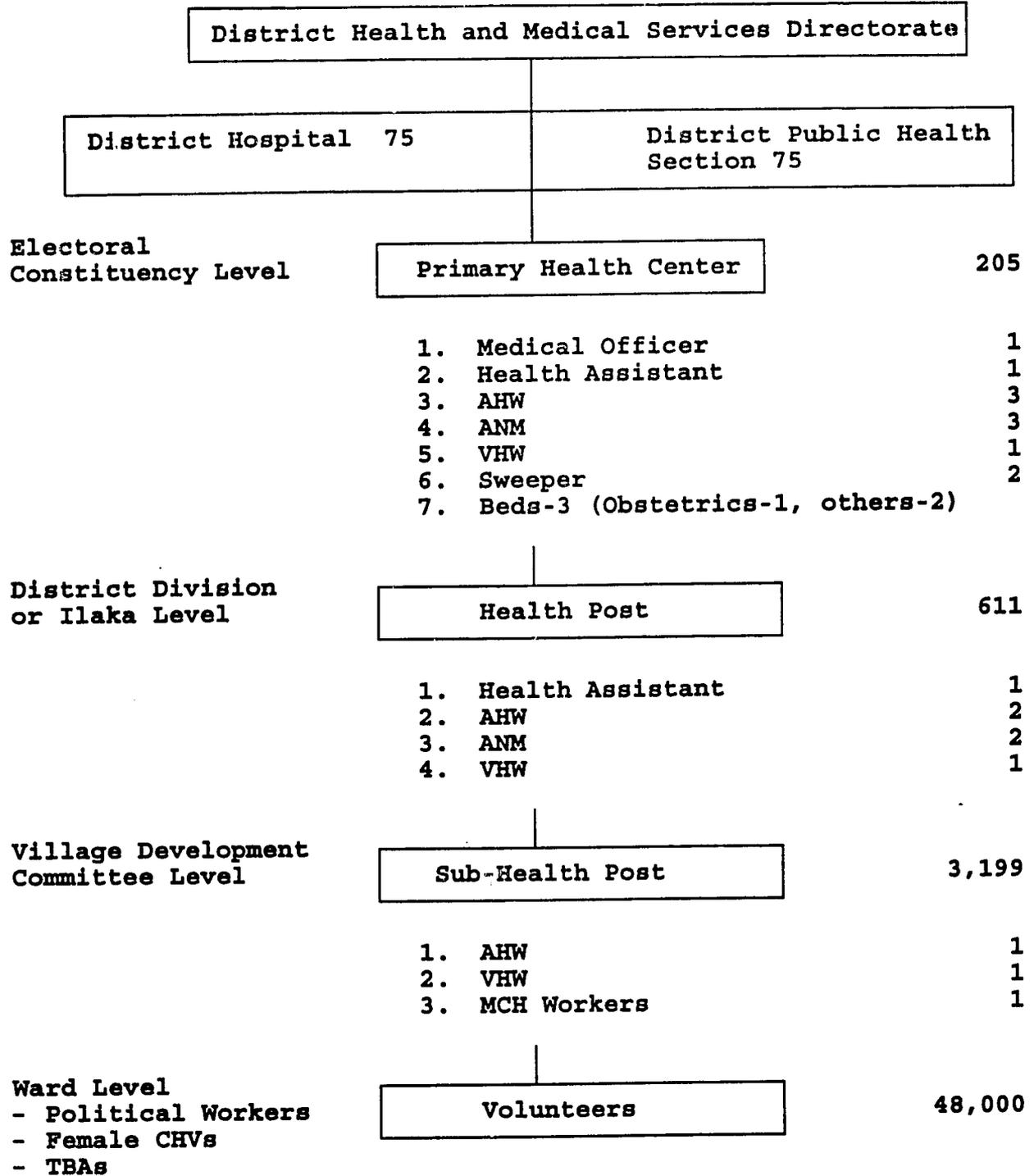
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<sup>3</sup>Andersen JD: *Health Worker Training*. Report prepared for UNICEF, September 1992.

<sup>4</sup>PHC personnel refers to staff at the sub-health post, health post, primary health center and district public health office as well as personnel involved in providing mobile FP services.

Figure 1

Proposed Health Infrastructure  
from District to Village



In addition, the MOH is proposing to develop and staff nearly 3,200 sub-health posts at the Village Development Committee level. These sub-health posts are intended to conduct many of the mandated outreach activities that health post staff have not been able to provide. Given the chronic staffing problems already existing at all levels of the current PHC system, however, it remains to be seen whether this ambitious new health infrastructure plan can be implemented in the near future.

## **ASSESSMENT OF FAMILY PLANNING TRAINING (PRE- AND IN-SERVICE)**

Over the years numerous reports have documented that the pre-service education of health professionals (from physicians to paramedics) in family planning is not well coordinated and ranges from sporadic lectures and presentations on family planning topics to varying degrees of information on contraceptive technology. Parenthetically, all pre-service training curricula for both the degree (MBBS and nursing) and the certificate programs — health assistants (HAs), auxiliary health workers (AHWs) and auxiliary nurse midwives (ANMs) — contain heavy doses of anatomy and physiology and population demography. (Even the bellboy at the Soaltee Oberoyi knew the total fertility rate of Nepal to the second decimal point!) Practical training in the provision of FP services, however, is totally lacking in both physician (MBBS) and nurse (basic certificate and BN) training and is provided in only limited, unpredictable amounts in the pre-service paramedic (HA, AHW and ANM) certificate programs.<sup>5</sup>

These findings were confirmed during the strategic planning exercise through:

- ◆ Discussions with relevant medical and nursing faculty and trainers at the IOM/Kathmandu, Tribhuvan University Teaching Hospital, Maternity Hospital and Bir Hospital
- ◆ Discussions with senior MOH personnel from the FP/MCH and Nursing Divisions
- ◆ Review of available curricular material from the degree-granting schools (medicine and nursing) and the certificate-granting programs (HA, AHW and ANM)

In addition, meetings were conducted with key representatives of the major donors (USAID, UNFPA and UNICEF) involved in the pre- and in-service training of health professionals. (For a detailed review of the unmet needs, options and constraints to strengthening the undergraduate reproductive health education and FP training of medical and nursing students, see **Annexes 4 and 5**, respectively.)

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<sup>5</sup>For a recent review of how basic training of PHC personnel is carried out (i.e., the main institutions involved in pre-service education) at the national, regional and district levels and how the different divisions of the MOH are supposed to organize and conduct their own special training programs, see **Annex 3**.

Regarding the in-service training of health professionals, the current situation is equally discouraging. The 1991 *Training Needs Assessment Report*, which was prepared for the FP/MCH Unit (Training Section) with assistance from AVSC/ARO, amply documents the "... serious need to change from the (current) sporadic, ad-hoc training (approach) to a coordinated and systematic training plan."<sup>6</sup>

A primary objective of the current assessment was to determine the quality and quantity of in-service training and to estimate the needs for basic refresher training in all clinical methods. Not surprisingly, a major finding was that, until recently, most physicians in Nepal have been trained in other countries and not to uniform medical standards. Furthermore, many have received only clinical training through abbreviated clinical apprenticeships, often in mobile VS units. As a consequence, they are not skilled in all clinical FP methods and often have limited, or outdated, knowledge about modern contraceptive methods. Most importantly, many also have only a limited appreciation of the importance of:

- ◆ Counseling, especially regarding voluntarism and informed consent
- ◆ Recommended (and doable) infection prevention practices and other quality assurance measures
- ◆ Clinic (or service delivery) management skills

## CONCLUSIONS AND RECOMMENDATIONS REGARDING TRAINING NEEDS

Currently, health professionals and paramedics in Nepal only sporadically receive classroom (didactic) and nearly all clinical FP training, through individual contraceptive method or procedure-specific courses (e.g., vasectomy training or "Depo" training). Even component parts of FP service delivery generally are taught as isolated in-service training courses (e.g., asepsis training, counseling training or operating theater management training). In large part, this situation reflects the lack of a national FP training policy and failure of the pre-service educational programs to integrate family planning fully into their curricula. Even in 1993, most faculty and trainers still view FP as a **method**, not as an integral component of PHC. As a consequence, in-service courses are fragmented and not comprehensive, and pre-service FP training of medical and nursing students and paramedics is extremely limited.

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<sup>6</sup>Minkler DH, Manandhar V and J Bhattarai: *Training Needs Assessment Report*. FP/MCH Division/MOH/GON and AVSC, 5-29 August 1991.

## **In-Service Training (Physicians, Nurses and Paramedics)**

Based on the historical and current analysis of the in-service training of physicians, nurses and paramedics in clinical FP methods, the following conclusions can be drawn and recommendations made:

1. There is a serious need to change the way the in-service training of physicians in surgical contraceptive methods (IUDs, injectables, Norplant and VS) is provided.
2. Currently, USAID/Nepal and UNFPA/UNICEF are the principal donors funding all GON-sponsored in-service FP training (service providers and trainers) and the pre- and in-service training of all paramedics, auxiliaries and community-level health workers (F/CHWs, MCH workers<sup>7</sup> and TBAs) as well. (Pre-service training of medical and nursing students currently is not supported by either of these organizations.)
3. Beginning July 15, 1993, the start of the next Nepalese fiscal year, USAID and UNFPA/UNICEF have agreed to split training responsibilities in the following way:
  - ◆ USAID/Nepal will be responsible for in-service training (service providers and trainers) for physicians, nurses and paramedics in all clinical FP methods with the exception of Norplant, which UNFPA will continue to support (AVSC to provide technical assistance).
  - ◆ UNFPA will continue to support pre- and in-service FP training of paramedics, auxiliaries and community-level workers in non-clinical FP methods and, as mentioned above, Norplant in-service training for physicians and selected paramedics (senior HAs and AHWs).
4. To address the documented deficiencies in in-service FP training there is an immediate need to:
  - ◆ Establish a working group (or task force) composed of key government, IOM and NGO representatives involved in FP to develop a comprehensive training and service delivery plan that will lead to the increased provision of quality clinical methods.
  - ◆ Establish a system for providing refresher training for VS surgical teams and support staff.

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<sup>7</sup>USAID/Nepal currently is sharing the cost of training this new cadre of health worker.

- ◆ Develop a basic FP training course for physicians and one for nurses and paramedics currently working in the public sector who, to date, have not been fully trained in all clinical contraceptive methods.
  - ◆ Develop a training information system (TIS) that links population information and projections with health manpower data in order to more accurately forecast FP training needs and requirements (numbers and types of workers needed).
5. Ultimately (in three to five years), if the proposed National Training Center (NTC) materializes, all in-service FP training, both classroom and clinical, should be coordinated by this body and, space permitting, be conducted at the NTC or the existing/proposed regional (satellite) training centers.

### **Pre-Service Training (Medical Students)**

Based on the historical and current analysis of undergraduate (pre-service) FP education and training of medical students, the following conclusions can be drawn and recommendations made:

1. Developing and introducing a comprehensive reproductive health education and FP training component into the medical (pre-service) curriculum of the IOM would serve several important functions, including:
  - ◆ Provision of a partial solution to the immediate and long-term training needs of the country
  - ◆ Establishment of a potentially sustainable, coordinated and systematic training system for physicians
  - ◆ Potential for establishing and maintaining national training and service delivery standards for all contraceptive methods
2. At present in Nepal, many of the strongest promoters and supporters of family planning are retiring or are nearing retirement age. In order to attract a new group of younger physicians (not more than eight to ten) into the family planning and population arena, it is recommended that a one year diploma program in reproductive health be established in the Ob/Gyn department.

Candidates for this program would be postgraduates (i.e., have successfully completed their internship) who have a strong interest and commitment to:

- ◆ Reproductive health, especially family planning

- ◆ Becoming a master trainer in addition to serving as a clinical skills trainer for all surgical contraceptive methods (injectables, IUDs, Norplant and VS)
- ◆ Learning about the public health/epidemiologic approach to the management and provision of family planning services, including program design, evaluation and project/contract writing
- ◆ Working in the public sector

This program could be implemented through the IOM within the next year. Trainees could divide their time between the IOM and maternity hospitals for clinical skills and training skills training; the public health program for epidemiology, biostatistics and evaluation training; and perhaps further training in key aspects of community medicine. Once graduated, these reproductive health specialists (RHSs) could serve in a number of roles. For example, they could become a source of new master trainers for the in-service training program; become the key staff needed to expand and strengthen the quality assurance and monitoring capacity of the national family planning program; or join the faculty of the Ob/Gyn department as master trainers in the pre-service clinical FP training program.

Initially, the program would be donor-supported for at least the first four to five years. If the RHSs program proves to be a success and there is need for additional physicians with this training, the program could be established as a permanent program in the department (i.e., similar to the current, one-year Ob/Gyn diploma program).

