

Sudurpaschim Province Government
Ministry of Social Development
Health Training Centre
Dhangadhi, Kailali

**TRAINING NEEDS ASSESSMENT
and EFFECTIVENESS STUDY
REPORT**

2082/083

Prepared by
Health Training Centre, Dhangadhi

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Dhangadhi, Kailali, Nepal

Acknowledgement

The Health Training Centre (HTC), Dhangadhi, Kailali, thanks everyone who helped with this Training Needs Assessment and Effectiveness Study for Fiscal Year 2082/83. We are grateful to the Ministry of Social Development, Sudurpashchim Province, for its policy and support. We also thank the senior health officials of the province, whose guidance kept the study on track. Our thanks go to the Health Offices and District Hospitals for their smooth coordination and support, and to the Health Section Chiefs at the dlocal levels for their active help during data collection. Finally, we thank the 1,087 health workers from all nine districts of Sudurpashchim Province. They gave their time and shared their experiences openly, which helped this study reflect the real situation of frontline health services. We are grateful to all of them, and to everyone who made this work possible

Executive Summary

Background. The Health Training Centre (HTC), Dhangadhi, is the provincial institution responsible for coordinating, managing, and certifying health-related trainings in Sudurpashchim Province. Following Nepal's transition to a federal structure, HTC has prioritised the institutionalisation of evidence-based Training Needs Assessment (TNA) as a precondition for designing demand-driven and outcome-oriented training programs. Past training delivery has been affected by inequities in participant selection, repetition of trainings, and mismatches between training content and post-level responsibilities, underscoring the need for a systematic TNA.

Objective. To identify the capacity-building training needs of health service providers working at different levels of government health institutions in Sudurpashchim Province.

Methods. A cross-sectional descriptive study with a mixed-methods (quantitative and qualitative) design was carried out across Sudurpashchim Province. Quantitative data were collected from government health workers in the province using a structured self-administered questionnaire deployed through Google Forms. Qualitative data were collected through semi-structured key informant interviews with heads of health offices, hospital in-charges, and senior health officials, selected through purposive sampling and continued until thematic saturation. Quantitative data were analyzed in IBM SPSS version 26 using descriptive statistics and cross-tabulations; qualitative data were analysed thematically using RQDA. The assessment was grounded in the Hennessy–Hicks framework, adapted to the Nepali health system context.

Results.

Quantitative findings: The study included 1,087 health workers from all nine districts of Sudurpashchim Province. Most were young (about 70% were under 35), and they were split almost equally between permanent (55.6%) and contract (43.6%) staff. Most were AHWs and ANMs working at the fourth and fifth levels. More than half (54.5%) said that some services at their health facility had stopped or slowed down because staff were not trained. This happened most often in family planning and reproductive health (IUCD, safe abortion, Implant), PAMS V2, and mental health. Each worker chose their top five training needs, which gave 5,392 choices across more than sixty topics. The most wanted trainings were PAMS V2 (294), HMIS/DHIS2 (261), Implant (209), Mental Health (203), and IMNCI (180). Skilled Birth Attendance (SBA) was special: fewer people chose it, but most who did (85 out of 127) put it as their top need.

Qualitative findings

We also talked to heads of health offices, hospital in-charges, and senior officials. Five main points came out of these talks. First, maternal, newborn, and reproductive health, especially Skilled Birth Attendance (SBA), was the need people named most. But often the real problem was not a lack of skills. It was that trained staff had left or been moved somewhere else. Second, more patients now come with emergencies, non-communicable diseases, and mental health problems, and training has not kept up with this rise. Third, people first asked for clinical trainings, but when we asked more, they also needed system and support skills, such as logistics (PAMS V2), treatment protocols, infection prevention, and communication. Fourth, the value of training is being lost because staff leave their jobs, training records are not kept well, and local governments move staff without looking at their training. So the same trainings are asked for again in places that already received them. Fifth, people did not just want more training. They wanted a better system: a yearly training plan from HTC, fair selection through offices, shorter grouped trainings, certificates given only after staff show they use the skill, courses made for the province, and on-site coaching and mentoring.

The study also checked how useful three clinical trainings had been, and the results were very good. Most workers (94% to 98%) said the SBA (n=236), Implant (n=281), and IMNCI (n=586) trainings were effective or very effective. Between 84% and 94% said their knowledge, confidence, and ability to spot problems had improved, and three out of four or more are still giving the service. Since their training, these workers have carried out 126,746 deliveries, served 33,379 Implant clients, and treated 218,270 children. This shows that the trainings worked well and are being used in daily work, so they should continue and reach more health workers.

Conclusions.

Health workers in Sudurpashchim Province clearly need more training, but the needs are not the same everywhere. The biggest needs are in family planning and reproductive health, health information and logistics systems (PAMS V2, HMIS/DHIS2), mental health, and child health. SBA is a top need for a smaller group of workers. The effectiveness study shows that past trainings in SBA, Implant, and IMNCI worked very well and are helping many patients, so they should continue and reach more workers. At the same time, the benefit of training is being lost because staff leave, training records are weak, and staff are moved without checking their training. HTC should therefore keep giving training based on real needs, and also fix the system. This means keeping good training records, making a yearly training plan, choosing trainees fairly through offices, giving certificates only after staff use their skills, making

courses for the province, and offering on-site coaching and mentoring. In this way, training will not be wasted and will lead to better and wider health services.

Keywords: Training Needs Assessment; Health workforce; Capacity building; Sudurpashchim Province; Nepal; Mixed methods; Hennessy–Hicks; Health Training Centre.

List of Acronyms and Abbreviations

Acronym	Full form
FY	: Fiscal Year
GoN	: Government of Nepal
HTC	: Health Training Centre
KII	: Key Informant Interview
MoSD	: Ministry of Social Development
NDHS	: Nepal Demographic and Health Survey
PHC	: Primary Health Care
RQDA	: R-package for Qualitative Data Analysis
SRH	: Sexual and Reproductive Health
TNA	: Training Needs Assessment
ToT	: Training of Trainers
WASH	: Water, Sanitation and Hygiene
WHO	: World Health Organization

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Key Findings at a Glance

Training Needs Assessment & Effectiveness Study-Sudurpashchim Province, FY 2082/83

Study Coverage

1,087	9	54.5%
Health workers surveyed	Districts covered	Facilities hit by training gaps

Patient Reach Since Training

126,746	33,379	218,270
Deliveries (SBA)	Women served (Implant)	Children treated (IMNCI)

Training Effectiveness

98%	95%	94%
SBA effective+	Implant effective+	IMNCI effective+

Top 5 Training Needs (by total mentions)

PAMS V2		294
HMIS / DHIS2		261
Implant		209
Mental Health		203
IMNCI		180

Source: Training Needs Assessment & Effectiveness Study, N = 1,087 health workers, all nine districts of Sudurpashchim Province.

1. Introduction

1.1 Background

The Health Training Centre (HTC), Dhangadhi, was established as the provincial institution responsible for the coordination, management, and certification of health-related trainings in Sudurpashchim Province. Since its establishment, HTC has been delivering a wide range of capacity-building trainings for health service providers across the province. To deliver these trainings in an effective, quality-assured, and well-managed manner, the Centre has progressively introduced provincial-level management structures, working procedures, and operational directives, and has continued to institutionalise its training management process in line with the evolving needs of the federal health system.

Following the implementation of Nepal's federal structure, HTC has been working to address the gaps in earlier training management practices and to update the training system in accordance with provincial requirements. Within this broader reform agenda, the Centre has placed particular priority on the Training Needs Assessment (TNA) process. The Centre has adopted the principle that no health training should be conducted without first establishing-clearly and on the basis of evidence-what the actual training need is, where it lies, and how it should be addressed.

In the past, training delivery in the sector has been affected by inequities in participant selection, repetition of trainings, irrelevance of training content to current service requirements, and mismatches between training and post-level responsibilities. The training management structure operating under HTC is designed to address these issues by introducing more transparent, accountable, and post-appropriate mechanisms for the identification, selection, and recommendation of trainees.

To perform their roles effectively, health workers require theoretical knowledge, practical skills, and continually updated competencies. Training is essential for developing these competencies. However, training needs differ depending on the level of facility, the cadre, and the service area for which a health worker is responsible. The systematic process used to identify the training required by a worker to perform their job effectively is referred to as the Training Needs Assessment. In simple terms, a TNA is the minimum evaluation process that determines whether training is required to improve a worker's performance and, if so, what kind of training is required. A TNA helps to identify the gap between actual and desired knowledge, skills, and competencies in the workplace.

TNA is a continuous process. Information is collected from the target group using predefined tools and questionnaires, the information is analysed, and a determination is made as to whether training has improved-or is likely to improve-a worker's performance. The process directly contributes to professional development, improved work efficiency, and better quality of health services.

The purpose of a TNA is to identify the knowledge and skill deficits that limit performance and to design appropriate training responses. A TNA also helps to identify the underlying causes of these deficits and to determine the most appropriate interventions to reduce them. Training needs assessment can be carried out at three levels:

(a) Individual level: Individual-level TNA determines what training a specific health worker requires to perform their assigned responsibilities. For example, whether a nurse providing delivery services at a primary health care centre needs further skill development can be determined through workplace observation, discussion, and-where required-direct skills testing.

(b) Group level: Group-level TNA identifies the combined training needs of multiple workers from the same cadre, discipline, or post. For example, this approach is used to determine what training is required to improve the service capacity of all Health Assistants or all Staff Nurses working across the province. Information is collected from many workers within the same cadre and analysed jointly.

(c) Organisational level: Organisational-level TNA identifies, in an integrated way, the training required by all cadres and disciplines working in a particular health institution. For example, the trainings required to improve waste management, raise laboratory quality standards, or strengthen emergency services in a primary health care centre would be identified through an organisational-level TNA. Information is collected from staff across all posts within the institution and analysed together.

1.2 Training Effectiveness-Rationale

The quality and effectiveness of the health service system depend largely on the knowledge, skills, behaviour, and professional competence of health workers. Evolving disease patterns, new treatment technologies, changing health policy, and updated service standards mean that providers require periodic updating of their knowledge and skills. Various training programs are conducted to address this need, but the extent to which these trainings have contributed to actual improvements in service quality has not been adequately studied.

Although significant resources are spent annually on health-sector training in Nepal, evaluation of training effectiveness remains limited. In most cases, training is judged successful on the basis of participant numbers, completion of training duration, or immediate post-training feedback. These indicators do not adequately capture whether training has produced sustained behavioural or performance change. If expected improvements in service delivery are not observed after training, the training cannot reasonably be regarded as effective.

In the health sector, where even small lapses can directly affect human life, the case for training effectiveness studies is particularly strong. Ineffective trainings may result in suboptimal treatment, delays in service delivery, weaknesses in infection prevention and control, and reduced client

satisfaction. It is therefore essential to evaluate the changes that training produces in providers' practical capacity, decision-making, and accountability.

Training effectiveness studies allow assessment of training content, instructional methods, trainer competence, training duration, and the workplace enabling environment. They also help to identify the training–practice gap. In many cases, skills acquired during training are not applied in the workplace because of shortages of equipment, lack of supervisory support, or weak monitoring—all of which reduce the effective impact of the training investment.

In a resource-constrained context such as Nepal, ineffective trainings represent a waste of time and resources and add additional burden to the health system. A systematic study of training effectiveness helps to make future trainings more results-oriented, more practical, and more closely focused on service quality improvement, and supports evidence-based decision-making by policy makers, planners, and health managers.

1.3 Importance of Training Need Assessment

Timely identification of training needs. TNA clearly identifies the gap between current capacity and expected performance among health workers. It ensures that training programs are grounded in real problems and real needs, and that resources are used efficiently. Trainings designed without an underlying TNA are unlikely to deliver the intended results; a sound TNA is therefore a precondition for effective, outcome-oriented health training.

Prioritisation of trainings. TNA helps determine which training needs are most important and most urgent. It supports efficient use of limited time and resources by ensuring that the right groups receive the right trainings at the right time, increasing the likelihood that training delivers measurable outcomes.

Targeted training planning. TNA enables the design of training packages that respond directly to identified needs, supporting appropriate selection of content, duration, and instructional methods. Targeted training tends to be more practical, more effective, and more likely to achieve the expected results.

Evidence-informed workforce planning. Aggregated TNA findings provide HTC and provincial authorities with a defensible basis for annual training plans, budget allocation, and the design of cadre-specific capacity development pathways.

Equity and transparency in selection. By generating a clear, documented record of who has and has not received training in which area, TNA supports more equitable participant selection and reduces unjustified repetition.

1.4 Prevailing Practices in Training Needs Assessment

A range of approaches for conducting TNA is in use internationally. In most sectors, capacity-building programs are preceded by some form of needs identification, and this practice is also followed in various sectors in Nepal. For example, in 2014 a TNA was carried out in the water, sanitation, and hygiene (WASH) sector in Nepal using a structured questionnaire combined with interviews and group discussions; the study identified the core competencies required by staff at different levels and the training packages required to develop them.

Among the various methods in use, the framework developed by Hennessy and Hicks in 2011 is widely regarded as the most established methodology for identifying training needs among health service providers. Hennessy and Hicks developed a generic TNA questionnaire and manual that can be adapted across different cadres of health workers. The methodology has been endorsed by the World Health Organization on the basis of validation studies in multiple countries and can be locally adapted for application in specific service settings. The present assessment is grounded in this approach, adapted to the structure and service delivery context of the Nepali health system.

1.5 Objectives

1.5.1 General Objective

To identify the capacity-building training needs of health service providers working at different levels of government health institutions in Sudurpashchim Province and to inform the design of evidence-based, prioritized training programs.

1.5.2 Specific Objectives

1. To identify the trainings required for the capacity development of health service providers from different cadres working at various levels of health institutions in Sudurpashchim Province.
2. To facilitate the update of records of health service providers who have and have not received the identified trainings.
3. To support the study of the effectiveness of selected trainings conducted in previous fiscal years.

2. Methods

2.1 Study Design

A cross-sectional descriptive study design with a multi-method (mixed methods) approach was adopted, integrating both quantitative and qualitative data collection techniques. This design was considered appropriate for assessing the current training needs, competency gaps, and capacity development requirements of health workers serving in different cadres and at different levels of health service delivery across Sudurpashchim Province.

2.2 Study Area and Population

The study was carried out across Sudurpashchim Province. The target population comprised of all health workers employed in government health institutions in the province, including those working at basic health service centers, primary health care centres, district and provincial hospitals, and tertiary-level hospitals. This included medical officers, specialist physicians, nursing staff, paramedics, public health officers, laboratory and pharmacy personnel, and other allied cadres.

2.3 Sampling and Participants

2.3.1 Quantitative Component

A census approach was adopted for the quantitative component. All government health workers serving in health institutions across the province were invited to participate, including doctors, nurses, paramedics, and other cadres. No exclusion was applied on the basis of geography, level of institution, or cadre, provided that the worker held a government appointment at the time of data collection.

2.3.2 Qualitative Component

For the qualitative component, purposive sampling was used to identify key informants. Informants included heads of health offices, in-charges and representatives of district and provincial hospitals, and senior officials of other health institutions whose roles provided insight into workforce capacity and training needs. Qualitative data collection continued until thematic saturation was achieved—that is, until additional interviews ceased to yield substantively new themes.

2.4 Data Collection Methods

2.4.1 Quantitative Data Collection

Quantitative data were collected using a structured, self-administered questionnaire deployed through Google Forms. The questionnaire was developed and pretested in advance and contained sections on socio-demographic characteristics, professional profile, past training experience, cadre-specific knowledge and skill requirements, identified training needs, preferred training modalities, and

perceived organizational and system-level capacity constraints. The link to the Google Form was circulated through institutional channels and health office focal points across the province.

2.4.2 Qualitative Data Collection

Qualitative data were collected following the quantitative phase so that interviews could be used to verify, contextualise, and deepen the quantitative findings. A semi-structured interview guide was used, and-with the informed consent of participants-interviews were audio-recorded. Data collection team were trained in qualitative interviewing techniques to ensure consistent and good-quality data.

2.5 Data Management and Analysis

Quantitative data entered through the Google Form were exported and analysed using IBM SPSS version 26 for further analysis. Descriptive statistics-including frequencies, percentages, and means-were used to summarise participant characteristics, training experience, identified training needs, and preferred modalities. Cross-tabulations were used to examine the distribution of training needs across cadre, level of institution, and other relevant variables.

Qualitative data were transcribed and analysed using thematic analysis with the support of RQDA (R-package for Qualitative Data Analysis). Initial codes were derived from the interview guide; emergent codes were added inductively during analysis. Themes were developed iteratively and triangulated with the quantitative findings to produce an integrated interpretation.

2.6 Ethical Considerations

The confidentiality of all information provided by participants was fully maintained. Personal identifiers were removed from datasets prior to analysis, and each participant was assigned a unique code. Findings are reported only in aggregate form so that no individual participant or institution can be identified. Participation was voluntary, and informed consent was obtained from all respondents-written consent for the quantitative survey through the Google Form's consent page, and verbal recorded consent for the qualitative interviews. Audio recordings and transcripts are stored securely and accessible only to the core study team.

2.7 Limitations

- The quantitative component relied on a self-administered online questionnaire, which may introduce self-selection bias and may under-represent health workers in facilities with limited internet connectivity.
- Although a census approach was adopted, actual response coverage depends on the willingness and availability of health workers to complete the form, and complete enumeration of the workforce cannot be guaranteed.

- The assessment is cross-sectional and therefore captures training needs at a single point in time; it does not track how these needs change over the course of a fiscal year.
- Self-reported information on past trainings is subject to recall bias, which may affect estimates of training history and exposure.
- This assessment focuses on the TNA component. Findings on the effectiveness of past trainings will be reported separately through the Training Effectiveness Study.

Results

Socio-demographic Characteristics of Health workers Participated in Training Need Assessment and Effectiveness Study

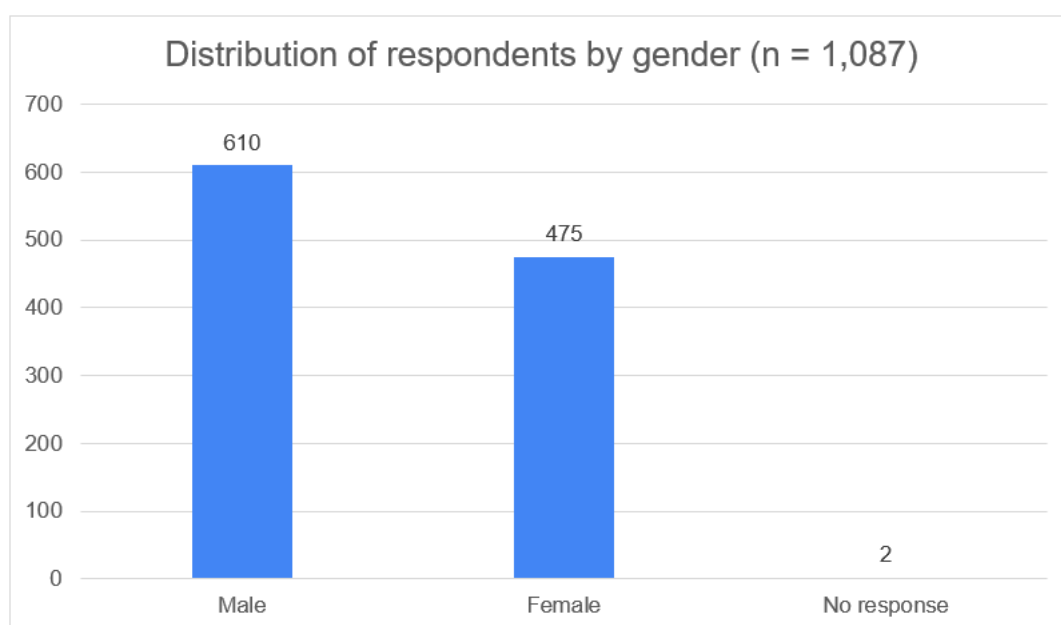
3.1 Gender distribution of Health Workers in Training Need Assessment

Table 1 shows the gender of the 1,087 health workers in the study. Most were men: 610 workers (56.1%). Women were fewer: 475 workers (43.7%). Only 2 workers did not give an answer (0.2%).

Table 1: Distribution of respondents by gender (N = 1,087)

Gender	Count	% of Total	% of Valid
Male (पुरुष)	610	56.1%	56.2%
Female (महिला)	475	43.7%	43.8%
No response (blank)	2	0.2%	-
Total	1,087	100.0%	100.0%

Figure 1: Distribution of respondents by gender (N = 1,087)



3.2 Age distribution of Health Workers in Training Need Assessment

The table shows that most of the health workers are young. About 6 out of every 10 (59.9%) are between 25 and 34 years old, and about 7 out of 10 are under 35. Only a small number are older - just 96 workers (about 9%) are 45 or above, and only 5 are 55 or older. This means the health workforce in the province is mostly made up of young, early-career staff.

Table 2: Age distribution of Health workers (N=1087)

Age category	Frequency	Percentage
<25	111	10.2%
25–34	651	59.9%
35–44	229	21.1%
45–54	91	8.4%
55+	5	0.5%
Total	1,087	100.0%

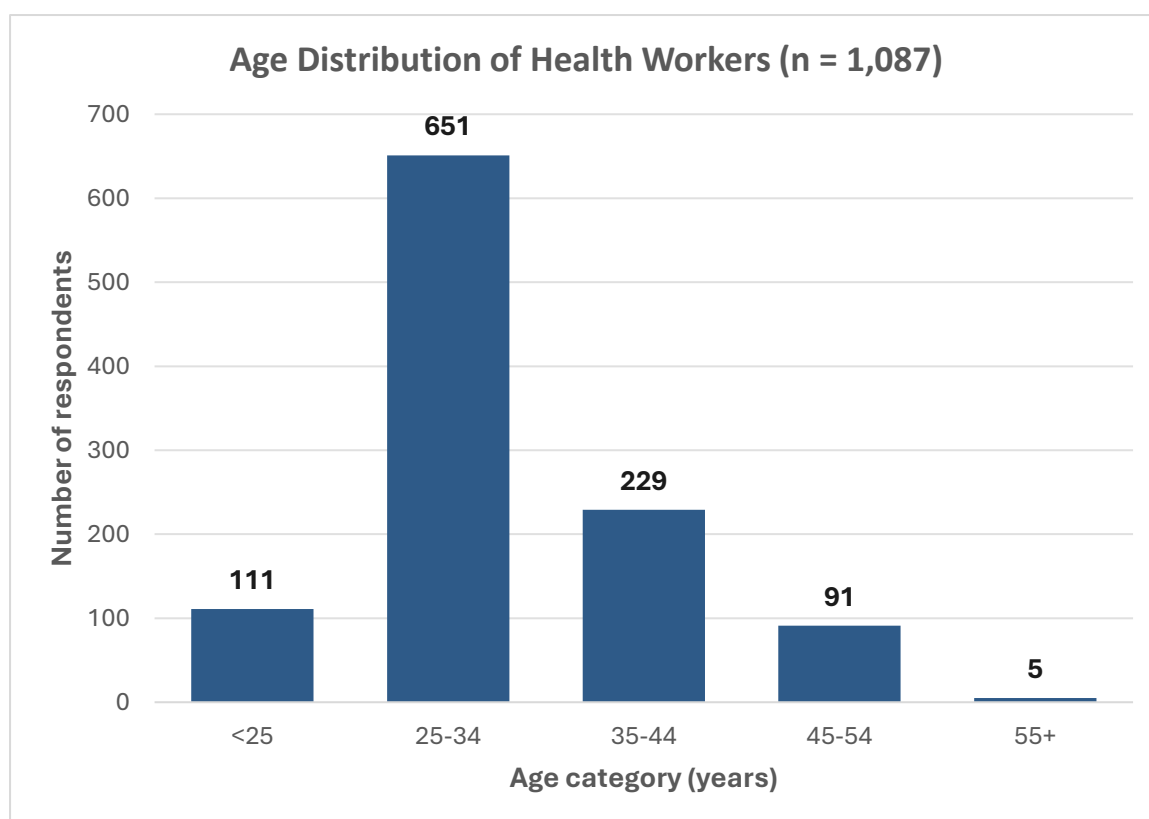


Figure 2: Age Distribution

3.3 Type of service of Health workers

Among total 1087 health workers more than half 55.6% were permanent staff and 43.6% were working on a contract basis and only 0.8% were in other category (consultant).