### **Pre-Service Training (Nursing Students)**

Based on the historical and current analysis of undergraduate (pre-service) FP education and training of nursing students, the following conclusions can be drawn and recommendations made:

1. Expanding and strengthening the reproductive health education and family planning training component of the basic nursing (pre-service) curriculum at the IOM/Kathmandu would serve several important functions, including:
  - ◆ Provision of a partial solution to the immediate and long-term training needs of the country
  - ◆ Establishment of a potentially sustainable, coordinated and systematic training system for nurses which could be "rolled out" to the other nursing campuses in future years at little additional cost

- ◆ Potential for establishing and maintaining national training and service delivery standards for all contraceptive methods
2. Most of the nearly 200 nurses graduating each year do not work as FP providers in the PHC system; therefore, it does not seem reasonable to provide all nursing students with clinical skills training in IUD insertion and removal during their basic (pre-service) training.<sup>8</sup> For the present, therefore, clinical skills (IUD) training should be limited to those untrained and/or inadequately trained female service providers (physicians, nurses and paramedics) who currently are working in the FP service delivery system and have the opportunity to use these skills.
  3. A major obstacle to increasing the use of IUDs in Nepal is the chronic lack of female service providers working in the FP service delivery system. Unless this problem is addressed and realistic solution(s) implemented, use of IUDs in Nepal will never be a significant component in the often proposed "... more balanced contraceptive method mix."<sup>9</sup> The lack of IUD service providers also impacts on the design of future IEC strategies aimed at promoting the use of long-term, reversible methods such as IUDs. Therefore, until this problem is resolved, expanding the availability, quality, access to and use of "Depo" (depo medroxyprogesterone acetate) and Norplant, both of which do not require a female service provider, becomes even more important in increasing the impact of the FP services.
  4. If introduction of a revised pre-service reproductive health component into the basic certificate nursing curriculum proves to be a cost-effective way to educate and train nursing students at the IOM/Kathmandu campus, extending the program to the six other nursing campuses should be considered.

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<sup>8</sup>Currently nurses are not permitted to insert/remove Norplant®, but this may change in the next few years as Norplant services are expanded countrywide.

<sup>9</sup>Thapa S: *Nepal Family Planning Sector: Background and USAID Sector Strategy*. USAID/Nepal, March 1992.

## **PART TWO**

### **TRAINING STRATEGY AND OBJECTIVES**

During the next five years the FP training strategy in Nepal will be twofold. The **initial phase** will be to increase the capability of the FP/MCH Unit (Training Section) to manage and conduct the **in-service** training of physicians, nurses and other health care workers in the provision of clinical FP methods (injectables, IUDs, Norplant and VS). Priority for this is based on the immediate need to provide additional trained clinicians to meet the acknowledged unmet demand for these clinical methods, especially injectables (DMPA) and VS. Strengthening and expanding the in-service training system, combined with linking it to a system for identifying the training needs (number, type and location of service providers to be trained as well as clinical skills requirements), should go a long way toward solving the "... fragmentation (of in-service training activities) which has existed for some time while (also) improving the quality of such training."<sup>10</sup>

Specific objectives of the in-service training strategy are to assist the GON:

1. Establish a working group (or task force) composed of key government, IOM and NGO representatives involved in FP to develop a comprehensive training and service delivery plan that will lead to the increased provision of quality clinical methods; initially in the 15 "institutionalized" districts and ultimately in all districts of Nepal. (The immediate plan calls for identification of existing service providers, possible clinical trainers and existing service delivery sites who could be available immediately for VS services and training.)
2. Establish a system for providing refresher training for VS surgical teams and support staff.
3. Develop a basic FP training course for physicians and one for nurses and paramedics currently working in the public sector who, to date, have not been fully trained in all clinical contraceptive methods. (These courses also should include those components of service delivery such as infection prevention/asepsis, counseling and operating theater management that currently are being taught as isolated activities.)
4. Develop a training information system (TIS) that links population information and projections with health manpower data in order to more accurately forecast FP training needs and requirements (numbers and types of workers needed).

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<sup>10</sup>Minkler DH, Manandhar V and Bhattarai J: *Training Needs Assessment Report*. FP/MCH Division/MOH/GON and AVSC, 5-29 August 1991.

5. Ultimately (in three to five years), incorporate all in-service FP training, both classroom and clinical, into the proposed National Training Center (NTC) which will be linked to the existing/proposed regional (satellite) training center system. (See **Annex 3** which details the roles and responsibilities of the proposed NTC in strengthening health manpower training.)

The **second phase** of the training strategy will be to introduce a comprehensive **pre-service** reproductive health education and FP training component into the curricula of the medical and nursing schools of the Institute of Medicine (IOM) in Kathmandu. This pre-service training activity, which will require four to five years to achieve, ultimately should be an important factor in assisting the GON expand the availability, quality, access to and use of family planning services in Nepal. In addition, it will serve as a cost-effective mechanism for providing basic reproductive health training through the indigenous educational system, thereby freeing up the FP/MCH Unit to focus their efforts on overseeing/providing refresher and/or continuing-education workshops and courses.

The basis for recommending the development and introduction of a pre-service training component into the curricula of the Nepalese health professional schools is detailed in the recent, excellent *Training Needs Assessment Report* prepared for the FP/MCH Unit (Training Section) with assistance from AVSC/ARO in 1991. Not surprisingly, this recommendation has been advanced repeatedly since inauguration of the medical school in the mid-1980s. This report, however, convincingly documents the "... serious need to change from the [current] sporadic, ad-hoc training [approach] to a coordinated and systematic training plan."

Specific objectives of the pre-service training strategy are to assist the GON:

1. Increase the number of physicians trained in FP, including the provision of all methods of surgical contraception, through competency-based, pre-service (internship) training of all medical graduates of the IOM.
2. Increase the number of nurses trained in FP through competency-based, pre-service training of all nursing graduates of the IOM/Kathmandu campus initially. (This pre-service training program would be expanded to include the other six nursing campuses as soon as possible.)
3. Increase the capacity of the IOM/Kathmandu to provide basic reproductive health education, including FP, to all medical and nursing students during their undergraduate (pre-service) years.
4. Increase the number of physicians with special training as Reproductive Health Specialists (RHSs) through a one-year diploma program in the Department of Ob/Gyn at the IOM.

(Evaluation indicators for the proposed pre-service training component are listed in **Annex 6**. These indicators are based on the stated goal of the Nepal Priority Country Strategy [NEP-COST] which is to expand the availability, quality, access to and use of FP methods.)

## **ACTION PLAN: SPECIAL CONSIDERATIONS**

In developing the five-year action plan for the FP training component, due consideration has been given to the fact that a number of other non-training, programmatic constraints must be addressed simultaneously to maximize the impact of the proposed training interventions (the most serious of these constraints are detailed in **Annex 7**). Improving the capability of existing and future health professionals to provide FP services will have only limited impact if these constraints are not addressed. This is because training, although critically necessary, is not sufficient; it is the post-training service delivery environment that ultimately determines training impact.

## **ACTION PLAN AND TIME FRAME: IN-SERVICE TRAINING COMPONENT**

The overall action plan and time frame for conducting most of the in-service training activities and interventions were prepared by the AVSC/ARO members of the Nepal Priority Country Strategy (NEP-COST) team with assistance from senior FP/MCH, FPAN and NFCC staff. This information is fully described in the *Nepal Priority Country Strategy Report: In-Service Training Component* prepared for USAID/Nepal (March 1993).

### **Providing Basic Family Planning Training to Physicians, Nurses and Paramedics**

Because of the documented deficiencies in basic FP training of all cadres of health professionals (physicians and nurses) and paramedics (HAs, AHWs and ANMs) and the need to correct this situation as quickly as possible, the USAID mission has decided to divide responsibility for assisting the FP/MCH Unit (Training Section) in developing, conducting and evaluating these new courses between AVSC/ARO and JHPIEGO. The division of labor will be along the following lines:

- ◆ Because AVSC/ARO is responsible for strengthening in-service training of physicians and nurses in VS (minilaparotomy and vasectomy) as well as FP counseling and other support activities such as "asepsis" and operating theater management training, they will be designated by USAID/Nepal to be responsible for development of the basic FP course for physicians and nurses.<sup>11</sup> (Plans for developing and conducting this course are described in the NEP-COST report being prepared by AVSC/ARO for USAID/Nepal.)

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<sup>11</sup>AVSC/ARO also will be responsible for certain aspects of Norplant® service provider training through a contract with UNFPA as well.

- ◆ JHPIEGO, on the other hand, has been asked to assist the FP/MCH Unit (Training Section) develop and conduct a similar training course for nursing and paramedical health workers (HAs, AHWs and ANMs).

### **Developing a Basic Family Planning Training Course**

At present in Nepal a one-week so-called "Depo" course is provided at the regional/district level to all paramedics (HAs, AHWs and ANMs) in need of this training. Responsibility for conducting this training rests with the FP/MCH Unit (Training Section). Each year training and service delivery targets are set and the necessary funding required is determined (GON Red Book). In the current GON Five-Year Plan (1992/97), funding from UNFPA has been secured for training up to 1,800 paramedics and 70 new trainers (SPHNs, PHNs and SNs). The mechanism for arriving at these numbers is detailed in **Annex 11**, which is taken from the FP/MCH Annual Workplan for 1992/93. The large number of paramedics reportedly needing "Depo" training during the current five-year plan is a reflection of the GON's decision to establish and staff nearly 3,200 new sub-health posts in the country. (An interesting question: Since massive efforts have gone into providing pre-service training for nearly 600 new AHWs per year for the next five years, why wasn't "Depo" training built into the new pre-service AHW curriculum when it was being revised during the past two years?)

The "Depo" course is the logical course to consider making into the Basic Family Planning (BFP) course, because it also deals, to a very limited extent, with all contraceptive methods (lectures) and is designed to be given to all cadres of nursing and paramedic staff (HAs, AHWs and ANMs). Accordingly, USAID/Nepal, has requested that JHPIEGO, with the help of the JSI/Nepal team (Dr. MacKenzie), assist the FP/MCH Unit (Training Section) in:

- ◆ Assessing the possibility of revising the course to more nearly reflect FP service provider needs
- ◆ Adapting/developing relevant new training materials
- ◆ Developing and field-testing the required new/revised TOT materials
- ◆ Assisting the designated trainers in teaching the new/revised BFP curriculum
- ◆ Evaluating the impact of this new BFP course in terms of relevant output indicators (e.g., increased new users, better continuation rates, altered method mix) as well as improved quality of services (e.g., better counseling, infection prevention practices and management of side effects and complications).

Because of the importance of DMPA as a major reversible contraceptive method used in the Nepal FP program and the need to improve the quality of service provider training as expeditiously as possible, USAID also has requested that a preliminary assessment of the content, quality and relevance of the current course be conducted and a draft report written before July 1993. (The terms and conditions for conducting this preliminary assessment, as well as relevant background information, is contained in Annex 12.)

Until the results of the preliminary assessment are known, it will not be possible to develop a detailed, multi-year action plan and budget for designing, developing, implementing and field-testing the BFP course and accompanying TOTs course. It is projected, however, that once the preliminary assessment is completed and the report submitted by July 1993, the process for modifying the service provider course and updating the trainers will take about 12-18 months. Furthermore, the types of activities needed and the time sequence for conducting them should be quite similar to that described for the IUD course (see below).

### **Revision of the IUD Training Course**

JHPIEGO, with assistance of the JSI/Nepal team (Dr. Paul MacKenzie, Family Planning Resource Person), also has been requested by USAID/Nepal to assess and revise (as necessary) the current in-service IUD course for nurses and paramedics and the IUD trainers course for these cadres as well. An analysis of the IUD training situation, prepared by Dr. MacKenzie in conjunction with the FP/MCH Unit, is appended (**Annex 8**). Also appended are copies of:

1. A draft implementation plan for IUD services from 2049 to 2054 (1992 to 1997) (**Annex 9**) prepared by the FP/MCH Unit
2. A list of IUD insertions (users) by district (**Annex 10**)

During the past year the JSI/Nepal team, primarily Dr. MacKenzie, has assisted the FP/MCH Unit Training Section (Dr. Jeevan Bhattarai) in revising the IUD training course outline, improving the teaching aids and introducing several of the components of the competency-based IUD training approach developed by JHPIEGO into trainer training courses. Additional support and assistance by JHPIEGO during the next five years will be provided to: a) further refine the IUD training course outline, b) provide supplemental training skills training to trainers, and c) evaluate the impact of these changes as they relate to improving the quality of service provision, improving continuation rates and increasing IUD use in designated districts of Nepal. (Assistance to the FP/MCH Unit in preparing their annual workplan and budget for IUD service provider and trainer training - and all other in-country activities and interventions associated with IUD training and service delivery as well - will continue to be managed by the JSI team and the USAID/Nepal mission.)

The time frame and sequence for conducting these proposed activities to strengthen IUD training for nurses and paramedics for the first and subsequent program years are listed below.

## **PROGRAM YEAR 1 (1993/94)**

### **1st Quarter (October - December)**

- ◆ JHPIEGO, with the JSI/Nepal team (Dr. MacKenzie), will assist the FP/MCH Unit (Training Section) review all training materials and training methodology, observe a service provider training course (if possible), and develop an action plan for providing assistance in strengthening the current service provider and trainers courses. (Three to six of the "best" IUD trainers located in the Central Region, and if necessary outside the region, will be part of this one-week IUD planning exercise.)
- ◆ JHPIEGO, with the JSI/Nepal team (Dr. MacKenzie), will assist the FP/MCH Unit (Training Section) revise, adapt and produce training and service provider teaching materials (in English).
- ◆ Provide needed teaching aids and other materials for up to four training sites (three FP/MCH and FPAN). This will include up to 20 ZOE<sup>R</sup> pelvic models, 100 hand-held uterine models, 10 IUD teaching slide sets and selected audio-visual equipment, if needed.

### **2nd and 3rd Quarters (January - June)**

- ◆ JHPIEGO, with the JSI/Nepal team (Dr. MacKenzie), will conduct an advanced training skills course(s) for FP/MCH Training Section trainers and selected clinical trainees from the IOM (medical and nursing faculty, FPAN, NFCC and other agencies as required. (The initial course will be conducted outside Nepal and will involve use of international training skills specialists provided by JHPIEGO.)
- ◆ JHPIEGO, with the JSI/Nepal team (Dr. MacKenzie), will assist the FP/MCH Unit (Training Section) conduct a two-week refresher TOT course for the IUD trainers. (If IUD trainers from the FPAN or other organizations are available, they could be included in this activity as well.)
- ◆ JHPIEGO, with the JSI/Nepal team (Dr. MacKenzie), will assist the FP/MCH Unit (Training Section) conduct a two-week service provider training course using the revised IUD training course outline, course materials and training approach (e.g., expanded use of models and more practical training in counseling).