Table 3: Type of service of Health workers

Type of Service	Frequency (n)	Percentage (%)
Permanent	604	55.6
Contract	474	43.6
Other (अन्य)	9	0.8
Total	1087	100.0

3.4 Currently working Level of Health workers

Among total participants most of the participants were working in 4th level (37.2%) followed by 5th level (31.4%), 231 participants were in 6th level and 7.1% and 3.1% were in 7th and 8th level respectively

Table 4: Currently working Level of Health workers (N=1087)

Level	Frequency	Percentage
4 th level	404	37.2
5 th	341	31.4
6 th	231	21.3
7 th	77	7.1
8 th	34	3.1
Total	1,087	100.0%

3.5 Position of Health workers Participated in the study

The table shows the different job positions of the 1,087 health workers in the study. The largest group was Auxiliary Health Workers (AHW), making up 203 workers (18.7%), and another 158 (14.5%) were Senior AHWs - so together about one in three workers came from the AHW group. Auxiliary Nurse Midwives (ANM) were the next biggest group with 166 workers (15.3%), along with 83 Senior ANMs (7.6%). Public Health Inspectors (PHI) numbered 120

(11.0%) and Health Assistants (HA) 70 (6.4%). Smaller numbers worked as Staff Nurses (48, 4.4%), Public Health Officers (47, 4.3%), Lab Assistants (30, 2.8%), HNIs (29, 2.7%), Medical Officers (28, 2.6%) and Radiographers (12, 1.1%). The remaining 93 workers (8.6%) were spread across many other positions, each making up less than 1% of the total.

Table 5: Position of Health workers Participated in the study (N=1,087)

Position	Frequency	Percentage
AHW	203	18.7%
ANM	166	15.3%
Sr. AHW	158	14.5%
PHI	120	11.0%
Sr. ANM	83	7.6%
HA	70	6.4%
Staff Nurse	48	4.4%
PHO	47	4.3%
Lab Assistant	30	2.8%
HNI	29	2.7%
Medical Officer	28	2.6%
Radiographer	12	1.1%
Other (<1%)	93	8.6%
Total	1,087	100.0%

3.6 Experiences of Health workers Participated in the study

Table 6 shows how many years the 1,087 health workers had been working in government health service. The largest group by far had more than 10 years of experience, 298 workers (27.4%). The rest were spread evenly across the other years: those with 2 and 3 years of experience were the next biggest groups (110 workers, 10.1%, and 112 workers, 10.3%), and a small number were less than one year (83 workers, 7.6%). Overall, this means the workforce includes a good mix of both highly experienced staff and many newer workers, with a large share being long-serving employees.

Table 6: Work experience of Health workers in government health service (N=1,087)

Experience (years)	Frequency	Percentage
<1	83	7.6%
1	44	4.0%
2	110	10.1%
3	112	10.3%
4	50	4.6%
5	52	4.8%
6	35	3.2%
7	82	7.5%

Experience (years)	Frequency	Percentage
8	80	7.4%
9	83	7.6%
10	58	5.3%
>10	298	27.4%
Total	1,087	100.0%

3.7 Education level of Health workers Participated

Table 7 shows the highest education qualification of the 1,087 health workers. The two most common qualifications were Diploma (363 workers, 33.4%) and TSLC (350 workers, 32.2%), which together made up about two-thirds of the workforce. About a quarter held a bachelor's degree (297 workers, 27.3%), while only a small number had higher degrees - 75 workers (6.9%) had a master's and just 2 (0.2%) had a PhD or above. This means most health workers had a basic or mid-level qualification, and very few had advanced academic degrees.

Table 7: Highest education qualification of Health workers (N=1,087)

Qualification	Frequency	Percentage
TSLC	350	32.2%
Diploma	363	33.4%
Bachelor	297	27.3%
Masters	75	6.9%
PhD and above	2	0.2%
Total	1,087	100.0%

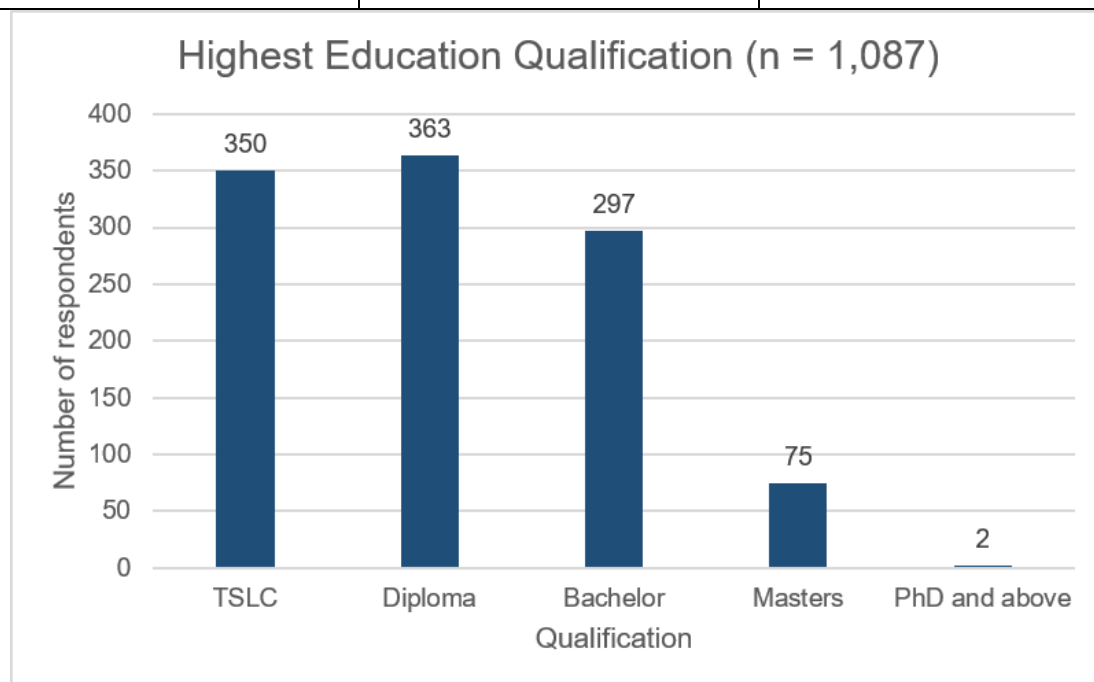


Figure 3: Highest education qualification of Health workers (N=1,087)

3.8 District wise distribution of Health workers participated in Study

Table 8 shows which districts the 1,087 health workers came from across Sudurpashchim Province. The largest numbers came from Kailali (186 workers, 17.1%), Baitadi (183 workers, 16.8%), and Acham (174 workers, 16.0%) - together these three districts made up about half of all participants. Moderate numbers came from Bajhang (117, 10.8%), Darchula (105, 9.7%), and Doti (101, 9.3%), while fewer came from Kanchanpur (87, 8.0%), Bajura (74, 6.8%), and Dadeldhura (60, 5.5%). This shows that health workers from every district in the province took part in the study, although some districts were represented more than others.

Table 8: District-wise distribution of Health workers participated in the study (N=1,087)

District	Frequency	Percentage
Kailali	186	17.1%
Baitadi	183	16.8%
Achham	174	16.0%
Bajhang	117	10.8%
Darchula	105	9.7%
Doti	101	9.3%
Kanchanpur	87	8.0%
Bajura	74	6.8%
Dadeldhura	60	5.5%
Total	1,087	100.0%

3.9 Services affected their facility due to lack of training

Health workers were asked whether services at their facility had been affected because staff lacked training. Out of 1,087 health workers, more than half - 592 (54.5%) - said yes, and services at their facility were affected due to lack of training. The remaining 495 workers (45.5%) said services were not affected. In short, services were disrupted in over half of the facilities, showing that the lack of trained staff is a real and widespread problem across the province.

Table 9: Services affected their facility due to lack of training (N=1087)

Response	Frequency	Percentage
Yes	592	54.5%
No	495	45.5%
Total	1,087	100.0%

3.10 Disrupted Health services in due to lack of training

Health workers who said services were affected were also asked which specific services were disrupted because they had not received training. A total of 477 workers named at least one

service, and because each worker could list more than one, the percentages below add up to more than 100%. The most disrupted services were family-planning and reproductive-health services - IUCD (80 mentions, 16.8%), Safe/Medical Abortion (72, 15.1%) and Implant (71, 14.9%) -followed by PAMS V2 (60, 12.6%) and Mental Health (56, 11.7%). This shows that the lack of training most affects family planning, reproductive health and mental health services across the province.