- ◆ JHPIEGO, with the JSI/Nepal team (Dr. MacKenzie), will assist the FP/MCH Unit (Training Section) and three to six of the "best" trainers finalize the IUD and trainer training materials and produce them in sufficient quantity to meet the training needs for the remainder of the year and PY 2 (1994/95) as well.

#### **4th Quarter (July - September)**

- ◆ JHPIEGO, with the JSI/Nepal team (Dr. MacKenzie), will assist the FP/MCH Unit (Training Section) and the same three to six "best" trainers conduct a two-day IUD training and service delivery evaluation meeting; develop an action plan for further JHPIEGO assistance and support (if needed).

#### **PROGRAM YEARS 2-5 (1994/98)**

It is not anticipated at this time that much additional JHPIEGO assistance will be needed unless there are significant changes in the way IUD training is handled by the USAID/Nepal mission (government redbook, etc.) or changes in the JSI/Nepal contract. Monitoring progress in conducting the prescribed training, problem-solving and assisting the FP/MCH Training Section develop a training information system (TIS) for determining the numbers to be trained and their disposition will continue to be provided by JHPIEGO with assistance from the JSI/Nepal team, at least through PY 2.

#### **PROGRAM YEAR 2 (1994/95)**

- ◆ JHPIEGO, with the JSI/Nepal team (Dr. MacKenzie), will assist the FP/MCH Unit (Training Section) to design and conduct a formal evaluation of IUD training and service delivery during PY 2. An important question this study should attempt to answer is whether IUD training needs to be conducted as a separate activity. At some point in time, IUD training should be regularized into the National Training Center and/or regional training centers. This study should be completed and the results made available for the second annual two-day IUD evaluation and planning meeting. The outputs from this meeting will be used to revise, if necessary, the service provider and trainers courses and/or course materials, etc.
- ◆ JHPIEGO, with the JSI/Nepal team (Dr. MacKenzie), will assist the FP/MCH Unit (Training Section) and the same three to six "best" trainers conduct the second annual two-day IUD evaluation and planning meeting; develop an action plan for further JHPIEGO assistance and support (if needed). (This meeting should be conducted as a time when

## **PROGRAM YEARS 3-5 (1995/98)**

- ◆ **PY 3-5:** Assist the FP/MCH Unit (Training Section) and the same three to six "best" trainers conduct the annual two-day IUD training and service delivery evaluation meeting; develop an action plan for further JHPIEGO assistance and support (if needed). (This meeting should be conducted at a time when the results can be used in planning the next FP/MCH workplan, April - June.)
- ◆ **PY 3:** If warranted, assist the FP/MCH Unit (Training Section) to formally review/revise all IUD service provider and TOT course outlines and training materials and produce sufficient quantities for training needs for the remainder of program years.
- ◆ **PY 5:** If warranted, assist the FP/MCH Unit (Training Section) to prepare the next five-year IUD training and service delivery workplan.

## **ACTION PLAN AND TIME FRAME: PRE-SERVICE TRAINING COMPONENT**

Because of the documented deficiencies in undergraduate (pre-service) education of medical and nursing students in FP, the pre-service training action plan will focus on developing and introducing a comprehensive reproductive health education and FP training component into the curricula of the medical and nursing schools at the IOM/Kathmandu. This action plan, which will require four to five years to implement, ultimately should be an important factor in assisting the GON expand the availability, quality, access to and use of FP services. In addition, it will serve as a cost-effective mechanism for providing basic reproductive health training through the indigenous educational system, thereby freeing up the FP/MCH Unit to focus their efforts on overseeing/providing refresher and/or continuing-education workshops and courses.

The time frame and sequence for conducting the proposed activities for the first two program years (PY 1 and 2) are listed in the following section. For the remaining years (PY 3-5), only highlights of the proposed activities needed to complete the process are provided.

### **PROGRAM YEAR 1 (1993/94)**

#### **1st Quarter (October - December)**

- ◆ Develop workscopes, identify Project Director(s) and Project Coordinator(s) and negotiate subagreements with the IOM and the Maternity Hospital.

- ◆ Establish a pre-service training advisory committee (PRE-TAC) comprised of 10-12 representatives from the IOM (the Dean; Chairs of relevant departments and divisions of the medical and nursing school); the Director of the Maternity Hospital; and senior representatives from the FP/MCH Unit, FPAN and the NFCC. USAID/Nepal and UNFPA also will be represented on the PRE-TAC.

The purpose of the PRE-TAC will be to set priorities for the proposed activities; review proposed clinical training plans (e.g., training of master and clinical trainers, adapting competency-based training materials, etc.); review of proposed curricular changes (medical and nursing schools) and training skills plans for key faculty; and oversee the design of the RHCs diploma program. It is envisioned that initially the PRE-TAC will meet twice per year until the various programs are in place and functioning. Thereafter, the PRE-TAC will meet on an annual basis to oversee progress in accomplishing each of the proposed interventions.

#### **2nd and 3rd Quarters (January - June)**

- ◆ Upgrade equipment, instruments and other items at the Maternity Hospital and FP/MCH clinic to assure the quality and cost-effectiveness of existing family planning services (IUDs, injectables, Norplant and laparoscopy) and minimize health risks to the client and clinic staff.
- ◆ Conduct a two-week course workshop with the medical and nursing staff at the Maternity Hospital to develop standardized, competency-based clinical training programs for the existing surgical contraceptive methods (interval IUDs, injectables, Norplant and postpartum IUDs and minilaparotomy). (This activity will be done with assistance from AVSC/ARO.)
- ◆ Conduct a two-week advanced training skills course for selected staff at the Maternity Hospital (and potentially faculty from the IOM/Kathmandu) who will serve as the clinical and counseling trainers for the medical and nursing students and interns.

#### **4th Quarter (July - September)**

- ◆ Assist key faculty members in developing the reproductive health (RH) diploma program for physicians, determining the selection criteria, selecting the candidates and implementing the program in the next academic year.

- ◆ Assist the Maternity Hospital (FP/MCH clinic) establish interval minilaparotomy services. In addition, during the year, AVSC/ARO will assist the Maternity Hospital (FP/MCH clinic) establish vasectomy services.
- ◆ Assist the PRE-TAC conduct a two-day program review meeting to assess progress to date and establish priorities for PY 2.
- ◆ **Administrative Support:** A Project Coordinator (100%), and two support staff (100%) will be recruited and space sought at the IOM/Kathmandu and/or the Maternity Hospital.<sup>12</sup> First-year costs will be greater in order to provide funds to set up and equip the office. (Space for the Project Coordinator and administrative staff should be provided at no cost to the project.)
- ◆ **Technical Assistance:** Throughout the year, technical assistance in the areas of surgical contraceptive methods, infection prevention, STDs, clinic management and other areas will be provided by JHPIEGO staff and consultant specialists as needed.

## **PROGRAM YEAR 2 (1994/95)**

### **1st Quarter (October - December)**

- ◆ With assistance from AVSC/ARO conduct a two-week course with the clinical trainers at the Maternity Hospital (and potentially at the IOM/Kathmandu) to establish interval minilaparotomy services and to develop/adapt interval minilaparotomy training materials for training interns in this procedure.
- ◆ Conduct a two-week training skills course for the selected medical and nursing faculty members to provide them with the knowledge and skills to become master trainers so that they can develop the basic reproductive components to be introduced into the medical and nursing curricula, teach it, evaluate it and modify it as necessary.

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<sup>12</sup>If surgical contraceptive services also will be provided at the IOM/Kathmandu hospital, it will be necessary to provide full (or part-time) project coordinator and support staff as well.

## **2nd Quarter (January - March)**

- ◆ Conduct a two-week curriculum development meeting with the master trainers to develop the overall RH component(s) and identify/develop/adapt the required teaching materials, including audio-visuals and other teaching aids.
- ◆ Conduct a two-day RH component coordination meeting of the PRE-TAC. The purpose of this meeting will be to review the final version of the overall RH component of the medical and nursing school curricular components and to finalize plans for introducing each section.

## **3rd Quarter (April - June)**

- ◆ Conduct a one-week curriculum development meeting to assist the faculty trainers finalize the third-year (MS-3) component of the RH curriculum for medical students and review all training materials, including audio-visuals and other teaching aids.
- ◆ Conduct a one-week curriculum development meeting to assist the master trainers finalize the second-year (NS-2) component of the RH curriculum for nursing students and review all training materials, including audio-visuals and other teaching aids.<sup>13</sup>

## **4th Quarter (July - September)**

- ◆ Field-test the educational and training materials, including audio-visuals and other teaching aids developed for both the medical (MS-3) and nursing school (NS-2) curricular components.
- ◆ Upgrade equipment, instruments and other items and provide training materials and teaching models for use at the IOM (medical and nursing schools).
- ◆ With assistance from AVSC/ARO conduct a two-week course with the clinical trainers at the Maternity Hospital (and potentially at the IOM/Kathmandu) to develop/adapt vasectomy (no-scalpel method) training materials for training interns in this procedure.
- ◆ Assist the PRE-TAC conduct a two-day program review meeting to assess progress to date and establish priorities for PY 3.

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<sup>13</sup>If it is decided to include a RH component in the two-year (BN) curricula, the action plan will be modified accordingly.

- ◆ **Administrative Support:** Project Coordinator(s) (50-100%) and required support staff (100%) will be supported with office space provided at the IOM/Kathmandu and/or the Maternity Hospital.<sup>14</sup>
- ◆ **Technical Assistance:** Throughout the year technical assistance in the areas of surgical contraceptive methods, infection prevention, STDs, clinic management and other areas will be provided by JHPIEGO staff and consultant specialists as needed.

### **PROGRAM YEARS 3-5 (1995 to 1998)<sup>15</sup>**

Highlights of activities scheduled in subsequent years (PY 3-5) will include:

- ◆ "Echo" training skills training for selected medical and nursing faculty assigned to teach the MS-3 and NS-2 reproductive health (RH) components of the medical and nursing school curricula during the early part of PY 3.
- ◆ Introducing the MS-3 section of the RH component of the medical school curriculum during PY 3.
- ◆ Evaluating and revising the MS-3 RH component and developing the final MS-5 RH component during the latter part of PY 3.
- ◆ Introducing the NS-2 section of the RH component of the medical school curriculum during PY 3.
- ◆ Evaluating and revising the NS-2 RH component and developing the final NS-3 RH component during the latter part of PY 3.
- ◆ Developing/adapting self-paced (written and/or computer-assisted) internship (IN-6) section of the RH component of the medical school curriculum during PY 3.
- ◆ "Echo" training skills training for selected medical and nursing faculty assigned to teach the MS-5 and NS-3 RH components of the medical and nursing school curricula during the early part of PY 4.

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<sup>14</sup>If surgical contraceptive services also will be provided at the IOM/Kathmandu hospital, it will be necessary to provide full (or part-time) project coordinator and support staff as well.

<sup>15</sup>If it is decided to include a RH component in the two-year (BN) curricula, the action plan will be modified accordingly.

- ◆ Introducing the MS-5 and NS-3 sections of the RH components of the medical and nursing school curricula during PY 4.
- ◆ Evaluating and revising the MS-5 and NS-3 RH components of the medical and nursing school curricula during the latter part of PY 4.
- ◆ Introducing the self-paced (written or computer-assisted) internship (IN-6) section of the RH component of the medical school curriculum during PY 4.
- ◆ Evaluating and revising the self-paced (written or computer-assisted) internship (IN-6) section of the RH component of the medical school curriculum during the latter part of PY 4.
- ◆ Evaluating and revising the entire RH component of the medical and nursing school curricula, including the RH diploma program, during the latter part of PY 5.

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## ANNEX 1

### SUMMARY OF DISCUSSION PAPERS:

### HEALTH WORKER TRAINING REPORT

Prepared by James D. Andersen, UNICEF Consultant  
September 1992

The following summaries are abstracted from each of the sections included in the *Health Worker Training* report which is based on Andersen's review of training documents and discussions with UN staff and HMG officials.

1. **Training Overview** addresses the underlying problems of poor management, nonexistent supervision, lack of positive (or negative) incentives. The lack of interest and poor productivity are problems worsened by donor agencies themselves. Suggested are ways to involve the community to sustain progress.
2. **Training Problems Identified** deals with the dissatisfaction of donor agencies with their inability to markedly change the unacceptable morbidity and mortality in Nepal. A number of consultant reports have made nearly identical observations and recommendations. Andersen's report classifies these problems into two categories: **Severe** (having a definite negative impact on the delivery of health services) and **Moderate** (making it difficult to work or sustain efforts by health workers).
3. **Developing Training Infrastructure** describes the need to involve the public and private schools in Nepal in the initiation of technical and vocational education programs designed to train health workers over the long term.
4. **Social Mobilization** suggests utilizing the newly elected Village Development Committees and District Development Committees to generate public interest and demand for health services, and to demand that health workers paid to offer services actually deliver those services or not be paid.
5. **Management Training for District Public Health Officers (DPHOs)** recognizes that DPHOs occupy the most crucial role in the delivery of public health programs. It calls for the institutionalization of training programs that have been tested and proven to be effective. (A revised curriculum for providing the much needed management training has recently been completed.)