Table 10: Health services disrupted due to lack of training (multi-response, n=477)

Health service disrupted	Frequency	% of respondents who named a service (n=477)	% of all respondents (N=1087)
IUCD	80	16.8%	7.4%
Safe/Medical Abortion	72	15.1%	6.6%
Implant	71	14.9%	6.5%
PAMS V2	60	12.6%	5.5%
Mental Health	56	11.7%	5.2%
Emergency/Critical Care	41	8.6%	3.8%
USG/Ultrasound	40	8.4%	3.7%
ASRH	36	7.5%	3.3%
Delivery/Birthing	33	6.9%	3.0%
Family Planning	33	6.9%	3.0%
Dental/Oral Health	31	6.5%	2.9%
ENT	107	22.4%	9.8%
VIA (cervical screening)	24	5.0%	2.2%
TB	25	5.2%	2.3%
Immunization	18	3.8%	1.7%
Burn Care	18	3.8%	1.7%
Nutrition/IMAM	18	3.8%	1.7%
DHIS2	17	3.6%	1.6%
Counselling	15	3.1%	1.4%
PMTCT	14	2.9%	1.3%
Recording & Reporting	14	2.9%	1.3%
IMNCI/CBIMNCI	14	2.9%	1.3%
SBA	13	2.7%	1.2%
Leprosy	13	2.7%	1.2%
Store/Logistic Management	12	2.5%	1.1%
Operation Theatre/OCMC	10	2.1%	0.9%
PTC/BLS	9	1.9%	0.8%
Cold Chain/EVM	7	1.5%	0.6%
ETB	6	1.3%	0.6%

Health service disrupted	Frequency	% of respondents who named a service (n=477)	% of all respondents (N=1087)
eHMIS	4	0.8%	0.4%
PNC	4	0.8%	0.4%
HFOMC	4	0.8%	0.4%
eLMIS	4	0.8%	0.4%
SNCU	4	0.8%	0.4%
KMC	3	0.6%	0.3%
GBV	2	0.4%	0.2%
HBB (newborn resuscitation)	2	0.4%	0.2%
ANC	1	0.2%	0.1%
Respondents who named ≥ 1 service	477		

3.11 Analysis of top five priority training needs among health workers

3.11.1 Overall training demand (all priorities combined)

Health workers asked for many kinds of training. Each of the 1,087 workers chose their five most important training needs. This gave 5,392 total choices, covering more than sixty different training topics. As Table 11 shows, the most asked-for training was PAMS V2, with 294 mentions (5.5%). Next came HMIS/DHIS2, with 261 mentions (4.8%). This shows that workers strongly want better skills in health information and data. The next most wanted training was about mothers and children: Implant (209, 3.9%), Mental Health (203, 3.8%) and IMNCI (180, 3.3%). After this came a group of trainings with about two to three percent each: Basic Emergency Care and PTC/BLS (153 each, 2.8%), ASRH (140, 2.6%), MLP (131, 2.4%), SBA (127, 2.4%), Immunization (119, 2.2%) and IUCD (115, 2.1%). The top ten trainings together made up 1,851 mentions, or 34.3% of all choices. So demand is focused on a few key areas, but it is still wide. The rest of the choices were made through many small or one-time requests. These were grouped together as “Other” (914 mentions, 17.0%). This large group is important. It shows many special and new skill gaps, such as climate change and health, dialysis, critical care, waste management and disaster preparedness. Each one is small on its own, but together they form a big part of the province’s training needs.

Table 11: Priority Training priority summary of all participants (N=1087)

Training	Total Mentions	% of Mentions
PAMS V2	294	5.5%
HMIS/DHIS2	261	4.8%
Implant	209	3.9%
Mental Health	203	3.8%
IMNCI	180	3.3%

Training	Total Mentions	% of Mentions
Basic Emergency Care	153	2.8%
PTC/BLS	153	2.8%
ASRH	140	2.6%
MLP	131	2.4%
SBA	127	2.4%
Immunization	119	2.2%
IUCD	115	2.1%
ROUSG	115	2.1%
Health Administration & Management	113	2.1%
MA	104	1.9%
Basic Burn Care	101	1.9%
PMTCT	93	1.7%
TB	93	1.7%
PEN Package	92	1.7%
COFP	90	1.7%
ENT	85	1.6%
VIA	80	1.5%
IPC	79	1.5%
IMAM	79	1.5%
Psychosocial Counselling	76	1.4%
CNSI	72	1.3%
CTS	69	1.3%
Critical Care/ICU	63	1.2%
In-service Training	61	1.1%
Leprosy	59	1.1%
NCD	47	0.9%
OT Training	45	0.8%
Waste Management	45	0.8%
Eye/ENT/Oral Health	45	0.8%
KMC	41	0.8%
HFOMC	40	0.7%
STP	40	0.7%
Dental	37	0.7%
Family Planning	35	0.6%
Safe Abortion Service	33	0.6%
Malaria	33	0.6%
FETP	32	0.6%
Dialysis	30	0.6%
Oral Health	28	0.5%
Eye Care	28	0.5%
ARDS	27	0.5%
PNC	26	0.5%
Climate Change & Health	25	0.5%
Nutrition	25	0.5%
Comprehensive Newborn Care	24	0.4%

Training	Total Mentions	% of Mentions
Disaster Management	24	0.4%
SNCU	23	0.4%
CAC	22	0.4%
ASBA	18	0.3%
Cold Chain Management	17	0.3%
First Aid	13	0.2%
TOT	12	0.2%
HBB	9	0.2%
GBV	8	0.1%
MNH	8	0.1%
MPDSR	7	0.1%
STI	7	0.1%
General Training Skills	5	0.1%
Panchakarma	5	0.1%
MISP	5	0.1%
Other (uncategorized / one-off)	914	17.0%
Total mentions	5,392	100.0%

3.11.2 Training demand by priority ranking

Table 12 breaks the same choices into the five priority levels. It shows how strongly workers wanted each training. PAMS V2 was first overall, and it also had the most first-priority choices (95). This makes it the most urgent need. The clearest pattern is for Skilled Birth Attendance (SBA). It was only tenth in total mentions (127), but it had 85 first-priority votes. This means almost everyone who chose it put it at the very top. So, a small group of maternal health workers see SBA as their most important need. Some other training also had many first-priority votes: IMNCI (56), MLP (54), HMIS/DHIS2 (53), Implant (48) and ROUSG (46). These are clear and urgent needs in child health, mid-level practice, health information and ultrasound. Other training were chosen mostly as lower priorities. For example, Basic Burn Care, IPC, IMAM, ENT and VIA were picked more often as third, fourth or fifth choice than as first. This shows wide but less urgent interest, which still matters for future. The total number of first-priority choices (1,085) is almost the same as the number of workers. This means nearly all workers finished the ranking, so the first-priority results are reliable. In short, the two tables suggest a simple plan: give the most wanted and most urgent trainings first, then slowly cover the many other needs shown in the lower ranks and in the “Other” group.

Table 12: Priority-wise distribution of training demand among all participants (N=1087)

Training	1st Priority	2nd Priority	3rd Priority	4th Priority	5th Priority	Total Mentions	% of Mentions
PAMS V2	95	69	47	50	33	294	5.5%
HMIS/DHIS2	53	57	46	57	48	261	4.8%
Implant	48	43	52	33	33	209	3.9%
Mental Health	41	34	48	36	44	203	3.8%
IMNCI	56	38	28	30	28	180	3.3%
Basic Emergency Care	32	29	30	25	37	153	2.8%
PTC/BLS	20	42	29	33	29	153	2.8%
ASRH	22	24	38	35	21	140	2.6%
MLP	54	19	25	15	18	131	2.4%
SBA	85	11	9	13	9	127	2.4%
Immunization	33	29	24	21	12	119	2.2%
IUCD	13	30	27	27	18	115	2.1%
ROUSG	46	24	19	18	8	115	2.1%
Health Administration & Management	35	27	17	17	17	113	2.1%
MA	20	34	21	20	9	104	1.9%
Basic Burn Care	4	16	20	32	29	101	1.9%
PMTCT	23	11	17	15	27	93	1.7%
TB	12	21	23	17	20	93	1.7%
PEN Package	12	23	10	23	24	92	1.7%
COFP	18	17	16	21	18	90	1.7%
ENT	4	19	22	15	25	85	1.6%
VIA	8	13	18	15	26	80	1.5%
IPC	9	9	22	15	24	79	1.5%
IMAM	6	14	17	18	24	79	1.5%
Psychosocial Counselling	10	18	9	15	24	76	1.4%
CNSI	13	23	17	14	5	72	1.3%
CTS	24	9	11	13	12	69	1.3%
Critical Care/ICU	18	14	15	6	10	63	1.2%
In-service Training	29	10	7	7	8	61	1.1%
Leprosy	13	8	11	13	14	59	1.1%
NCD	4	7	11	10	15	47	0.9%
OT Training	9	11	12	8	5	45	0.8%
Waste Management	3	6	8	11	17	45	0.8%
Eye/ENT/Oral Health	5	13	10	8	9	45	0.8%
KMC	2	7	9	11	12	41	0.8%
HFOMC	5	14	8	4	9	40	0.7%
STP	9	7	6	10	8	40	0.7%
Dental	8	10	6	6	7	37	0.7%
Family Planning	4	7	9	7	8	35	0.6%
Safe Abortion Service	1	10	8	5	9	33	0.6%
Malaria	8	7	5	10	3	33	0.6%
FETP	16	4	4	3	5	32	0.6%
Dialysis	6	6	6	4	8	30	0.6%

Training	1st Priority	2nd Priority	3rd Priority	4th Priority	5th Priority	Total Mentions	% of Mentions
Oral Health	9	7	6	4	2	28	0.5%
Eye Care	0	7	11	5	5	28	0.5%
ARDS	6	3	7	6	5	27	0.5%
PNC	3	5	7	4	7	26	0.5%
Climate Change & Health	1	2	4	9	9	25	0.5%
Nutrition	1	0	11	5	8	25	0.5%
Comprehensive Newborn Care	4	3	7	4	6	24	0.4%
Disaster Management	1	2	7	5	9	24	0.4%
SNCU	5	7	3	3	5	23	0.4%
CAC	1	7	9	1	4	22	0.4%
ASBA	10	2	1	4	1	18	0.3%
Cold Chain Management	3	2	3	5	4	17	0.3%
First Aid	0	1	2	6	4	13	0.2%
TOT	2	3	2	2	3	12	0.2%
HBB	0	1	0	3	5	9	0.2%
GBV	1	1	2	1	3	8	0.1%
MNH	4	2	2	0	0	8	0.1%
MPDSR	1	2	0	1	3	7	0.1%
STI	1	0	1	4	1	7	0.1%
General Training Skills	3	1	0	0	1	5	0.1%
Panchakarma	4	0	1	0	0	5	0.1%
MISP	1	1	1	0	2	5	0.1%
Other (uncategorized / one-off)	88	177	194	239	216	914	17.0%
Total mentions	1,085	1,080	1,078	1,077	1,072	5,392	100.0%
No response (blank)	2	7	9	10	15		

Qualitative results of Training need analysis

The qualitative component of the training needs analysis was carried out across nine districts of Sudurpashchim Province, ensuring that perspectives were drawn from a geographically and administratively diverse cross-section of health facilities. Following the quantitative phase, semi-structured interviews were conducted with health workers and key informants in each of the nine districts to verify, contextualise, and deepen the quantitative findings. This multi-district approach captured district-specific service gaps, deployment realities, and training priorities, allowing common themes to be distinguished from issues unique to particular localities. The findings presented below synthesise these district-level insights into the cross-cutting themes that emerged.

Part 1. Codebook

Fifty-three codes (C01–C53) developed inductively from line-by-line reading of all 18 transcripts. Each code is defined, illustrated by a representative quotation in the respondent’s own words, and linked to the source transcript(s).

Code	Definition	Example quote	Source(s)
C01 SBA skill shortage	Insufficient number of staff trained in Skilled Birth Attendance, including loss of previously trained staff who have left service.	“अहिले २२ जना नर्सिङ स्टाफमा करिब १०–१२ जनाले SBA तालिम लिन बाँकी छ”	T09
C02 Advanced SBA gap	Need for Advanced SBA training beyond basic SBA, especially for nursing and tertiary referral settings.	“Advance SBA को चाही गत माघ महिनामा आको थियो तर त्यति बेला doctor ले जान मान्नु भएन”	T07
C03 CAC / PAC abortion gap	Provider shortage for first- and second-trimester comprehensive and post-abortion care, even where MD Gynaecologists are in post.	“CAC PAC तालिम MD Gynecologist भएपनी trained doctor नै चाहिन्छ ... second trimester को समस्या भईराको हुन्छ”	T07; T06, T10, T12
C04 Implant skill gap	Health workers trained in Implant insertion/removal are insufficient or have left; remaining staff cannot deliver consistently.	“तालिम लेको manpower को कमि भएर service दिन सकेको छैन”	T03; T08, T12, T13
C05 IUCD skill gap	Insufficient IUCD-trained providers across facilities offering family-planning services.	“IUCD ... तालिम लेको manpower को कमि”	T03; T08, T13

Code	Definition	Example quote	Source(s)
C06 Minilap / Vasectomy gap	Doctors trained in permanent FP methods are scarce; federal programmes cannot be implemented locally.	“Minilap को तालिम आवश्यक छ ... संघ बाट आएको कार्यक्रम पनि डाक्टरहरु नपाएर हामीलाई कार्यक्रम चलाउन गाह्रो”	T08; T05
C07 SNCU operating without trained staff	Special Newborn Care Units are running but assigned doctors and nurses have not received SNCU-specific training.	“SNCU संचालन गरेको छौं तर डाक्टर हरूले SNCU को training लेको छैनन्”	T07; T04, T10
C08 OT-TM staffing collapse	Operating Theatre / Theatre Management trained staff have left; single remaining trained worker cannot sustain surgical load.	“अहिले चाहिँ तालिम लिएको एकजना मात्र हुनुहुन्छ। अर्थोपेडिक केसहरु पनि चल्नै हुन्छ”	T10; T06
C09 mhGAP / mental health for MOs	Medical Officers need mhGAP-aligned mental health training to identify and manage depression, anxiety, psychosis at point of care.	“Mental health related case haru एकदमै बढिरहेको कारणले ... MH Gap training हरू पनि आवश्यक देखिन्छ”	T06; T05, T09, T10
C10 Community mental health expansion	Mental-health services not available in communities; trained paramedical cadres needed to expand coverage downward.	“समुदायमा मानसिक स्वास्थ्य सेवाहरु पनि विस्तार गर्न सकिएको छैन”	T05; T03, T08
C11 Suicide and psychiatric burden	Frontline staff are encountering suicide cases and psychiatric morbidity without skills to intervene early.	“कहिलेकाइ suicide को cases हरू पनि देखिन्छ , यसलाई ... प्रारम्भिक अवस्था मै रोक्न सकेको भय राम्रो”	T02; T03
C12 Psychosocial counselling depth	Beyond mhGAP, longer (6-month) psychosocial counselling training is sought for OCMC and GBV survivor support.	“OCMC को लागि Counselling service हरू जस्तै ६ महिने psychosocial counselling training”	T06; T08
C13 NCD / PEN package	WHO PEN package and NCD-focused trainings needed as HT, DM, and cancer caseloads rise at community level.	“गाउँ तिर र प्राय सबै बस्ति हरू तिर ४, ५ जना जति cancer को बिरामी हरू छन्”	T03; T02, T05, T07, T11, T14
C14 Snakebite management	Paramedic-level training in snakebite identification and treatment needed; tied to seasonality and new service launches.	“Snakebite ... Season मा आउछ , अस्ति २,४ वटा cases हरू आको थियो”	T07; T12, T13
C15 BLS / ALS / primary emergency	Basic and Advanced Life Support and primary emergency-care training needed for ER paramedics and nursing.	“ALS/BLS ... इमर्जेन्सी ह्यान्डलिङ गर्ने केसहरुमा फरक पर्छ”	T10; T04, T06, T09, T13

Code	Definition	Example quote	Source(s)
C16 Trauma care	Trauma and accident-case management training needed in district-level ERs.	“ER तिर trauma र Basic emergency care तालिम एकदमै आवश्यक छ”	T04; T10, T13
C17 ICU training	ICU equipment in place at some district hospitals but trained nurses absent, blocking ICU operation.	“ICU का उपकरणहरु पनि छन्, तर nurses नभएका कारणले ... ICU संचालन गर्न सकिरहेका छैनौं”	T04; T06, T10
C18 Burn management	MoHP policy to establish burn wards requires burn-management training for nurses and MOs.	“जलन वाई स्थापना गर्ने ... जलनको तालिम नर्स तथा मेडिकल अफिसरहरुको लागि”	T04; T10
C19 IP and waste management	Infection Prevention and clinical waste management reported as the largest operational quality gap at hospital level.	“IPC र वेस्ट म्यानेजमेन्ट अस्पतालको अहिले हेर्दा खेरि सबभन्दा ठूलो समस्या त्यसमै छ”	T10; T04, T09
C20 PAMS V2 logistics	Newly rolled-out PAMS V2 (logistics management system) training repeatedly requested; multiple respondents admit own unfamiliarity.	“PAMSV2 ... हामी आफै पनि अनविज्ञ छौं”	T02; T01, T03, T07, T11, T14
C21 STG / Standard Treatment Protocol	New MOs lack orientation to Nepal’s standard treatment guidelines; STG training requested early in posting.	“STP को तालिम पनि सबै M.O. लाई दिदा राम्रो ... at least one week or 10 दिन को दियो भने त्यो standard protocol अनुसार treatment”	T07; T10, T14
C22 Medico-legal training	Hospitals report only one medico-legal-trained doctor; absence on leave halts the service.	“एक जना मात्र डाक्टर हुनुहुन्छ उहाँ पनि बिदामा हुनुहुन्छ”	T07; T06
C23 USG by MOs / paramedics	Rural ultrasound training being designed; MO release sought for 16-day course.	“USG को त चाहिने हो”	T10; T13
C24 ECG by non-doctor cadres	Only doctors can currently perform ECG in some palika facilities; paramedics need training so 24/7 services can continue.	“ECG गर्न सक्ने मान्छे डाक्टर बाहेक अरु छैनन्, प्यारामेडिक्सहरुलाई पनि यो तालिम”	T12 [singleton]
C25 Pharmacy stock and disposal	Pharmacy cadre is the least-trained group in hospital settings; stock analysis, store management and disposal needed.	“सबैभन्दा तालिमहरु कम पाएका हाम्रो pharmacy मा कार्यरत स्वास्थ्यकर्मीहरु हुन्”	T04 [singleton]
C26 Lab: blood transfusion and TB microscopy	Lab staff need blood-transfusion training (hospital) and TB	“ल्याबका स्वास्थ्यकर्मीहरुलाई blood transfusion तालिम ... TB microscopy”	T04; T03

Code	Definition	Example quote	Source(s)
	microscopy (district) competency.		
C27 BCC and communication	Staff need behaviour-change communication training; pressure of high workload erodes “smile-included service”.	“स्टाफहरूमा BCC र कम्युनिकेसनको ट्रेनिङहरू चाहिँ चाहिन्छ”	T10; T09
C28 Skill-based vs knowledge-based training	Knowledge can be virtual but skill demands physical hands-on training; one-day theory trainings seen as low-value.	“स्किलको कुरामा फिजिकल नै राम्रो हुन्छ”	T09; T04, T08
C29 Behavioural / attitudinal training	Beyond skill, attitudinal change toward patient care is needed; some respondents place this above clinical content.	“पोजेटिभ एटिट्युड विकास गर्ने व्यवहारिक तालिम एकदमै आवश्यक छ”	T09; T10
C30 Quality-of-care erosion	Vital signs taken without quality, leading to missed clinical deterioration (e.g., late-presenting eclampsia).	“भाइल लिएको भए त त्यो अगाडि नै पत्ता लाग्ने चिज हो नि”	T10 [singleton]
C31 Refresher need	Many staff completed training long ago and need refresher to maintain skill; demand is for refreshers, not first-time training.	“धेरै स्वास्थ्यकर्मीले धेरै समय पहिला तालिम पाएको हुनाले अहिले Refresher तालिमको आवश्यकता”	T12; T08, T09
C32 Onsite coaching and mentoring	Onsite coaching preferred over off-site training for skill maintenance and for newly recruited staff.	“obstetrics सम्बन्धी onsite coaching & mentoring चाहिन्छ”	T04; T05, T10
C33 Conditional certification / KPI	Training certificate should be issued only after the participant has demonstrated the trained service or run a CME.	“सहभागीले आफैले कुनै तालिम संचालन गरेमा, CME संचालन गरेमा ... तालिमको प्रमाणपत्र दिने व्यवस्थालाई एकदमै अनिवार्य”	T04 [singleton]
C34 Cluster short trainings	Multiple 1–2 day trainings should be packaged together to reduce HR disruption and cost.	“१/२ दिने तालिमहरू संचालन गर्नुभन्दा भए अरु तालिमहरू जोडेर गरिदिनुहोस्”	T04; T11
C35 No training records at office	District offices lack a complete record of who has been trained in what; staff sometimes nominated twice while others remain untrained.	“कर्मचारीले कुन कुन तालिम लेको छ भन्ने कुराको विवरण ... तालिम केन्द्रले राख्न पर्छ”	T03 [singleton]
C36 No annual training calendar	Without an annual calendar from HTC, offices cannot plan human-resource coverage around training releases.	“वार्षिक तालिका बनाएर हामीलाई दिनुभयो भने कुन cadre लाई कुन तालिम हुदैछ भन्ने थाहा”	T04 [singleton]

Code	Definition	Example quote	Source(s)
C37 Late or office-bypassing nominations	Nominations sometimes reach the individual before the office; offices cannot manage release.	“हामीले चिठी प्राप्त गर्नु भन्दा अगाडी नै व्यक्ति लाइ खबर गैसकेको हुन्छ”	T03; T07
C38 All-staff-from-one-facility nominations	HTC sometimes calls all staff from a single facility at once, leaving no one to deliver services.	“एउटा स्वास्थ्य संस्थाका सबै स्वास्थ्यकर्मीलाई सँगै बोलाइदिने गर्नुहुन्छ कहिलेकाही, त्यस्तो गरिदिनु भएन”	T04 [singleton]
C39 Cadre mismatch (trained vs serving)	The cadre receiving training is sometimes different from the cadre actually delivering the service in the field.	“सेवा दिने स्वास्थ्यकर्मीहरू ... र त्यस सेवासम्बन्धी तालिम प्राप्त गर्ने स्वास्थ्यकर्मीहरू ... फरक हुन्छन्”	T05; T09
C40 Post-training competency not verified	Trained staff sometimes cannot perform basic procedures (e.g., venipuncture); knowledge-to-skill transfer is not tested.	“तालिम लिएर आए पनि vein open गर्न नजान्ने पनि हुन्छन्”	T05 [singleton]
C41 Province-specific evidence-based curriculum	Training materials must reflect Sudurpashchim’s specific morbidity profile and data, not just federally approved content.	“हाम्रो सुदूरपश्चिमको सन्दर्भमा मिल्ने तालिम सामग्री ... हाम्रो प्रदेशका issue मा आधारित, data-driven, evidence-based”	T05 [singleton]
C42 Trainer quality / CTS pre-requirement	Trainers must themselves be expert and CTS-trained for clinical training delivery to be effective.	“प्रशिक्षक हरू expert हुन पर्छ सँगै CTS training हरू लेको हुनपर्छ”	T06 [singleton]
C43 CTS site development	Peripheral hospitals (e.g., Bayalpata) interested in becoming clinical training sites if standards documentation is provided.	“बयलपाटालाई क्लिनिकल तालिम केन्द्र (CTS) को रूपमा विकास गर्न पनि सकिन्छ”	T09 [singleton]
C44 NGO project phase-out gap	NGO-supported facilities (NSI in Baitadi, prior Nyaya Health in Bayalpata) lose trained staff during transition.	“अब असारको अन्तिममा उहाहरू ६,७ जनाले छोड्दै हुनुहुन्छ ... असार पछि एकैताली gap fulfill हुन गरे छ”	T06; T09
C45 Adding services without staffing	New services (dialysis, snakebite centres) launched before adequate trained staffing is in place.	“हामीले कार्यक्रमहरू थपिरहेको छौं त्यहि अनुसार कर्मचारी नभएको”	T13; T12
C46 Geographic barriers to delivery	Despite SBA availability, home deliveries persist due to geographical access; transport unreliable.	“भौगोलिक कठिनाइले गर्दा ... ८ वटा home delivery भएको”	T01; T02
C47 Specialist doctor absence	Specialist physicians absent; cases manageable locally are	“यतै manage हुने case हरू पनि refer गर्नुपर्ने अवस्था”	T06 [singleton]