6. **Self-Assessment for Village Health Workers** recognizes the absence of monitoring and supervision. While suggesting the need for improvement in this area, it provides a guide for the development of a format for self-assessment that will give workers (without supervision) some indication of how well they are performing.
7. **Training Information for Donor Agency Participation** suggests the development of a training newsletter to enhance the coordination of donor agencies through communications.
8. **Upward Mobility** identifies a major problem of health worker dissatisfaction, turnover and wasted training. Health worker positions are not related and do not provide a natural progression from one position to a higher one. Workers end up in dead-end positions with little hope of advancement. (Also contained in this section is a listing of all health worker positions with their respective education and training requirements.)
9. **Inventory of Training** is a computer spreadsheet of projected training for all health workers by position (**Annex 2**). It identifies the number of participants, course length, total training days, location of training, responsible agency and donor supporting the training. This inventory will allow all (organizations and agencies) concerned to focus on combining and spacing training to make it more cost-effective and efficient from a teaching point of view. It also points out serious duplication and problems in collecting basic information. This inventory is only a starting point for agency/donor input and refinement.

## ANNEX 2

### TRAINING OF HEALTH WORKERS IN NEPAL FIVE YEAR PLAN: 1992 - 1997

HEALTH WORKER CATEGORY	NUMBERS	SPECIFIC TRAINING	LENGTH (DAYS)	TOTAL TRNG DAYS	LOCATION	AGENCY PROVIDING TRAINING	DONOR	COMMENTS
<b>CLINICAL TRAINING</b>								
Physicians	46	Laparoscopy	24	1104	Kathm.	FP/MCH	UNFPA	BIR/MATERNITY HOSPITALS Training Sites will be dev. in Birat Nagar, Bharatpur, Pokhara, Nepalganj, Dhanagarhi inc. Bir Hospital, Maternity Hospital and Chetrapaticline.
	110	Minilap	24	2640	Reg. Hosp.	FP/MCH	UNFPA	
	240	Vasectomy	18	4320	Reg. Hosp.	FP/MCH	UNFPA	
	50	VSC Refresher	10	500	Reg. Hosp.	FP/MCH	UNFPA	
	320	Norplant (In/Rem)	6	1920	Reg. Hosp.	FP/MCH	UNFPA	
	500	FP Mgt. (Med. Off.)	1	500	Kathm.	FP/MCH, NMA	UNFPA	
	40	AIDS Mgt. (Med. Off.)	2	80	Bhartpur	CHL/NMA	WHO/UNDP	
<b>Total Physicians</b>	<b>1306</b>		<b>85</b>	<b>11064</b>				
Senior Nurses	60	O.T Management	12	720	Reg. Hosp.	FP/MCH	USAID	
	30	Depo TOI	30	900	Reg. Hosp.	FP/MCH	UNFPA	
	150	IUCD Insertion	30	4500	Reg. Hosp.	FP/MCH	USAID	
Nurses	200	Asepsis	7	1400	Reg. Hosp.	FP/MCH	USAID	
	30	IUCD Refresher	12	360	Reg. Hosp.	FP/MCH	USAID	? Course length
	200	FP Counseling	6	1200	Reg. Hosp.	FP/MCH	UNFPA	
	300	Inservice Education	12	3600	Kathmandu	DON	UNFPA	
	30	Managing Hosp Nursing	12	360	Kathmandu	DON	UNFPA	
		Mgt & Planning Workshop (1)	3	0	Kathmandu	DON	UNFPA	Check # participants
		Dev. Trng. Mater. Workshop (1)	5	0	Kathmandu	DON	UNFPA	Check # participants
	30	Hosp. Nur. Mgt. HIV/AIDS Workshop	3	90	Kathmandu	CHL/NMA	WHO/UNDP	
<b>Total Nurses</b>	<b>1030</b>		<b>132</b>	<b>13130</b>				
Senior Paramedics	80	Norplant (In/Rem)	18	1440	Reg. Hosp.	FP/MCH	UNFPA	

HEALTH WORKER CATEGORY	NUMBERS	SPECIFIC TRAINING	LENGTH (DAYS)	TOTAL TRNG DAYS	LOCATION	AGENCY PROVIDING TRAINING	DONOR	COMMENTS
<b>NON-CLINICAL TRAINING - DISTRICT STAFF</b>								
DPHO	125	FP Mgt. Training	6	750	NTC/RTC	NTC/PHD	UNFPA	
	95	MCH Mgt. Training	6	570	Kath/Pokhara	FP/MCH	UNFPA	
	25	MCH Workshops	2	50	Regions	FP/MCH/RHSD	UNFPA	Combined with FCHV PP WKSP
	18	AIDS Orientation Mtg.	1	18	Kathmandu	CHL/IEC	WHO/UNDP	
	82	Microplanning	5	410	Regions	EPI	UNICEF	82 out of 332
	5	EPI Surveillance of IM/Dis	3	15	Districts	EPI	UNICEF	5 out of 225
	24	EPI Mid-level Management		0	Kathm.	EPI	UNICEF	? course length (24/208)
	150	FCHV District Review Meetings	2	300	Districts	PHD/FCHV	UNFPA	2 mtgs/year (? other staff)
	125	PHC Management Training	30	3750	Kathmandu	PHD	UNDP	
<b>Total DPHOs</b>	<b>649</b>		<b>55</b>	<b>5863</b>				
DPHO Assistants	75	FP Refresher	10	750	Districts	NTC/PHD	UNFPA	75 of 4000 DPHO-A & HP Staff
	75	MCH District level training	6	450	Districts	FP/MCH/RHSD	UNFPA	75 out of 2250 (30/dist X 75)
	75	Nutrition	5	375	Regions	PHD (NTR)	WHO/FAO	
	77	Microplanning	5	385	Regions	EPI	UNICEF	77 out of 332
	148	EPI Mid-level Mgt.		0	Kathm.	EPI	UNICEF	? course length (148/208)
	3304	ARI Training	2	6608	Districts	CDD/ARI	UNICEF/WHO	
	1478	ARI Refresher Trng.	2	2956	Districts	CDD/ARI	UNICEF/WHO	
	1649	Diarrhoeal Diseases	6	9894	Dist/RHSD	CDD/ARI	UNICEF/USAID	
	22	TBA Dist.Mgt.Orient	1	22	Districts	DON	UNICEF	? number of trainees/dist.
<b>Total DPHO Asst</b>	<b>6903</b>		<b>37</b>	<b>21440</b>				
<b>NON-CLINICAL TRAINING - HEALTH POST AND SUB-HEALTH POST STAFF</b>								
Health Post I-C	36	EPI Mid-level Mgt.		0	Districts	EPI	UNICEF	? course length (36/208)
	816	Nutrition	5	4080	Districts	PHD (NTR)	WHO/FAO	
	816	PHC Management	30	24480	RTC/Dist	PHD	UNDP	
	40	Malariology Orientation	12	480	Mal.Trng.Cen.	MCD	WHO/USAID	
<b>Total HPIC</b>	<b>1708</b>		<b>47</b>	<b>29040</b>				

HEALTH WORKER CATEGORY	NUMBERS	SPECIFIC TRAINING	LENGTH (DAYS)	TOTAL TRNG DAYS	LOCATION	AGENCY PROVIDING TRAINING	DONOR	COMMENTS
Health Post Staff	3925	FP Refresher Training	10	39250	Districts	NTC/PHD	UNFPA	3975 of 4000 DPHO-A/HP Staff
	2175	MCH District level training	6	13050	Districts	FP/MCH/RHSD	UNFPA	2175 of 2250 (30/dist X 75)
	1000	PHC Management (ANM)	30	30000	RTC/Dist	PHD	UNDP	
	4225	MIS - Health Post Staff		0	RHSD/Dist	RHSD/DPHO	UNFPA	? Check length of training
	9600	MIS - Sub-Health Post Staff		0	RHSD/Dist	FP/MCH	UNFPA	? Course length
	37	AIDS Workshop	2	74	Kathmandu	CHL/IEC - SC	WHO/UNDP	
	1500	Leprosy Orientation	6	9000	Mal.Tr.Ctr	Leprosy-RHSD	NSL/GERMAN RELIEF ASSOC/INF	
	300	EPI - Basic Training	6	1800	Districts	EPI	UNICEF	(includes VHWs)
	220	EPI - Surveillance of Im/Dis	3	660	Districts	EPI	UNICEF	220 out of 225
	2472	ARI Training	2	4944	Dist/HP	CDD/ARI	UNICEF/WHO	
	2257	ARI Refresher Trng.	2	4514	Dist/HP	CDD/ARI	UNICEF/WHO	
	2351	Diarrhoeal Diseases	4	9404	Districts	CDD/ARI	UNICEF/WHO	
	19	TBA HP/Community Orientation	1	19	Districts	DON	UNICEF	? Number of trainees/HP
	1363	Microplanning	3	4089	Regions	EPI	UNICEF	
	1500	Depo Training	6	9000	Reg. Hosp.	FP/MCH	UNFPA	
	2400	Basic Training (AHW)	360	864000	RTCs	FP/MCH	UNFPA	2400 by MOH, 1004 by IOM
	4015	Nutrition (AHW)	5	20075	Districts	PHD (NTR)	WHO/FAO	
	1600	PHC Management (AHW)	30	48000	RTC/Dist	PHD	UNDP	
	25	Elec. laparoscopy (AHW)	24	600	Reg. Hosp.	FP/MCH	USAID	
<b>Total HP Staff</b>	<b>40984</b>		<b>500</b>	<b>1058479</b>				
MCHWs	3200	Basic Training	90	288000	RTCs	FP/MCH	UNFPA	
Village HW	750	Basic Training	90	67500	RTCs	PHD	UNFPA	
	4000	FP Refresher Trng	7	28000	District	FP/MCH	UNFPA	
	4066	EPI Refresher Trng	3	12198	District	EPI.	UNICEF	
	2801	Retaining			District	EPI.	UNICEF	
	4015	Nutrition	3	12045	District	PHD (NTR)	WHO/FAO	
	150	Depo	7	1050	District	FP/MCH	UNFPA	
	4000	EPI Disease Surveillance	1	4000	District	EPI	UNICEF	4000 out of 10000
	4066	EPI Refresher Training	3	12198	District	EPI	UNICEF	
	8030	Primary Health Care Refresher	30	240900	District	PHD	UNDP	4015 VHWs twice/5 years
<b>Total VHW</b>	<b>31878</b>		<b>144</b>	<b>377891</b>				

HEALTH WORKER CATEGORY	NUMBERS	SPECIFIC TRAINING	LENGTH (DAYS)	TOTAL TRNG DAYS	LOCATION	AGENCY PROVIDING TRAINING	DONOR	COMMENTS
<b>TECHNICIAN/ADMINISTRATIVE TRAINING</b>								
Laboratory Tech.	8	HIV Screening Workshop	5	40	Kathmandu	CHL	WHO/UNDP	
Cold Room Tech	36	EPI Basic Training	12	432	Kathm.	EPI	UNICEF	
Cold Chain Ass't	97	Microplanning	5	485	Regions	EPI	UNICEF	97 out of 332
<b>Total Cold Ch.</b>	<b>133</b>		<b>17</b>	<b>917</b>				
Accountants	20	Accounting methods		0	Kathmandu	FP/MCH	UNFPA	? Length of course
Storekeepers	20	Logistics		0	Kathmandu	FP/MCH	UNFPA	? Length of course
<b>NON-CLINICAL TRAINING - COMMUNITY/VILLAGE DEVELOPMENT COMMITTEE/DISTRICT DEVELOPMENT COMMITTEE LEVEL</b>								
FCHVs	43785	Basic Training	20	875700	HP/SHPs	PHD/FCHV	UNFPA/UNICEF/USAID	
	22568	ARI	2	45136	HP/SHPs	CDD/ARI	UNICEF/WHO	
	20313	ARI Refresher Trng.	2	40626	SP/SHPs	CDD/ARI	UNICEF/WHO	
	4000	EPI Disease Surveillance	1	4000	District	EPI	UNICEF	4000 out of 10000
	36135	Nutrition	3	108405	HP	PHD (NTR)	WHO/FAO	
	167789	Review Meetings	2	335578	HP/SHPs	PHD/FCHV	UNFPA/UNICEF/USAID	
	4015	Trng. Review Mtg.	6	24090	HP/SHPs	PHD/FCHV	UNFPA/UNICEF/USAID	
<b>Total FCHVs</b>	<b>298605</b>		<b>36</b>	<b>1433535</b>				
TBA	12000	Initial Training	10	120000	Dist/HP/SHP	DON	UNFPA/UNICEF/WHO/REDD BARNA	
	14500	Refresher Training	4	58000	Dist/HP/SHP	DON	UNFPA/UNICEF/WHO/REDD BARNA	
	2000	EPI Disease Surveillance	1	2000	District	EPI	UNICEF	2000 out of 10000
	25000	Review Meetings	2	50000	DPHO/HP/SHP	DON	UNFPA/UNICEF/WHO/REDD BARNA	
	22000	FP Training	2	44000	HP	DON	UNFPA	? Check numbers (3/HP per yr)
<b>Total TBAs</b>	<b>75500</b>		<b>19</b>	<b>274000</b>				

HEALTH WORKER CATEGORY	NUMBERS	SPECIFIC TRAINING	LENGTH (DAYS)	TOTAL TRNG DAYS	LOCATION	AGENCY PROVIDING TRAINING	DONOR	COMMENTS
Vill. Dev. Comm.	4015	FCHV Orientation/Seminar	1	4015	VDC Level	PHD/FCHV	UNFPA/UNICEF/WHO/REDD BARNA	
Dist. Dev. Comm.	75	Orientation/Seminar			District	DPHO	UNFPA/UNICEF/WHO/REDD BARNA	
	840	FCHV Orientation/Seminar	1	840	District	FP/MCH	UNFPA/UNICEF/WHO/REDD BARNA (75 DIST)	
	2250	MCH Orientation	1	2250	District	FP/MCH	UNFPA 30 per district	
<b>Total DDCs</b>	<b>3165</b>		<b>2</b>	<b>3090</b>				
Social Leaders	7560	HP Orientation	1	7560	HP	FP/MCH	UNFPA	
Mothers Groups	43765	Orientation	1	43765	Wards	PHD/FCHV	UNFPA/UNICEF	(20 WARDS)
Pr School Teacher	15000	Diarrhoeal Diseases	3	45000	HP	PHD/CDD/ARI	UNICEF/USAID	
Scouts	15000	Diarrhoeal Diseases	3	45000	HP	PHD/CDD/ARI	UNICEF/USAID	
<b>TRAINING OF TRAINERS - ALL LEVELS</b>								
Regional Level	25	PHC Training	30	750	Kathmandu	PHD	UNDP	
	25	PHC Annual Trainers Workshop	5	125	Kathmandu	PHD	UNDP	
	33	MCH Master Trainers	7	231	Kath/Pokhara	FP/MCH	UNFPA	
	225	MIS Trainers		0	Kath/RHSD	FP/MCH	UNFPA	
<b>Total Reg. Tr.</b>	<b>308</b>		<b>42</b>	<b>1106</b>				
DPHO Level	92	Training			District	DPHO	UNFPA	
	22	TBA Training	17	374	District	DON	UNFPA	UNFPA/UNICEF/WHO/REDD BARNA ? Number of trainees/districts
	75	FCHV Training	6	450	District	PHD/FCHV	UNFPA	UNFPA/UNICEF/USAID ? Donor, 75 out of 2760
<b>Total Dist. Tr.</b>	<b>189</b>		<b>23</b>	<b>824</b>				
HP Level	92	Training			District	DPHO	UNFPA	
	33	Trainers Workshop	7 days			FP/MCH	UNFPA	
	2685	FCHV Training	6	16110	District	PHD/FCHV	UNFPA	UNFPA/UNICEF/USAID 2685 out of 2760
<b>Total HP Tr.</b>	<b>2810</b>		<b>6</b>	<b>16110</b>				

HEALTH WORKER CATEGORY	NUMBERS	SPECIFIC TRAINING	LENGTH (DAYS)	TOTAL TRNG DAYS	LOCATION	AGENCY PROVIDING TRAINING	DONOR	COMMENTS
<b>WORKSHOPS/SEMINARS/STUDIES</b>								
Health Education	8	Health Education	7	56	Kathm.	HE Sect.	UNFPA	
Health Education	560	HE Training	45	25200	Kathm.	HE Sect.	UNFPA	
Senior Staff		FCHV Curriculum	30		Kathmandu	PHD	UNFPA/UNICEF	? # of participants
Regional Staff	25	FCHV Prog. Plan	3	75			UNFPA/UNICEF	
Senior Staff		PHC Curr/PD/Mat	60	0	Kath/RTC	PHD	UNDP	? # of participants
High Level Staff		MCH Seminar	2	0	Kathmandu	FP/MCH	UNFPA	? # of participants
Senior Staff		MIS Mat. Develop		0	Kathmandu	FP/MCH	UNFPA	? # of participants
NGOs	250	AIDS NGO Orient.	5	1250	Bhartpur	CHL/NMA	WHO/UNDP	
Blood Bank Staff	36	AIDS Blood Bank	1	36	Kathmandu	NRC/NBTSC	WHO/UNDP	
Social Workers	120	AIDS Social Worker	2	240	Dhading/Sind	NRC/NBTSC	WHO/UNDP	
	25	AIDS/STD Management		0	Kathmandu	AP & CP	WHO/UNDP	? length, participants, agency
		Studies						
Detailed proposal awaited		PHC Training						

**ANNEX 3**

**REPORT OF THE TASK FORCE**

*on*

**THE ESTABLISHMENT OF THE**

**NATIONAL TRAINING CENTER**

*for*

**STRENGTHENING HEALTH MANPOWER TRAINING**

**Kathmandu, December 1992**

**Nepal Technical Report  
August 1993**

## **Report of the Task Force on the Establishment of the National Health Training Center for Health Manpower Training**

- 1. Background:** Training has been an area of priority for the Ministry of Health (MOH) since the beginning of the organization of health services in the country. Its importance has grown over time, and as of today, training is incorporated as an integral part of every primary health care (PHC) program.

Training of PHC<sup>1</sup> personnel is carried out at national, regional and district levels. Currently, the main institutions involved in training are the MOH and the Institute of Medicine (IOM). In addition, the numerous NGOs involved in the health sector train their own staff.

The different divisions of the MOH organize and coordinate their own training programs which are carried out at the central level, at regional training centers (RTCs) and in the districts. Training units at the central level include:

- The Manpower Development and Training Division, which coordinates fellowships for training programs abroad
- The National Coordination Unit, which was established in 1992 and coordinates the training of staff at the sub-health post (SHP) level, Auxiliary Health Workers (AHWs), Maternal-Child Health Workers (MCHWs) and Village Health Workers (VHWs)
- The Public Health Division plans and coordinates training programs at the RTCs and conducts training on teaching methodology, IEC, evaluation, monitoring and supervision for various cadres
- The Environmental Sanitation Unit trains district health educators in sanitation promotion
- The National Tuberculosis Center provides technical training for its staff
- The Health Education Section organizes basic training for health education technicians

The other key training institution is the IOM of Tribhuvan University which has different departments that train various cadres of health workers at basic, certificate, bachelor and postgraduate levels. About 85% of the total manpower receive basic training by the IOM. As far as the training of PHC

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<sup>1</sup>PHC personnel refers to staff at the sub-health post, health post, primary health center and District Public Health Office levels.

personnel is concerned, the Nursing and AHW Campus provides training to general nurses, assistant nurse midwives (ANMs) and AHWs. Besides Kathmandu, nurses are trained at different campuses throughout the country.

The Medical Education Department of the IOM provides upgrading training for Health Posts In-Charge. It also functions as a resource center in training issues. The department provides curriculum development and revision, and distance learning programs for health post workers.

The Family Health Center of the Department of Community Medicine of the IOM provides training on family planning issues to medical personnel.

Besides training activities, the Health Learning Materials Unit produces textbooks for health workers and other medical manuals.

MOH in-service training at the regional level takes place in five RTCs in Dhankuta (Eastern Region); Pathlaha (Central Region); Pokhara (Western Region); Surkhet (Mid-Western Region) and Dhangadi (Far-Western Region). The training schedule, program and budget are prepared at the central level by the Public Health Division. The financial administration of the RTCs is in the hands of the Regional Health Directors (RHDs).

The five RTCs plus an additional training centers at Janakpur, Rajbiraj, Biratnagar and Nepalganj are being used to train the health workers required under the 1991 Health Policy to staff the SHPs. Field training for RTC trainees takes place at neighboring health posts.

At the district level, most of the in-service training, particularly programs run by the different divisions or sections of the MOH (EPI, Malaria, etc.) is carried out. Most of these programs have their own trainers who organize or carry out their activities independent of other programs. Training for mid-level and grassroots-level health workers takes place at the District Public Health Office. Health posts conduct training programs for grassroots-level health personnel, such as Female Community Health Volunteers (F/CHW). Foreign and national NGOs also conduct training at this level.

As described above, the number of institutions and levels involved in training are many, which leads to problems of coordination, currently exacerbated because the number of professionals, paramedics, volunteers, TBAs and other social and political leaders to be trained to deliver PHC services as envisioned in the HMG's 1991 Health Policy is huge. Responsibility for in-service training is diffused throughout the MOH and is carried out almost independently without coordination between the various divisions/sections of the Ministry. Because of the vertical approach in training, there is often a duplication of contents and disruption of field activities. In addition, training quality often is not up to the mark. There is currently no one body that has the mandate to coordinate all

training activities and to provide institutional leadership to meet the total training requirements of PHC workers.

In order to improve coordination and implementation of training activities, the government has recognized the need for establishing a National Training Center (NTC) in Kathmandu. A Task Force chaired by the National Training Coordinator has been formed to discuss and make recommendations on the following issues:

- Organizational role of the NTC
- Organogram for the NTC
- Staffing pattern for the NTC
- Physical facilities required for the NTC
- List of equipment and supply requirements for the NTC
- Steps to be taken to establish the NTC
- Budget for the NTC for the Eighth Five-Year Plan.

## **2. Recommendations of the Task Force:**

Having discussed these issues in depth, in light of the 1991 Health Policy, the Task Force recommended the following:

### **A. Organizational Role of the NTC**

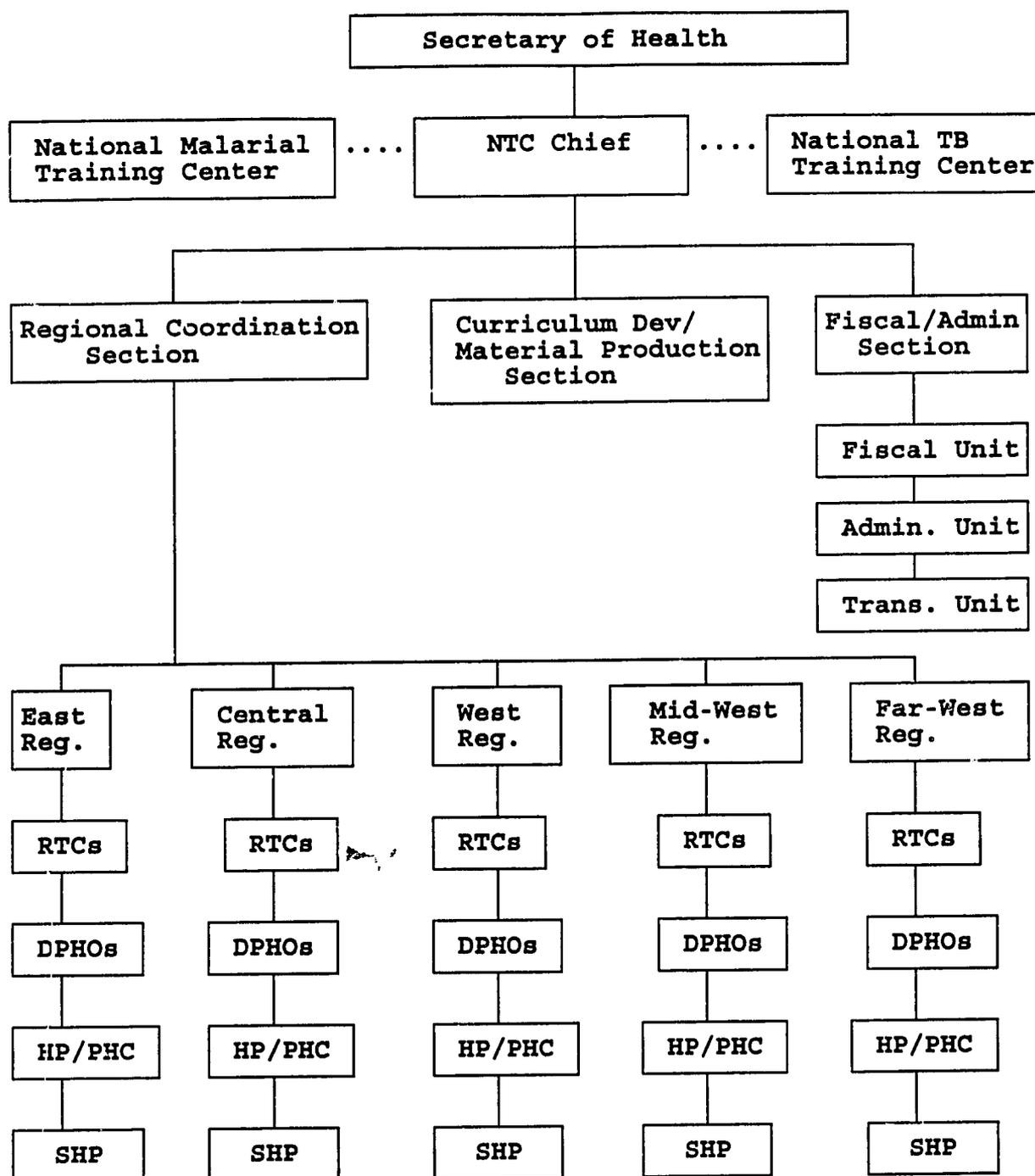
The purpose of the proposed NTC is to serve as a focal point for all PHC-related training activities. In collaboration with other relevant institutions, it will establish and enforce policies related to in-service and basic training of health workers in the MOH system or supporting the system, such as those trained by local and international NGOs. It will standardize and raise the quality of training provided to health workers in an integrated manner, through providing technical and methodological expertise and supervision. To achieve this purpose, the NTC will:

- Coordinate in-service training for various levels of health staff at all levels
- Standardize and ensure quality control in the basic training of those categories of health workers trained by the MOH in the RTCs, or other schools set up by the MOH for this purpose. This will be accomplished through supervision of training activities and follow-up of trained workers
- Liaise with other institutions providing basic and in-service training, including the IOM and NGOs, to ensure similar curricula and standards are maintained

- In consultation with the Health Learning Materials Center of the IOM, develop and maintain a National Resource Center for Training Manpower within the NTC with curricula and teaching and learning materials for access by trainers and supervisors
- Train public health officers, medical officers and senior public health officers in management
- In collaboration with other training institutions and divisions, review and revise job descriptions and curricula for health workers, and develop models of training materials to be adapted to local needs by RTCs or districts
- In collaboration with the IOM and relevant divisions, prepare a national long-term training plan
- Supervise and support the work of the RTCs through regular visits and coordination of inputs, especially in terms of needs assessments for in-service training, and monitoring and evaluation of training courses
- Train new trainers as required for RTCs and assess the needs of existing RTC trainers for further methodological or technical training
- Gradually assume responsibility for organizing and coordinating technical training, such as for EPI or malaria, in an integrated fashion while relying on each division's or section's trainers for specific technical inputs
- Conduct and coordinate research on training methodology and develop and maintain a National Research Center on Training Manpower within the NTC, in coordination with the National Health Research Council
- Maintain a core of expert trainers to assist RTCs, DPHOs, NGOs or other agencies upon request
- Under the direction of the MOH, gradually assume responsibility for coordinating inputs to training activities (e.g., from major donors)

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B. Proposed Organogram for the NTC



### C. Staffing Pattern for the NTC

Considering the proposed role of the NTC, a total of 19 positions have been recommended, as in the table below.