Code	Definition	Example quote	Source(s)
	referred up because patients expect specialist care.		
C48 Supervisor / monitor capacity	Those supervising and monitoring service quality are themselves an audience for training.	“supervision monitoring गर्नेमा पनि एक किसिमको दक्षता हुन जरुरि छ”	T14 [singleton]
C49 Procurement, accounts, admin training	Health-section staff need procurement, accounting and administration training beyond clinical content.	“प्रशासनिक, खरिद व्यवस्थापन र लेखा सित सम्बन्धित तालिमहरु”	T12 [singleton]
C50 Mid-level cadres most undertrained	AHW, ANM, HA, and Staff Nurses identified as priority audience for training at basic health-service level.	“Mid level को जनशक्ति लाई तालिमको बढी आवश्यकता ... AHW, ANM, HA, staff nurse”	T03; T08, T12
C51 Climate-change-and-health	Environmental and climate-related health training surfaces as an emerging need.	“climate change सम्बन्धी तालिम पनि आवश्यक छ”	T08 [singleton]
C52 Federal-only training restriction critique	Running only federally approved trainings is insufficient; province and district should design context-specific content.	“जुन-जुन संघबाट स्वीकृत हुन्छन्, ती मात्रै संचालन गर्नुपर्छ भन्ने छैन”	T05 [singleton]
C53 Performance appraisal post-training	Post-training performance appraisal should be formalised; experience-sharing and case studies integrated into methodology.	“case-study present पनि गर्नुपर्छ ... अनुभव share गर्ने पनि गराउनु पर्छ, performance appraisal पनि”	T05 [singleton]

Part 2. Themes

Five major themes emerged from the analysis. For each, the description, supporting categories of codes, frequency across the 9 represented districts, and representative quotations are presented.

Theme 1. Maternal, newborn, and reproductive health remains the most consistently named clinical gap but much of the demand reflects re-training and redeployment, not first-time skill supply

Description.

Across every represented district, respondents named some aspect of the maternal-newborn-reproductive health continuum as a priority. SBA was the single most frequently named training. The demand pattern is heterogeneous: at one extreme, Bayalpata Hospital reports that 10-12 of 22 nursing staff still need SBA (alongside a falling delivery volume); at the other extreme, Badimalika municipality reports adequate SBA coverage yet still records home deliveries, attributing the gap to geography rather than to training. Implant and IUCD demand is repeatedly traced by district-office respondents back to records and redeployment problems rather than to genuine training supply shortfalls.

Subthemes.

- SBA and Advanced SBA at hospital and birthing-centre level
- Comprehensive abortion care (CAC, PAC, MA, second-trimester)
- Family-planning device skills (Implant, IUCD, Minilap, Vasectomy)
- Newborn intensive care (SNCU) without SNCU-trained staff
- Operating theatre and anesthesia team (OT-TM)

Representative quotations.

“CAC PAC तालिम MD Gynecologist भयपनी trained doctor नै चाहिन्छ ... second trimester को समस्या भईराको हुन्छ ... medico-legal तालिम हामी संग एक जना मात्र डाक्टर हुनुहुन्छ उहाँ पनि बिदामा हुनुहुन्छ।” (T07, Darchula Hospital)

“तालिम लेको manpower को कमि भयर service दिन सकेको छैन ... पाएको मान्छेले छोडेर नयाले माग्छन ... कुनै मा चै एउटै स्वास्थ्य संस्थामा दुई भन्दा बढी कर्मचारीले एउटै तालिम लेको छन्।” (T03, Bajura Health Office)

“अहिले महिनामा ३०-४० र वर्षमा ४००-५०० जति डेलिभरी हुन्छ। पहिला महिनामा १०० सम्म र वर्षमा १००० भन्दा बढी हुन्थ्यो ... करिव १०-12 जनाले SBA तालिम लिन बाँकी छ।” (T09, Bayalpata Hospital)

Theme 2. Emergency response, NCDs, and mental health are expanding caseloads that current training coverage has not kept up with

Description.

Respondents at both hospital and district-office levels described rising caseloads in emergencies (snakebite, trauma, PTC/BLS, poisoning, burns), in non-communicable diseases (hypertension, diabetes, cancer at village level), and in mental health (including suicide cases at periphery). This theme is distinct from Theme 1 in that the demand is forward-looking: it reflects a service-portfolio expansion that has outpaced the training pipeline rather than persistent failure to staff a known service. Dialysis at Tikapur and the new snakebite centre at Krishnapur exemplify the pattern of services launched ahead of trained staffing.

Subthemes.

- Emergency life support and trauma (PTC, BLS, accident, poisoning)
- Snakebite management – seasonal and tied to new service centres
- ICU and burn-management as new MoHP priorities
- NCD / PEN package and chronic-disease management
- mhGAP for MOs and community mental-health expansion
- Dialysis and other tertiary services launched ahead of staffing

Representative quotations.

“मानसिक रोगका बिरामीहरुको संख्या दिन प्रतिदिन बढ्दै गएको ... नसर्ने रोग सम्बन्धि पनि केहि स्वास्थ्यकर्मीहरुलाई ... तालिम दिन पायो भने त्यो पनि अलिकति राम्रै हुन्छ।” (T11, Kanchanpur palika)

“गाउँ तिर र प्राय सबै बस्ति हरु तिर ४, ५ जना जति *cancer* को बिरामी हरु छन् अनि *hypertension* र *diabetes* को बिरामी हरु पनि बढिरहेका छन् ... *anxiety*, *depression* मा पर्नेहरुको संख्या पनि बढिरहेको छ।” (T03, Bajura Health Office)

“हामीले कार्यक्रमहरु थपिरहेको छौं त्यहि अनुसार कर्मचारी नभएको कारणले हामीलाई अप्ठेरो भईरहेको छ ... हाम्रो *dialysis* सुरु भएको छ तर पर्याप्त मात्रामा कर्मचारी छैन।” (T13, Tikapur Hospital)

“कहिलेकाइ *suicide* को *cases* हरु पनि देखिन्छ, यसलाई ... प्रारम्भिक अवस्था मै रोक्न सकेको भय राम्रो हुन्थ्यो।” (T02, Martadi municipality)

Theme 3. Health-system and supportive skills (logistics, protocols, IP, communication) are persistently undervalued in initial training requests but are repeatedly named as bottlenecks once probed

Description.

PAMS V2 (the logistics management system) is named in four districts, most often by respondents who admit they themselves are not fully familiar with it. Standard Treatment Protocol orientation for newly recruited MOs, Infection Prevention and waste management, BCC and communication, supervisor competency, and procurement training all sit in this category. These are not the headline asks of any single transcript, but they recur across cadres and districts – and the Mangalsen eclampsia anecdote (vitals taken but not acted on) shows how absence of these supportive skills converts directly into preventable clinical deterioration.

Subthemes.

- PAMS V2 logistics and process simplification
- STG / Standard Treatment Protocol orientation for new MOs
- Infection Prevention and clinical waste management
- BCC, communication, and attitudinal/quality-of-care training
- Procurement, accounting, and administrative training for health-section staff
- Supervisor and monitor competency as a distinct training audience

Frequency of mention across districts: 7 / 9 districts.

Representative quotations.

“सेवा त क्वालिटीमा हेर्छौं भने छ, यति पर्सन्ट ए.एन.सी. भनिएला तर क्वालिटी हेर्छौं भने छैन। भाइटल लिएको भए त त्यो अगाडि नै पत्ता लाग्ने चिज हो नि।” (T10, Mangalsen Hospital)

“PAMSV2 ... हामी आफै पनि अनविज्ञ छौं” (T02, Martadi municipality)

“STP को तालिम पनि सबै M.O. लाई दिदा राम्रो हुन्थ्यो ... सेवाकालीन सुरु हुनु भन्दा पहिला वा सेवा आयोगको एक महिना भित्र त्यो तालिम *at least one week or 10 दिन* को दियो भने त्यो *standard protocol* अनुसार *treatment* हुन्थ्यो।” (T07, Darchula Hospital)

Theme 4. Training investments are being eroded by turnover, weak records, and palika-level deployment decisions

Description.

This theme is the strongest critical finding of the assessment. Multiple respondents – most directly Bajura Health Office and Bajhang District Hospital – describe a system in which training is delivered, certificates are issued, and trained staff then leave service, are transferred without their training record following them, or are redeployed by palika administrators independently of their training profile. The result is the paradox that the same trainings (Implant, IUCD, SBA) keep appearing as “needs” in districts that have, in fact, hosted those trainings repeatedly. The fix is partly administrative (records, deployment policy) and partly contractual (NGO project phase-out planning).

Subthemes.

- Post-training turnover, especially in NGO-supported facilities
- Trained staff redeployed without training record following them
- Palika-level deployment decisions disconnected from training profile
- Mid-level cadres (AHW, ANM, HA, SN) most exposed to this churn
- Cadre mismatch between those receiving training and those delivering service

Supporting categories of codes.

Workforce structural barriers (C44, C47, C50). Training-system administrative critique (C35, C39, C40). Service expansion without staffing (C45 where relevant).

Frequency of mention across districts: 5 / 9 districts (Bajura, Bajhang, Baitadi, Achham, Kanchanpur).

Representative quotations.

“तालिम केन्द्रले कर्मचारीले कुन कुन तालिम लेको छ भन्ने कुराको विवरण राख्न पर्छ ... अनि कर्मचारीको वितरण पनि पालिकाले आफ्नै तरिकाले गरेको छ।” (T03, Bajura Health Office)

“तालिम लिएका स्वास्थ्यकर्मीहरू केहि समय राम्ररी सेवा गर्न नपाएर छिट्टै *turnover* भएर जान्छन्।” (T05, Bajhang Health Office)

“असारको अन्तिममा उहाहरु ६,७ जनाले छोड्दै हुनुहुन्छ त्यसैले असार पछि एकैताली *gap fulfill* हुन गारे छ।” (T06, Baitadi Hospital)

Theme 5. Respondents want structural reform of how training is planned, delivered, and verified – not only more training

Description.

The clearest constructive contribution comes from Bajhang District Hospital, where management has already built an internal monthly competency-assessment tool. Across multiple sites, respondents converge on a specific reform package: annual training calendar from HTC; nominations through

offices rather than to individuals; no “all-staff-at-once” nominations; clustered short trainings; conditional certification tied to a demonstrated CME or KPI; province-specific evidence-based curricula rather than only federally approved content; trainer-quality assurance through verified CTS credentials; and onsite coaching and mentoring as the modality for skill maintenance.

Subthemes.

- Annual training calendar and earlier nominations
- Conditional certification tied to demonstrated service or CME
- Cluster short trainings to reduce HR disruption
- Onsite coaching and mentoring as the maintenance modality
- Province-specific, evidence-based curriculum content
- CTS development at peripheral hospitals; trainer-quality assurance
- Post-training follow-up, competency testing, and performance appraisal

Supporting categories of codes.

Training-system administrative critique (C36, C37, C38, C52). Training quality and pedagogy (C41, C42, C43, C53). Modalities (C31, C32, C33, C34).

Frequency of mention across districts: 6 / 9 districts (Bajhang, Achham, Bajura, Baitadi, Darchula, Dadeldhura).

Representative quotations.

“तालिम लिइसकेपछि सहभागीले आफैले कुनै तालिम संचालन गरेमा, CME संचालन गरेमा अथवा निर्धारित सेवा दिए पछि मात्रै तालिमको प्रमाणपत्र दिने व्यवस्थालाई एकदमै अनिवार्य गरिदिनुपर्छ ... *key performance indicators* बनाएर पनि थाहा पाउन सकिन्छ ... कृपया १/२ दिने तालिमहरू संचालन गर्नेपर्ने भए अरु तालिमहरू जोडेर गरिदिनुहोस्” (T04, Bajhang District Hospital)

“तालिमहरू *design* गर्दा हाम्रो प्रदेशका *issue* मा आधारित हुनुपर्छ, *data-driven* हुनुपर्छ, *evidence based* हुनुपर्छ, जुन-जुन संघबाट स्वीकृत हुन्छन्, ती मात्रै संचालन गर्नुपर्छ भन्ने छैन।” (T05, Bajhang Health Office)

“प्रशिक्षक हरू *expert* हुन पर्छ संग संगै CTS training हरू लेको हुनपर्छ यो भयो भने उहाहरूले *deliver* गर्ने *knowledge* पनि *effectively use* हुन्थ्यो।” (T06, Baitadi Hospital)

Effectiveness Study results Results

As part of this assessment, three training effectiveness studies were conducted, covering Skilled Birth Attendant (SBA) training, Implant training, and Integrated Management of Neonatal and Childhood Illness (IMNCI) training. The findings for each of the three training courses are presented in the sections that follow.

4. Skilled Birth attendants Training Effectiveness

4.1 Overall effectiveness of SBA training

All 236 health workers who completed Skilled Birth Attendant (SBA) training were asked how effective the training was. Almost all rated it positively 152 (64.4%) said it was very effective and 80 (33.9%) said it was effective. Only 1 worker (0.4%) found it moderately effective, and 3 (1.3%) did not answer.

Table 13: Overall effectiveness of SBA training (n=236)

Category	Frequency	Percentage
अत्यन्त प्रभावकारी (Very effective)	152	64.4%
प्रभावकारी (Effective)	80	33.9%
मध्यम प्रभावकारी (Moderately effective)	1	0.4%
(missing)	3	1.3%
Total	236	100.0%

4.2 Adequacy and usefulness of practical practice

Participants were asked whether the practical (hands-on) practice during the training was adequate and useful. A large majority agreed -114 (48.3%) strongly agreed and 96 (40.7%) agreed. A small number disagreed (5, 2.1%) or strongly disagreed (17, 7.2%).

Table 14: Adequacy and usefulness of practical practice (n=236)

Category	Frequency	Percentage
पूर्ण रूपमा सहमत (Strongly agree)	114	48.3%
सहमत (Agree)	96	40.7%

Category	Frequency	Percentage
तटस्थ (Neutral)	3	1.3%
असहमत (Disagree)	5	2.1%
पूर्ण रूपमा असहमत (Strongly disagree)	17	7.2%
(missing)	1	0.4%
Total	236	100.0%

4.3 Improvement in knowledge and skills

When asked whether their knowledge and skills had improved after the training, 132 workers (55.9%) strongly agreed and 75 (31.8%) agreed. Only a few disagreed (6, 2.5%) or strongly disagreed (17, 7.2%).

Table 15: Improvement in knowledge and skills (n=236)

Category	Frequency	Percentage
पूर्ण रूपमा सहमत (Strongly agree)	132	55.9%
सहमत (Agree)	75	31.8%
तटस्थ (Neutral)	2	0.8%
असहमत (Disagree)	6	2.5%
पूर्ण रूपमा असहमत (Strongly disagree)	17	7.2%
(missing)	4	1.7%
Total	236	100.0%

4.4 Increase in confidence after training

Participants were asked whether their confidence had increased after the training. Most agreed - 131 (55.5%) strongly agreed and 82 (34.7%) agreed, while 15 (6.4%) strongly disagreed and 5 (2.1%) disagreed.

Table 16: Increase in confidence after training (n=236)

Category	Frequency	Percentage
पूर्ण रूपमा सहमत (Strongly agree)	131	55.5%
सहमत (Agree)	82	34.7%
असहमत (Disagree)	5	2.1%
पूर्ण रूपमा असहमत (Strongly disagree)	15	6.4%
(missing)	3	1.3%
Total	236	100.0%

4.5 Improvement in complication identification

Workers were asked whether their ability to identify complications had improved after the training. 134 (56.8%) said it had much improved and 72 (30.5%) said it had greatly improved, while 25 (10.6%) reported moderate improvement a clear overall gain in clinical skill.

Table 17: Improvement in complication identification (n=236)

Category	Frequency	Percentage
अत्यन्त सुधारिएको छ (Greatly improved)	72	30.5%
धेरै सुधारिएको छ (Much improved)	134	56.8%
सामान्य रूपमा सुधारिएको छ (Moderately improved)	25	10.6%
थोरै पनि सुधारिएको No (Not improved)	2	0.8%
सहमत (other)	1	0.4%
(missing)	2	0.8%
Total	236	100.0%

4.6 Improvement in ANC/PNC service quality

Participants were asked whether the quality of the antenatal and postnatal care (ANC/PNC) they provide had improved. 149 (63.1%) reported much improvement and 72 (30.5%) reported great improvement, showing that the training strengthened routine maternal care.

Table 18: Improvement in ANC/PNC service quality (n=236)

Category	Frequency	Percentage
अत्यन्त सुधार गरेको छ (Greatly improved)	72	30.5%
धेरै सुधार गरेको छ (Much improved)	149	63.1%
मध्यम सुधार गरेको छ (Moderately improved)	10	4.2%
थोरै पनि सुधार गरेको No (Not improved)	2	0.8%
सहमत (other)	1	0.4%
(missing)	2	0.8%
Total	236	100.0%

4.7 Currently providing SBA service

Workers were asked whether they are currently providing SBA (delivery) services. Most are - 198 (83.9%) provide the service, 25 (10.6%) provide it but not regularly, and 13 (5.5%) do not provide it at present.

Table 19: Currently providing SBA service (n=236)

Category	Frequency	Percentage
Yes (Yes)	198	83.9%
Not regularly (Not regularly)	25	10.6%
No (No)	13	5.5%
Total	236	100.0%

4.8 Deliveries conducted since training

Trained workers were asked how many deliveries they had conducted since the training. Of the 221 who answered, the largest groups had conducted 201–500 deliveries (56, 25.3%) and 101–200 deliveries (46, 20.8%). A further 40 (18.1%) had conducted 1–50. Fifteen workers did not respond.

Table 20: Deliveries conducted since training, by range (n=221 valid)

Deliveries range	Frequency	Percentage
0	1	0.5%
1–50	40	18.1%
51–100	33	14.9%
101–200	46	20.8%
201–500	56	25.3%
501–1000	24	10.9%
1001–2000	9	4.1%
>2000	12	5.4%
Total (valid)	221	100.0%
(missing)	15	

4.9 Summary statistics of deliveries since training

The table below summarizes the number of deliveries conducted since training among the 221 workers who answered. On average each had conducted about 574 deliveries, though the median was 200, showing that a few very high values raise the average. Together they reported 126,746 deliveries.

Table 21: Summary statistics of deliveries since training (n=221 valid)

Statistic	Value
Valid responses (n)	221
Mean	573.5
Median	200
Std Dev	1399.4

5. Effectiveness Implant Training

5.1 Overall effectiveness of Implant training

All 281 health workers who completed Implant training were asked how effective the training was. Almost all rated it positively -137 (48.8%) said it was effective and 129 (45.9%) said it was very effective, so about 94.7% gave a positive rating.

Table 22: Overall effectiveness of Implant training (n=281)

Category	Frequency	Percentage
अत्यन्त प्रभावकारी (Very effective)	129	45.9%
प्रभावकारी (Effective)	137	48.8%
मध्यम प्रभावकारी (Moderately effective)	10	3.6%
कम प्रभावकारी (Less effective)	1	0.4%
प्रभावहीन (Ineffective)	2	0.7%
(missing)	2	0.7%
Total	281	100.0%

5.2 Relevance of training to daily work

Participants were asked whether the training was relevant to their daily work. The large majority agreed, confirming that the Implant training matched the real tasks workers carry out at their facilities.

Table 23: Relevance of training to daily work (n=281)

Category	Frequency	Percentage
पूर्ण रूपमा सहमत (Strongly agree)	106	37.7%
सहमत (Agree)	120	42.7%
तटस्थ (Neutral)	12	4.3%
असहमत (Disagree)	13	4.6%
पूर्ण रूपमा असहमत (Strongly disagree)	30	10.7%
Total	281	100.0%

5.3 Adequacy and usefulness of practical practice

Participants were asked whether the practical (hands-on) practice during the training was adequate and useful. Most agreed, indicating that workers had enough supervised practice to build their skills.

Table 24: Adequacy and usefulness of practical practice (n=281)

Category	Frequency	Percentage
पूर्ण रूपमा सहमत (Strongly agree)	115	40.9%
सहमत (Agree)	129	45.9%
तटस्थ (Neutral)	6	2.1%
असहमत (Disagree)	6	2.1%
पूर्ण रूपमा असहमत (Strongly disagree)	24	8.5%
(missing)	1	0.4%
Total	281	100.0%

5.4 Improvement in knowledge and skills

When asked whether their knowledge and skills had improved after the training, the great majority reported clear improvement, showing that the training succeeded in strengthening workers' Implant-related competence.

Table 25: Improvement in knowledge and skills (n=281)

Category	Frequency	Percentage
अत्यन्त राम्रो सुधार भएको छ (Greatly improved)	90	32.0%
राम्रो सुधार भएको छ (Improved well)	173	61.6%
मध्यम सुधार भएको छ (Moderately improved)	11	3.9%
थोरै पनि सुधार भएको No (Not improved)	2	0.7%
कति सुधार भएको No (Not improved)	2	0.7%
(missing)	3	1.1%
Total	281	100.0%

5.5 Increase in confidence

Participants were asked whether their confidence in providing Implant services had increased after the training. Most reported a clear gain in confidence, which is essential for safely offering the service.

Table 26: Increase in confidence after training (n=281)

Category	Frequency	Percentage
अत्यन्त बढेको छ (Greatly increased)	108	38.4%
राम्रोसँग बढेको छ (Increased well)	152	54.1%
मध्यम रूपमा बढेको छ (Moderately increased)	13	4.6%
कति पनि बढेको No (Not increased)	3	1.1%
थोरै पनि बढेको No (Not increased)	2	0.7%
(missing)	3	1.1%
Total	281	100.0%

5.6 Improvement in complication identification

Workers were asked whether their ability to identify complications had improved after the training. The majority reported much or great improvement, showing better clinical judgement in spotting problems early.

Table 27: Improvement in complication identification (n=281)

Category	Frequency	Percentage
अत्यन्त सुधारिएको छ (Greatly improved)	80	28.5%
धेरै सुधारिएको छ (Much improved)	168	59.8%
मध्यम रूपमा सुधारिएको छ (Moderately improved)	27	9.6%
कति पनि सुधार भएको No (Not improved)	3	1.1%
(missing)	3	1.1%
Total	281	100.0%

5.7 Improvement in Implant usage rate

Participants were asked whether the rate at which Implants are used at their facility had improved after the training. Most reported improvement, suggesting that the training helped increase uptake of the method.