Sl. No.	Post Description	Grade	Number required
1.	Chief, Training Officer	G I Tech	1
2.	Sr. Training Officer	G II Tech (Under Secretary)	1
3.	Sr. Training Officer	G II Tech (Assist. Secretary)	2
4.	Training Officer	G H I Tech	3
5.	Adm. Officers	G III Tech	1
6.	Training Assistants (HA/PHNs)	NG I Tech	3
7.	Typist/Adm. Assistant	NG I Adm	1
8.	Accountant	NG I Adm	1
9.	Driver		1
10.	General service staff		5
<b>Total</b>			<b>19</b>

**D. Physical Facilities Required for the NTC**

In order to provide offices for the staff, room for the National Resource Center for Training Manpower, National Research Center on Training Manpower, as well as accommodations for training RTC staff and senior health staff, and other space required to perform its assigned activities; the NTC will require the following facilities at a minimum:

1. Classroom facilities for 30 participants including rooms for group work and discussion
2. Hostel facilities for 30 participants
3. Library room
4. Trainers' room for seven trainers including chief training officers
5. Store
6. Rooms for Administration and Fiscal Unit
7. Conference hall
8. Canteen
9. Kitchen
10. Adequate sanitary provision

**E. Equipment and Supply Requirements for the NTC**

A list of equipment and supply requirements as determined by the Task Force in light of the functions and physical facilities envisaged for the NTC has been developed.

**F. Establishment of the NTC**

It will take time to integrate and channel all MOH training programs through the NTC. The NTC itself will need time to develop organizational maturity in order to take over the total training requirements for PHC workers. Therefore, its work should proceed in steps, as follows:

- Step 1. The NTC should occupy the space presently assigned for it in the Teku Conference Hall and store room. Because this space will not be sufficient as more staff are assigned, additional space from existing facilities in the Teku complex needs to be arranged on an interim basis.
- Step 2. Staff positions for the NTC should be established as per the Task Force's recommendations and filled as soon as possible.
- Step 3. Basic equipment, supplies and transportation should be provided to enable the NTC to begin to perform its functions.
- Step 4. From FY 2050/51, all budget allocations for training should be channeled through the NTC.
- Step 5. The additional physical facilities as suggested earlier should be constructed as soon as possible, and complete equipment provided.
- Step 6. Gradually, the NTC should assume all the functions assigned to it by carefully liaising with the existing MOH divisions and sections involved, especially regarding location of existing training personnel and resources.

## G. Estimated Budget for the NTC

### i. Establishment costs

● Construction of NTC	Rs. 8,272,000/-
● Equipment/Furniture including Transport facilities	Rs. 3,302,500/-
	<hr/>
	Rs.11,574,500/-

ii. **Operational Costs**

Salary for NTC staff per year:	Rs. 672,900/-
Allowances/yr	Rs. 15,600/-
TA/DA for NTC staff/yr	Rs. 200,000/-
Service utilities/yr	Rs. 50,000/-
Repair/Maintenance/yr	Rs. 30,000/-
Stationery/yr	Rs. 20,000/-
Fuel for Transport/yr	Rs. 60,000/-
Contingency	Rs. 15,000/-

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**Total Rs. 1,063,500/-**

Total for five year:  $1,063,500 \times 5 =$  Rs. 5,317,500/-

iii. **Program Budget**

Will depend on the training programs to be conducted by the NTC.

## ANNEX 4

### ASSESSMENT OF PRE-SERVICE TRAINING (MEDICAL STUDENTS)

#### UNMET NEEDS

Medical education in Nepal is sanctioned under the Institute of Medicine (IOM) which is a division of the Tribhuvan University and an autonomous institution within the Ministry of Education. Entrance requirements for students are a minimum of 10 plus 2 years of primary and secondary education. Because only 30-35 new students are accepted per year (and 20-25 are graduated), competition for the available positions is quite keen. (At present the number of Nepalese students who receive their medical education outside the country is not known; however, it probably does not exceed 30-50 per year and is decreasing as government capacitation fees to India no longer are provided.) Undergraduate training lasts five years, but medical licensure is not granted until the student doctor successfully completes a one-year internship (six years total). Both the undergraduate training and internship are covered within the mandate of the Tribhuvan University.

By most standards, the medical curriculum at the IOM is quite innovative. Not only is the method of instruction based on problem-solving rather than didactic (classroom) presentations, but also the curriculum is community-oriented and is not based on the more traditional medical (curative) system. In addition, unlike many medical schools in Asia, the final written examination is completed at the end of the fifth (and final undergraduate year). Thus, the internship is solely devoted to practical training. In India for example, the final qualifying examination is not given until after the internship. As a consequence students spend little or no time in the clinic, operating theater or in the community learning to practice medicine. Finally, and most importantly in terms of introducing a stronger reproductive health/FP component into the curriculum, modifications to the curriculum are encouraged and the mechanism for securing approval is neither extremely difficult nor time consuming according to the Dean of the IOM. (The latter is very encouraging, because in many countries gaining approval for revising/changing the curriculum is a long, tortuous process.)

At present, exposure to family planning topics and practice is limited to a few presentations and observational sessions in the FP/MCH clinic during the third year (one month) and fifth year (two and one-half months) rotations on the Ob/Gyn service at the Maternity Hospital. In addition, all medical students spend two weeks at the FPAN. Here again, however, their experience is largely observational. They do not even learn to perform IUD insertion and removal, or manage the side effects/complications of the surgical contraceptive methods. Even during the six-week internship rotation on Ob/Gyn, the new doctors only receive limited practical training in the FP/MCH clinic at the Maternity hospital.

According to the Medical Director at the Maternity Hospital, during the internship the primary focus is on clinical training in essential obstetrics and gynecologic procedures – not family planning procedures. She readily agreed, however, that the internship rotation could be restructured to enable each intern to gain competence in performing all of the surgical contraceptive methods except laparoscopy and in managing side effects and most complications. Furthermore, because the FP/MCH clinic, which is housed in a free-standing facility, is operated by the MOH, she saw no reason why vasectomy services could not be initiated as well.)

At the present time, approximately 50% (10-15 physicians) of each internship class apply for positions with the government. (According to the Dean, currently a total of about 30-40 physicians each year apply for government positions.) The remaining 50% stay on at the medical school as junior (one-year) or senior (two-year) registrars (house staff) in one or more of the medical, surgical or specialty departments before entering either government service or private practice. In addition, the Ob/Gyn department accepts two graduates per year for a special diploma program in Ob/Gyn. (Unfortunately, even during this one-year postgraduate training program, the residents do not receive any exposure to family planning. For example, although they observe/assist with diagnostic laparoscopy cases, laparoscopy for voluntary sterilization is not performed at the IOM teaching hospital!)

## **OPTIONS AND CONSTRAINTS**

During our discussions with the Dean (Dr. P.C. Karmacharya), the Acting Chairperson of Ob/Gyn (Dr. Rita Manandhar) and the Director of the Maternity Hospital (Dr. Laxmi Nani Shrestha), there was universal, even enthusiastic, support for revising the medical curriculum to include basic reproductive health education and clinical skills training in all surgical contraceptive methods (except laparoscopy) to all students before completion of the internship. (As documented in the AVSC-sponsored training needs assessment, the IOM coupled with clinical training at the Maternity Hospital constituted the best option for establishing a National Training Center.)

Although it was not possible during this site visit to fully assess the feasibility of developing a pre-service reproductive health education and FP training program for medical students at the IOM, no major constraints were identified. (Even the apparent lack of clinical training space at the IOM campus, which was reported in the 1991 training needs assessment, did not seem to be a problem. The current dean, who has held the position for over a year – with four years remaining – felt that finding suitable space to provide FP services and training would not be a problem.)

## ANNEX 5

### ASSESSMENT OF PRE-SERVICE TRAINING (NURSING STUDENTS)

#### UNMET NEEDS

Nursing education for five of the seven nursing campuses in Nepal is sanctioned under the Institute of Medicine (IOM) which is a division of the Tribhuvan University and an autonomous institution within the Ministry of Education. The five IOM campuses are located in Kathmandu (Maharajganj) and at Birganj, Biratnagar, Nepalganj and Pokhara. The two remaining nursing campuses are located in Kathmandu at the Bir Hospital and in Lolitpur. They are deputed to the MOH and the United Missions of Nepal (UMN), respectively. The nursing campus at the IOM in Kathmandu serves as the main campus, and the Nursing Education Division office, which oversees the operation of all seven nursing programs, is located at this campus. Each nursing campus is headed by a Campus Chief, and the Nursing Education Director (Dr. Uma Devi Das, PhD) is the senior faculty administrator and coordinator for all seven nursing campuses.

Entrance requirements for the three-year basic nursing certificate (BNC) program are a minimum of a class 2 SLC. (At the IOM campus in Kathmandu, however, 10-20% of the entering students are former ANMs who just have a SLC and have at least three years working experience.) At present, approximately 200 students per year enter one of the seven nursing campuses (60 at the IOM/Kathmandu and 30-40 at the six other campuses). An advanced degree (Bachelor of Nursing) program also is available at the IOM campus in Kathmandu. Entrance requirements for the two-year BN degree are a nursing certificate and a minimum of three years working experience. Enrollment for this program is limited to about 40 students per year. (The BN degree program is designed to replace the former Public Health Nursing program.)

The curriculum for the BNC program is comprehensive and well laid out. Roughly one third of the curriculum is devoted to each of the following areas: PHC, community nursing and hospital medicine. It was last revised in 1987, and according to the IOM Campus Chief (Mrs. Dhana Nani Lohani) plans are under way to begin formal review of the curriculum during the coming year. Currently, the same curriculum is used at all nursing campuses. However, because there is no Nursing Council in Nepal and inter-campus communication is difficult, there is considerable variation in the way the curriculum is taught and used. The official language of instruction is English and more than half of the textbooks and the curriculum are in English.

Although FP, as a component of PHC, is covered by several classroom presentations during the second and third years of the basic (certificate) nursing program, formal training in contraceptive technology, clinic management and counseling are not specifically dealt with. Moreover, even during the nursing students' assignment on the Ob/Gyn service either at the IOM Teaching Hospital or at the Maternity Hospital,

they do not receive clinical training in the provision of IUDs, injectables or Norplant. Finally, although roughly one-third of the nurse training is devoted to PHC, the special aspects of FP service delivery are not fully addressed here either.

In many respects the design of the BN degree curriculum is similar to that of the BNC program. With the BN degree program, however, all students take the same core courses during the first year. During the second year they can elect to specialize in either the community nursing or hospital tracks. (In the past selection for entrance, which is governed by the MOH, often led to an uneven split, because the hospital medicine track was more popular. In recent years, vigorous efforts on the part of the faculty to find more candidates interested in the community nursing track has corrected this problem to a certain extent.) As is the case with the BNC program, FP as an integral component of PHC is not covered in the BN curricula.

The BN program is important because it aims to prepare graduates who will be capable of assuming leadership roles in community nursing and hospital settings - a much needed role model if nursing as a profession is to change its image in Nepal. In addition, the BN program prepares graduates to be more effective educators both for teaching and/or improving nursing practice by applying the results of needs-based research.

## **OPTIONS AND CONSTRAINTS**

In talking with the IOM Campus Chief and Assistant Campus Chief, both expressed a genuine interest in strengthening the reproductive health component of the basic nursing certificate program and in increasing the opportunity for nursing students to receive more practical training in family planning methods and service delivery. Preliminary discussions with the Nursing Education Division's Director initially were less positive. (At present her energies are focused on securing the remaining funding needed to get a Master of Nursing degree program started at the IOM/Kathmandu. She has worked diligently over the past several years to develop the program, which is designed to meet the increasing needs for advanced degree nurses in both academia and government service.) During our second meeting with her, she was much more supportive of the need to strengthen the pre-service training of nursing students in FP.

Assuming the IOM nursing campus leaders and faculty are interested in strengthening the reproductive health component of the BNC program, there should be no physical (space) problem at the Maternity Hospital and the affiliated FP/MCH clinic.

The most serious constraint to supporting pre-service nursing education, or pre-service training of any cadre of female health workers for that matter, is the problem of how to provide them with a satisfactory working environment where they can safely work and live once they have completed their training. For example, only about 30% of posted ANM positions currently are filled. This problem has plagued the FP/MCH and PHC programs in Nepal, and most other countries in South Asia, for nearly 40 years.

This problem is complicated further by the lack of supervision, especially in remote areas, and the nearly 100% dominance of male health workers occupying management positions (HAs and DPHOs). (Interestingly, in India one approach to providing a safe working environment for female paramedical staff is to have the staff live collectively in a central area and be transported on a daily basis to the health post where they work. Obviously, this would not work where travel time is long or difficult. But perhaps this approach could be tried in areas of the terai where population density is high and travel less difficult.) Unfortunately, unless this problem is resolved, undergraduate (pre-service) clinical skills training (e.g., IUD training) of all nursing students probably is not cost-effective and unnecessarily increases the risk to clients.

## **ANNEX 6**

### **LOGICAL FRAME/PRISM EVALUATION INDICATORS**

1. 100% of IOM/Kathmandu medical interns trained in surgical contraceptive methods by 1995
2. 100% of IOM/Kathmandu nursing students trained in family planning service delivery by 1996
3. Revised reproductive health/family planning component developed and introduced into the medical and basic nursing program curriculum in place by 1997
4. 12 clinical skills trainers providing training to medical and nursing students at the Maternity Hospital by 1995
5. 12 medical and nursing faculty trained as master trainers at the IOM/Kathmandu by 1996
6. 8 Reproductive Health Specialists (RHSs) have received their diploma by 1998 and 75% are working in the public sector

## ANNEX 7

### CONSTRAINTS TO FAMILY PLANNING TRAINING AND SERVICE DELIVERY

Prepared by Roy Jacobstein, MD/MPH, Chief CMT Division, AID/R&D/POP.  
February 1993.

In addition to the program of support that AVSC and JHPIEGO have proposed for training and service delivery, there are a number of systemic problems that must be addressed simultaneously to maximize the impact of their work. Even though these problems are well-known and frequently cited, many of them have not yet been addressed. They rest largely in the domain of management of the Nepal family planning program and speak to the true commitment of those organizations and individuals involved. That is, if these problems aren't addressed, the rhetorical commitment by the government of Nepal to reducing population growth rates and providing family planning services will not be mirrored in reality.

In particular, the enhanced and coordinated education and training proposed by AVSC and JHPIEGO to improve the capability of existing and future personnel to provide family planning services will have a limited impact if these problems are not addressed. This is because training is a critically necessary but not sufficient intervention; it is the post-training service environment that ultimately determines training impact.

Most noteworthy among these systemic problems are:

1. Lack of a comprehensive national training program.
2. Concomitant lack of a national training plan linked to service delivery needs/goals, including appropriate trainee selection and subsequent placement and support at the service site.
3. Serious shortages of family planning provider staff, particularly female workers. This is exacerbated by maldistribution of existing staff and reflects the overall dearth of health personnel in Nepal. (For example, there are not more than 1200-1300 physicians in the entire country, and 60-70% of them are located in the Kathmandu valley.)
4. Inadequate supervision and monitoring of existing staff, inadequate opportunities for staff advancement, and a lack of relationship between performance, especially family planning service provision performance, and reward, whether monetary or non-monetary. All of this saps individual motivation and commitment, and leads to rapid turnover of staff, non-provision of services, and the like.

5. Insufficient communication and coordination among donors, between donors and the MOH, and among the other organizations involved in family planning in Nepal. (This was exemplified by how few people the team encountered who had seen the excellent report on training by UNICEF consultant James Andersen, or the FP/MCH Unit's *National Medical Standard for Contraceptive Services*.)

Even though the solution to these problems needs to be primarily a government effort, USAID can contribute in a number of ways, in addition to the specific contributions of the CAs. Regarding training, the need for a national training plan, linked to service delivery goals, could ideally be transmitted in such a way that the government bought into it and took the lead in formulating it. Such a plan would also lead to greater donor communication and coordination, particularly if the key donors, USAID and UNFPA, were involved in the plan's formulation.

From the point of view of service delivery, dialogue with the government to address the service impediments noted above could be productive. The comprehensive programmatic approach to support a national family planning program envisaged by USAID may catalyze a similar approach and commitment to service delivery by the MOH. (Again this would be very productive and perhaps synergistic if synchronized with UNFPA.)

Perhaps, once the current MOH reorganization is complete, the MOH could take the lead in establishing some sort of high-level tripartite group (MOH, USAID, and UNFPA) to address these problems. (Representatives from other organizations, e.g., NFCC, IOM, FPAN, JSI, and other bilateral and multilateral donors, could also be involved as appropriate, perhaps on working groups formed to address specific problems or activities.) Moreover, all organizations and agencies involved in service delivery must recognize that in light of geography, poverty and limited health infrastructure, mobile teams will necessarily and appropriately be a part of the approach to service delivery in Nepal for the foreseeable future. This should not undermine the "institutionalization" approach, or be seen as a reversal of it. Rather it should be seen as underscoring the primacy of service delivery and the importance of providing services through multiple approaches. Such an effort implies analyzing and addressing various motivational factors that may be operative in order to ensure quality service provision. Language conditions thought. (Thus "camps" and "incentives," have a decidedly more sinister ring and are perhaps less accurate than "outreach teams" and "compensation for services." Of course, whatever the terminology, the same attention to service quality and to method choice should be given as in fixed sites, and is not inherently precluded.)

Finally, another effort that would underscore the primacy of family planning service delivery and be a benchmark of program commitment would be the reliable and regular availability of family planning services, particularly Depo Provera for postabortion clients at the Maternity Hospital, who comprise 40% of the gynecology clients there.

## **ANNEX 8**

### **IUD SERVICES IN NEPAL**

Prepared by Paul MacKenzie, MD,  
Family Planning Resource Person, JSI/Nepal  
February 1993.

#### **IUD IN-SERVICE TRAINING COMPONENT**

##### **A. Analysis of IUD Training Needs in Nepal**

###### **1. IUD services through HMG:**

- The only type of IUD now supplied in Nepal is the CuT 380A.
- IUDs have been provided in Nepal for over 20 years, but have an unfavorable reputation due to some complications and rumors.
- Very few Nepalese have access to IUD services. At present it is estimated that there are only about 5,000 current users and about 2,500 new users per year.
- Last year IUDs were inserted in only 26 districts out of 75. In most cases, services are restricted to the district center. Previously there were 42 districts where IUD services were certified but this no longer has meaning due to shortages of qualified providers and lack of supplies. (Three districts recently have begun providing IUD services at one health post, and several other districts have one or two health posts where some IUDs are inserted by trained ANMs.)

###### **2. IUD services through other providers:**

- This year about 20 Ob/Gyns in Kathmandu valley have been provided with IUDs as part of the private physicians' program. About three to five other doctors in terai towns provide IUDs supplied from India.
- FPAN puts in small numbers of IUDs in ten district branches (last year total insertions were only 195).

- Some mission hospitals and Save the Children Fund/US staff put in small numbers of IUDs.

### **3. IUD training:**

- The main barrier to IUD services is lack of trained providers.
- IUD training is not part of pre-service training for paramedics, nurses or doctors.
- There is no in-service IUD training program for doctors. The service depends mostly on paramedics and nurses; however, most female Ob/Gyns have learned to insert IUDs. Male medical doctors are generally not providers.
- In-service training for nurses and ANMs has been provided for about 160 people in the past decade. Most of them are no longer providing IUDs because they have been transferred to other posts.
- Last year eight new IUD providers were trained, all in the Central region through the USAID-funded program with that region.
- This year, 15 new IUD trainers were trained in January 1993. In addition, there are funds to train 50 new service providers this year using these new trainers.
- Although many (over 30) IUD trainers have been trained in the past, most are no longer active. Several experienced public health nurses (PHNs), however, are available and could be retrained as trainers.
- Because the FP/MCH Unit has no accurate list of current providers, an assessment of active IUD providers in the 42 districts is being conducted and will be completed by March 1993. Preliminary analysis of the data collected thus far indicates that, in each of the 15 institutionalized districts at least one IUD provider is present at the district center. Outside the valley, however, there are about only 30 or 40 active providers, mostly ANMs.

### **4. How many providers need to be trained?**

- In order to have at least two providers at district centers in each of the 42 districts would require another 40-50 trainees. To expand to all 75 districts would require another 65-70, providing there is no attrition or transfers.

- To have IUD services at two of the health posts in each of 40 districts would require another 160-170 trainees.
- A modest plan would be to train 30 providers yearly for the next five years. A more ambitious, but feasible, plan would be to train 60 yearly. Unfortunately the training capacity is there, but candidates for training may not be available in most of these districts.
- In many districts there are no female staff suitable for IUD training. Although HMG employs over 1,800 ANMs, most are assigned to hospitals. (If even half the 1,200 ANM health post positions were filled and if half of them were selected, there would be about 300 ANMs who potentially could be trained during the next five years.)

**5. How many IUD trainers are needed?**

- To have a training program in a region, at least three to four trainers are needed. The Central region has enough trainers but the Eastern and Western regions need a few more, and there are none in the other two regions as yet. (Unfortunately, there are almost no potential trainers available in these two regions.) Given the rate of transfers, another TOT program for ten trainers next year, and perhaps another in two years, should be sufficient.

**6. Summary of unmet needs for IUD training:**

- The service program could use 200 to 400 more IUD providers over the next four years depending on how fast expansion of services is desired.
- More IUD trainers are needed; approximately 20 (10 x 2 groups) over the next four years would be reasonable and doable.
- A basic (in-service) FP training course for all physicians (especially females) returning to Nepal would be useful. (Although physicians are not the main IUD providers, relevant new information and at least management of common side effects and complications should be included in the course.)

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## **B. Analysis of Component Area**

### **1. Unmet needs:**

- Most people have no access to IUD services due to lack of providers.
- About 80 to 100 more providers are needed to provide services at district centers in 65-70 of the 75 districts, provided there is no attrition or transfers.
- About 100 more new service providers would allow expansion of IUD services to two health posts in each of 25 districts.
- About 20 more IUD trainers are needed over the next four years, again provided there is no attrition or transfers.

### **2. Constraints:**

- The number of sites with sufficient IUD client flow for training is limited. At present, only three regions have sufficient potential to support training because in only six districts are over 100 IUDs inserted yearly in the entire country.
- There is a lack of suitable candidates for training in some districts.
- There is a lack of suitable candidates to become IUD trainers in two regions -- the mid-western and far-western regions.
- There are limited senior staff in the training section at FP/MCH Unit available to conduct TOTs and to oversee services to ensure that an acceptable quality of care is being maintained.
- To date, selection of trainees has not always been optimal (e.g., candidates selected either are not working in FP or are posted back to a district or to positions where they are/can not use their training).

### **3. NGO/Public/Private sector training capacity:**

- Only HMG has sites with enough IUD client flow for training at present.
- Only HMG has IUD trainers now, with the exception of FPAN which still has one good trainer.

## **C. Objectives**

- To improve the quality of IUD training of service providers for the national FP program.
- To standardize IUD training through improvements in training trainers and conducting service provider IUD training courses.
- At the end of the four years, to have trained 20 IUD trainers and 200 IUD providers using a competency-based training approach which is cost-effective and minimizes risks to clients and staff.

## **D. Strategy and Action Plan**

### **1. Elements and outcomes:**

- **Elements**

- Trainers selection and allowances
- Trainees selection and allowances
- Training sites
- Training curriculum (syllabus, course outline, schedule and training methodology)
- Training materials and models

- **Outcomes**

- Trained trainers
- Trained service providers

### **2. Mechanisms:**

- Fund in-country training activities through redbook and supplemental plans as currently is being done.
- Eliminate special funds to the central region.
- Improve the quality by using a competency-based training approach which uses pelvic models for development of skill competency and beginning skill proficiency before actually allowing trainees to provide IUD services to clients (JHPIEGO technical assistance). Doing this should shorten the training time needed to produce certified providers.

- Put more emphasis on counseling, especially practice during training through role plays and use of volunteers.
- Decentralize IUD training in three and, if feasible, in all five regions.

**3. Actors:**

- Training Section of FP/MCH Unit.
- Technical assistance and support from JSI/Nepal and JHPIEGO.

## ANNEX 9

### DRAFT IMPLEMENTATION PLAN FOR IUD SERVICES IN NEPAL: 2049-2054 (1992-1997)

#### BASELINE DATA

2048-49 IUD acceptors New: 2,517 Users: 9,246  
Target for 2054 from NPC New: 15,600 Users: 33,100  
Only 35 districts reported insertions

2049-50 Certified sites 54 in 42 districts (includes 3 HPs)  
NGO sites: FPAN 11, UMN 2, Other ?  
Private doctors program in Kathmandu: 18

IUD training by Year:	Basic IUD	TOT	New Acceptors
2040-41	3	0	1,050
2041-42	17	0	850
2042-43	0	?	1,259
2043-44	0	0	1,806
2044-45	31	?	3,171
2045-46	60	15	2,368
2046-47	32	11	4,394
2047-48	9	0	2,555
2048-49	8	0	2,517
2049-50 planned	50	15	

Current location of trained providers is not known.

#### OBJECTIVES

1. By NY 2054 (1997) to have sufficient IUD service sites and IUD providers to enable the national targets for IUD to be achieved.
2. To improve all IUD services to the national standard.

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## **SUB-OBJECTIVES**

### **1. Services**

- 1.1 To provide IUD services at **certified district centers** in the following numbers of districts:

<b>Year</b>	<b>District Centers</b>
2048-49	35
2049-50	42
2050-51	
2051-52	
2052-53	
2053-54	

- 1.2 To establish criteria for which health centers and health posts are suitable for IUD and to equip and certify those that meet the criteria.

- 1.3 To provide IUD services at the following number of health posts:

<b>Year</b>	<b>Number of Health Posts/Centers</b>
2048-49	0
2049-50	3
2050-51	
2051-52	
2052-53	
2053-54	

- 1.4 To expand the number of IUDs provided by private doctors as follows:

<b>Year</b>	<b>Number of doctors providing IUDs</b>
2048-49	0
2049-50	18
2050-51	
2051-52	
2052-53	
2053-54	



1.5 To expand the provision of IUD through NGOs as follows:

Year	Number of NGO sites
2048-49	
2049-50	
2050-51	
2051-52	
2052-53	
2053-54	

## 2. Training

2.1 To have at least two trained IUD providers in each certified district center.

2.2 To expand the training of IUD providers as follows:

Year	Trainees
2048-49	8
2049-50	50
2050-51	
2051-52	
2052-53	
2053-54	

2.3 To have at least five IUD trainers in each region.

2.4 To train trainers for IUDs as follows:

Year	TOT	Trainees
2048-49	0	
2049-50	15	
2050-51		
2051-52		
2052-53		
2053-54		

2.5 To provider IUD refresher training to all providers every five years.

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### **3. Logistics and Supply**

- 3.1 To provide an adequate supply of IUDs at each certified service site.
- 3.2 To minimize the number of IUDs that expire before use.
- 3.3 To provide at least four sets of IUD insertion instruments to each certified IUD service site and to ensure that all equipment and supplies to meet the national standard.

### **4. Certification and Quality Assurance**

- 4.1 To ensure that all sites providing IUD insertion meet the national standard.
- 4.2 To certify all IUD providers and service sites.

### **5. Research**

- 5.1 To conduct an IUD acceptor follow-up study to determine continuation, pregnancy and complication rates at one year after insertion.

## LONG-RANGE PLAN FOR IUD SERVICES AND TRAINING IN NEPAL

### DRAFT FOR DISCUSSION ONLY

TARGET	2048/9 1991/2	2049/50 1992/3	2050/1 1993/4	2051/2 1994/5	2052/3 1995/6	2053/4 1996/7	2054/5 1997/8
ACCEPTORS	2,500	6,700	8,500	10,600	13,000	15,600	18,600
USERS	9,200	9,000	12,600	16,900	21,600	26,900	33,100
<b>DISTRICTS</b>							
EASTERN	8	10	10	14	14	14	16
CENTRAL	14	14	18	18	19	19	19
WESTERN	11	11	11	14	14	14	16
MID-WEST	3	5	7	7	10	12	15
FAR-WEST	6	6	6	7	8	9	9
TOTAL	42	46	52	60	65	68	75
OTHER HOSP.	10	10	12	12	12	12	12
PRIVATE DOCT	0	20	32	44	50	60	80
NGO SITES	10	10	20	30	40	50	60
<b>HEALTH POST</b>							
EASTERN	0	0	5	5	11	17	20
CENTRAL	0	3	8	12	17	23	30
WESTERN	0	0	5	7	12	18	20
MID-WEST	0	0	2	6	8	10	12
FAR-WEST	0	0	2	4	7	10	12
TOTAL	0	3	22	34	55	78	94
TOTAL SITES	62	89	138	180	222	268	321
<b>BASIC TRAIN</b>							
EASTERN	0	10	16	16	16	16	16
CENTRAL	8	26	16	16	16	16	16
WESTERN	0	10	16	16	16	16	16
MID-WEST	0	6	8	8	8	16	16
FAR-WEST	0	4	8	8	8	16	16
TOTAL	8	56	64	64	64	80	80
<b>TOT TRAIN</b>							
EASTERN	0	4	2	1	1	0	2
CENTRAL	0	3	2	1	1	0	2
WESTERN	0	4	2	1	1	0	2
MID-WEST	0	2	2	1	1	0	2
FAR-WEST	0	2	2	1	1	0	2
TOTAL	0	15	10	5	5	0	10

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## ANNEX 10

### LIST OF IUD INSERTIONS (USERS) BY DISTRICT IN NEPAL

IUD INSERTIONS IN CERTIFIED DISTRICTS: (\* = NOT CERTIFIED)

REGION/DISTRICT	2047-48 1990-91	2948-49 1991-92	TO MONTH	2049-50 NEW	MIS USING
<b>EASTERN REGION</b>					
DHANKUTA	92	19	BHADRA	2	152
ILAM	34	31	ASWIN	9	37
JHAPA	229	99	ASWIN	10	133
MORANG	85	163	ASWIN	16	0
OKHALDYUNGA*	3	39	ASWIN	12	10
SAPTARI	70	153	KARTIK	10	267
SIRAHA	21	6	ASWIN	0	18
SUNSARI	52	45	ASWIN	3	111
UDAYAPUR	2	21	ASWIN	0	18
<b>CENTRAL REGION</b>					
BHAKTAPUR	102	97	ASWIN	26	586
CHITWAN	25	14	KARTIK	27	76
DHANUSHA	110	127	KARTIK	52	164
KATHMANDU	961	1016	KARTIK	496	1252
LALITPUR	112	216	ASWIN	45	513
MOHATTARI*	4	0	KARTIK	0	0
MAKWANPUR	16	34	KARTIK	10	63
NUWAKOT	2	0	KARTIK	3	0
PARSA	78	56	ASWIN	14	341
SARLAHI	57	0	BHADRA	5	10
BARA	0	0	ASWIN	0	0
DOLAKA	0	5	ASWIN	0	5
RAUTAHAT	0	0	KARTIK	0	0
SINDHULI	0	0	KARTIK	0	0
SINDHUPALCHOWK	0	0	ASWIN	0	0

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**WESTERN REGION**

RUPANDEHI	186	164	KARTIK	33	575
BAGLUNG	89	57	ASWIN	13	0
KAPILVASTU	13	17	KARTIK	2	0
KASKI	46	41	BHADRA	7	329
LAMJANG	3	0	ASWIN	0	0
ARGHAKHANCHI	0	0	KARTIK	0	0
GORKHA	0	0	ASWIN	0	0
PALPA	0	0	KARTIK	0	9
NAWALPARASI	25	0	KARTIK	0	0
SYANJA	3	12	ASWIN	0	0
TANAHUN	9	3	BHADRA	0	0

**MID-WESTERN REGION**

BANKE	20	21	ASWIN	6	2
DANG	49	40	KARTIK	0	0
SURKHET	0	3	ASWIN	1	0

**FAR-WESTERN REGION**

KAILALI	33	11	KARTIK	4	62
KANCHANPUR	7	0	KARTIK	0	0
DOTI	0	0	KARTIK	0	0
DARCHULA	0	0	ASWIN	0	0
DADEL DHURA	0	0	KARTIK	0	0
BAITARI	0	0	BHADRA	0	0

### IUD INSERTIONS BY YEAR: NEPAL

YEAR	INSERTIONS	YEAR	INSERTIONS
2023-24 (1966-67)	1806	2036-37 (1979-80)	1036
2024-25 (1967-68)	2614	2037-38	81
2025-26	69	2038-39	82
2026-27	70	2039-40	83
2027-28	71	2040-41	84
2028-29	72	2041-42	85
2029-30	73	2042-43	86
2030-31	74	2043-44	87
2031-32	75	2044-45	88
2032-33	76	2045-46	89
2033-34	77	2046-47	90
2034-35	78	2047-48	91
2035-36	79	2048-49	92

### IUD TRAINING BY YEAR: NEPAL

YEAR	BASIC IUD	TOT
2040-41 (1983-84)	3	-
2041-42 (1984-85)	17	-
2042-43 (1985-86)	0	30 (DMPA and IUD)
2043-44 (1986-87)	0	-
2044-45 (1987-88)	31	-
2045-46 (1988-89)	60	15
2046-47 (1989-90)	32	11
2047-48 (1990-91)	9	0
2048-49 (1991-92)	8	0
2049-50 (1992-93)	50: 40 FP/MCH 10 CRHD	15 (workplan)
2050-51 (1993-94)		
2051-52 (1994-95)		

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## ANNEX 11

### EXCERPT FROM THE FP/MCH Unit ANNUAL WORKPLAN 2049-2050 (1992-1993)

#### DEPO PROVERA (DMPA)

The FP/MCH Unit will continue to conduct training of Depo Provera (DMPA) providers (nurses and AHWs at the district and Health Post service sites). From 1992 - 1997, 1,800 staff will be trained. For the most part, trainees will be selected from currently institutionalized districts and also in accordance with HMG's future strategy for the institutionalization of districts. Trainees from other districts and health post service sites also will be trained.

Besides DMPA training, the FP/MCH Unit will conduct training of DMPA trainers. These trained trainers (SPHN, PHN, SN) will conduct training of Depo service providers in their respective regions. Participants for trainer training will be selected from each region.

Regular training of DMPA service providers during the eighth Five-Year Period are as follows:

Region	Service Outlet (Ilaka HP)	Existing DMPA Service Outlets	Remaining to be Implemented	Manpower to be Trained
Eastern	193	157	36	72
Central	249	201	48	96
Western	230	159	72	144
Mid- Western	168	120	48	96
Far-Western	108	78	30	60
Totals	949	715	234	468

**Proposed DMPA Service Outlets and Training Requirements  
(Existing DMPA Outlets: 715)**

Year	Hospital/PHC/HP		Sub-Health Post		Total	
	Outlets	No. of trainees each year	Outlets	No. of trainees each year	Outlets	No. of trainees each year
92/93	865	300	--	--	865	300
93/94	949	200	50	100	999	300
94/95		80	200	320	1200	400
95/96		80	330	320	1350	400
96/97		80	500	320	1450	400
<b>Total</b>	<b>949</b>	<b>740</b>	<b>500</b>	<b>1060</b>	<b>1450</b>	<b>1800</b>

In the current fiscal year (1992/93), we have 715 service outlets for DMPA services; 150 service outlets will be added and two paramedicals will be trained from each new outlet (300 total). During the second year of the eighth five-year plan (93/94), DMPA services will be expanded to 50 sub health posts; 199 VHWs will be trained to provide DMPA injections. By the end of the five-year period, DMPA services are expected to be available in about 1,000 hospitals/PHC Health Posts and NGO clinics and in about 500 sub-health posts. Altogether, 740 ANM/AHWs and 1,060 VHWs will be trained to provide DMPA injections.

## DMPA Training by Regions

### DEVELOPMENT REGIONS

Year	Eastern	Central	Western	Mid-Western	Far-Western	Total
92/93	60	80	80	40	40	300
93/94	40	60	80	80	40	300
94/95	80	100	100	60	60	400
95/96	100	100	80	60	60	400
96/97	80	100	100	60	60	400
Total	360	440	440	300	260	1800

Training of trainers (from each of five regions) in DMPA will be conducted as follows:

FY	Trainers	Manpower to be trained per region
1992/93	14	2 to 3 senior nurses or PHNs
1993/94	14	2 to 3 senior nurses or PHNs
1994/95	14	2 to 3 senior nurses or PHNs
1995/96	14	2 to 3 senior nurses or PHNs
1996/97	14	2 to 3 senior nurses or PHNs

Although there is a great demand for DMPA services at the village level, many of the women residing in villages that are distant from the health posts are unable to obtain services; therefore, a two-year pilot study will be conducted to recruit and train VHWs as DMPA service providers at the VDC level.

In the first two years of the study, 130 VHWs from Rupandehi and Lalitapur districts will receive training in DMPA. Following training, they will be expected to provide DMPA and follow-up services to continuing clients who live far from the health post. A proposal for further training of VHWs will be developed for the years 1994 - 1997, based on the results and feasibility of the pilot study.

## ANNEX 12

### TERMS AND CONDITIONS FOR CONDUCTING THE PRELIMINARY ASSESSMENT OF THE "DEPO" COURSE

In developing the terms and conditions for conducting the preliminary assessment of the "Depo" course provided by the FP/MCH Unit (Training Section) a number of assumptions were made. They included:

1. Since JHPIEGO currently has no active programs in Nepal, responsibility for and funding of all aspects of the proposed preliminary course assessment and preparation of the report would rest with USAID/Nepal and/or the JSI/Nepal team.
2. USAID/Nepal will ask the JSI/Nepal team (Dr. Mackenzie) to prepare an analysis of the unmet demand for basic family planning (BFP) services, including the number of service providers and trainers needed, and constraints and options similar to that prepared for the IUD training component (**Annex 8**), within the next two to three months.
3. Responsibility for assisting the FP/MCH Unit and USAID/Nepal in developing the annual workplan and budget (including in-country costs) as well as providing various monitoring activities will continue to be provided by the JSI/Nepal team (Dr. MacKenzie).
4. Until the results of the preliminary assessment are known, it will not be possible to develop a detailed, multi-year action plan for designing, developing, implementing and field-testing the BFP course and accompanying TOTs course.

Prior to leaving Nepal a meeting was held on February 26, 1993, with Molly Gingerich (HP Officer, USAID/Nepal), Dr. Paul MacKenzie (JSI/Nepal team), and Dr. Noel McIntosh (JHPIEGO) to discuss the objectives and time frame for conducting the preliminary assessment of the current "Depo" course and for reporting the results. Also present at this meeting was Marta Levitt, PhD, a FP program and training specialist, who tentatively has agreed to conduct the proposed training needs assessment with Dr. MacKenzie. Because both Dr. Levitt and Dr. MacKenzie have limited time, the three objectives of this exercise will be the following:

1. Drs. Levitt and MacKenzie will attend at least one "representative" course conducted outside Kathmandu in order to assess (briefly) the course content, relevance, deficiencies, teaching methods and materials, quality of instruction and trainee and trainer evaluation. (Concise, narrative report due by June 1, 1993, if possible.)

2. Dr. Levitt, assisted by Dr. MacKenzie, will conduct a preliminary assessment of potentially useable FP educational materials, course outlines, handouts, etc. in Nepali, which could be used in the new/ revised basic family planning (BFP) course. (Annotated list to be prepared and submitted by July 1, 1993, if possible.)
3. Based on the above, and with input from USAID/Nepal and the JSI/Nepal team, Dr. Levitt will prepare a workscope for a 12-18 months technical assistance contract to assist the FP/MCH Unit (with additional assistance from JHPIEGO and the JSI/Team) in designing, developing, implementing and field-testing the new BFP course and accompanying TOTs course.