Table 28: Improvement in Implant usage rate (n=281)

Category	Frequency	Percentage
अत्यन्त सुधार गरेको छ (Greatly improved)	64	22.8%
धेरै सुधार गरेको छ (Much improved)	163	58.0%
मध्यम सुधार भएको छ (Moderately improved)	41	14.6%
थोरै सुधार भएको छ (Slightly improved)	7	2.5%
कत्ति पनि सुधार भएको छ No (Not improved)	3	1.1%
(missing)	3	1.1%
Total	281	100.0%

5.8 Currently providing Implant service

Workers were asked whether they are currently providing Implant services. Most are-210 (74.7%) provide the service regularly, 55 (19.6%) provide it sometimes, and 16 (5.7%) do not provide it at present.

Table 29: Currently providing Implant service (n=281)

Category	Frequency	Percentage
हो, नियमित रूपमा (Yes, regularly)	210	74.7%
कहिलेकाहीँ (Sometimes)	55	19.6%
No (No)	16	5.7%
Total	281	100.0%

5.9 Women served with Implant since training

Trained workers were asked how many women they had served with Implants since the training. Of the 258 who answered, the largest group had served 1–50 women (120, 46.5%), followed by 51-100 (59, 22.9%) and 101–200 (43, 16.7%). Twenty-three workers did not respond.

Table 30: Women served with Implant since training, by range (n=258 valid)

Women served (range)	Frequency	Percentage of valid
0	1	0.4%
1–50	120	46.5%
51–100	59	22.9%
101–200	43	16.7%
201–500	26	10.1%
501–1000	8	3.1%
1001–2000	0	0.0%
>2000	1	0.4%
Total valid	258	100.0%
Missing	23	

5.10 Summary statistics of women served

The table below summarizes the number of women served with Implants since training among the 258 workers who answered. On average each had served about 129 women, though the median was around 57, showing that a few high values raise the average. Together they served 33,379 women.

Table 31: Summary statistics of women served since training (n=258 valid)

Statistic	Value
Valid responses (n)	258
Missing	23
Mean	129.4
Median	56.5
Std Dev	208.5

6. Effectiveness IMNCI Training

6.1 Overall effectiveness of IMNCI training

All 586 health workers who completed IMNCI training were asked how effective the training was. Almost all rated it positively 330 (56.3%) said it was effective and 222 (37.9%) said it was very effective, giving about 94.2% positive ratings.

Table 32: Overall effectiveness of IMNCI training (n=586)

Category	Frequency	Percentage
अत्यन्त प्रभावकारी (Very effective)	222	37.9%
प्रभावकारी (Effective)	330	56.3%
मध्यम प्रभावकारी (Moderately effective)	19	3.2%
कम प्रभावकारी (Less effective)	2	0.3%
प्रभावहीन (Ineffective)	3	0.5%
(missing)	10	1.7%
Total	586	100.0%

6.2 Relevance of training to daily work

Participants were asked whether the training was relevant to their daily work. The large majority agreed 249 (42.5%) agreed and 231 (39.4%) strongly agreed confirming that the IMNCI training matched the real tasks workers carry out at their facilities.

Table 33: Relevance of training to daily work (n=586)

Category	Frequency	Percentage
पूर्ण रूपमा सहमत (Strongly agree)	231	39.4%
सहमत (Agree)	249	42.5%
तटस्थ (Neutral)	15	2.6%
असहमत (Disagree)	20	3.4%
पूर्ण रूपमा असहमत (Strongly disagree)	65	11.1%
(missing)	6	1.0%
Total	586	100.0%

6.3 Adequacy and usefulness of practical practice

Participants were asked whether the practical (hands-on) practice during the training was adequate and useful. Most agreed 306 (52.2%) agreed and 193 (32.9%) strongly agreed indicating that workers had enough supervised practice to build their skills.

Table 34: Adequacy and usefulness of practical practice (n=586)

Category	Frequency	Percentage
पूर्ण रूपमा सहमत (Strongly agree)	193	32.9%
सहमत (Agree)	306	52.2%
तटस्थ (Neutral)	13	2.2%
असहमत (Disagree)	24	4.1%
पूर्ण रूपमा असहमत (Strongly disagree)	42	7.2%
(missing)	8	1.4%
Total	586	100.0%

6.4 Improvement in knowledge and skills

When asked whether their knowledge and skills had improved after the training, 407 (69.5%) said they had improved well and 105 (17.9%) said they had greatly improved, showing that the training clearly strengthened workers' IMNCI competence.

Table 35: Improvement in knowledge and skills (n=586)

Category	Frequency	Percentage
अत्यन्त राम्रो सुधार भएको छ (Greatly improved)	105	17.9%
राम्रो सुधार भएको छ (Improved well)	407	69.5%
मध्यम सुधार भएको छ (Moderately improved)	62	10.6%
कति पनि सुधार भएको No (Not improved)	4	0.7%
(missing)	8	1.4%
Total	586	100.0%

6.5 Increase in confidence

Participants were asked whether their confidence in providing IMNCI services had increased after the training. Most reported a clear gain 387 (66.0%) said their confidence had increased well and 119 (20.3%) said it had greatly increased.

Table 36: Increase in confidence after training (n=586)

Category	Frequency	Percentage
अत्यन्त बढेको छ (Greatly increased)	119	20.3%
राम्रोसँग बढेको छ (Increased well)	387	66.0%
मध्यम रूपमा बढेको छ (Moderately increased)	70	11.9%
(missing)	10	1.7%
Total	586	100.0%

6.6 Improvement in complication identification

Workers were asked whether their ability to identify complications in children had improved after the training. 400 (68.3%) reported much improvement and 95 (16.2%) reported great improvement, showing better clinical judgement in spotting problems early.

Table 37: Improvement in complication identification (n=586)

Category	Frequency	Percentage
अत्यन्त सुधारिएको छ (Greatly improved)	95	16.2%
धेरै सुधारिएको छ (Much improved)	400	68.3%
मध्यम रूपमा सुधारिएको छ (Moderately improved)	79	13.5%
(missing)	12	2.0%
Total	586	100.0%

6.7 Improvement in quality of care

Participants were asked whether the quality of the care they provide to children had improved after the training. 400 (68.3%) reported much improvement and 97 (16.6%) reported great improvement, indicating a clear gain in service quality.

Table 38: Improvement in quality of care (n=586)

Category	Frequency	Percentage
अत्यन्त सुधार गरेको छ (Greatly improved)	97	16.6%
धेरै सुधार गरेको छ (Much improved)	400	68.3%
मध्यम सुधार गरेको छ (Moderately improved)	77	13.1%
(missing)	12	2.0%
Total	586	100.0%

6.8 Currently providing IMNCI service

Workers were asked whether they are currently providing IMNCI services. Most are - 443 (75.6%) provide the service regularly and 115 (19.6%) provide it sometimes, while a small number do not provide it at present.

Table 39: Currently providing IMNCI service (n=586)

Category	Frequency	Percentage
हो, नियमित रूपमा (Yes, regularly)	443	75.6%
कहिलेकाहीँ (Sometimes)	115	19.6%
No (No)	28	4.8%
Total	586	100.0%

6.9 Children served via IMNCI since training

Trained workers were asked how many children they had served through IMNCI since the training. Of the 475 who answered, the largest group had served 1–50 children (141, 29.7%), followed by 51–100 (85, 17.9%) and 201–500 (82, 17.3%). One hundred and eleven workers did not respond.

Table 40: Children served via IMNCI since training, by range (n=475 valid)

Children served (range)	Frequency	Percentage of valid
0	0	0.0%
1–50	141	29.7%
51–100	85	17.9%
101–200	80	16.8%
201–500	82	17.3%
501–1000	41	8.6%
1001–2000	26	5.5%
>2000	20	4.2%
Total valid	475	100.0%
Missing	111	

6.10 Summary statistics of children served

The table below summarises the number of children served through IMNCI since training among the 475 workers who answered. On average each had served about 460 children, though the median was 150, showing that a few very high values raise the average. Together they served 218,270 children.

Table 41: Summary statistics of children served since training (n=475 valid)

Statistic	Value
Valid responses (n)	475
Missing	111
Mean	459.5
Median	150
Std Dev	1044.8
Maximum	10000
Sum (total served)	218270

Overall Summary of Training Effectiveness

Table 42 brings together the main effectiveness findings from all three clinical trainings-Skilled Birth Attendant (SBA, 236 participants), Implant (281 participants) and IMNCI (586 participants)-so they can be compared side by side. Across every measure the results are consistently strong. Almost all participants rated their training effective or very effective (between 94% and 98%), and large majorities reported that their knowledge and skills, their

confidence, and their ability to identify complications had improved (mostly between 84% and 94%). About three-quarters or more of the trainees are still providing the related service, and together they have reached very large numbers of patients since being trained-126,746 deliveries, 33,379 implant clients and 218,270 children. Overall, the table shows that all three trainings were well received and are being put into practice, which supports continuing them and extending them to more health workers.

Table 42: Comparison of training effectiveness across SBA, Implant and IMNCI trainings

	SBA (n=236)	Implant (n=281)	IMNCI (n=586)
Participants (n)	236	281	586
Rated training effective / very effective	98.3%	94.7%	94.2%
Knowledge & skills improved	87.7%	93.6%	87.4%
Confidence increased	90.2%	92.5%	86.3%
Complication identification improved	87.3%	88.3%	84.5%
Currently providing the service	83.9%	74.7%	75.6%
Service volume since training	126,746 deliveries	33,379 implant clients	218,270 children

Annexes

Annex 1: Quantitative data Collection questionnaire

तालिम आवश्यकता पहिचान तथा प्रभावकारिता अध्ययन

(Training Need Assessment and Effectiveness Study)

प्रश्नावली

तालिम आवश्यकता पहिचान (Training Needs Assessment and Effectiveness Study) भन्नाले कुनै स्वास्थ्य संस्था वा लक्षित समूहमा कार्यरत कर्मचारीहरूले आफ्नो जिम्मेवारी तथा कार्यसम्पादन प्रक्रिया प्रभावकारी रूपमा निर्वाह गर्न आवश्यक पर्ने ज्ञान, सीप, व्यवहार तथा दृष्टिकोण के-कस्ता छन् र ती कुन हदसम्म पर्याप्त छन् भन्ने विषयको व्यवस्थित मूल्याङ्कन प्रक्रिया हो।

यस प्रक्रियामार्फत तालिम आवश्यक छ कि छैन भन्ने निर्धारण गर्नुका साथै, तालिम आवश्यक भएमा तालिमको प्रकार, विषयवस्तु, विधि, अवधि तथा तालिम प्रदान गर्ने निकाय/व्यक्तिको पहिचान गर्न सहयोग पुग्दछ। सोही उद्देश्यका लागि यो Google Form तयार गरिएको हो।

उद्देश्य

1. कार्यसम्पादन प्रक्रियामा देखिएका तालिमसम्बन्धी आवश्यकता पहिचान गर्नु।
2. आवश्यक तालिमहरूको प्राथमिकता निर्धारण गर्नु।
3. छनौट भएका तालिमहरूको प्रभावकारिता अध्ययन गर्नु।

यस Google Form मार्फत संकलन गरिने इमेल ठेगाना तथा अन्य जानकारी गोप्य राखिनेछ। यी विवरणहरू केवल तालिम आवश्यकता पहिचान, तालिम योजना तथा कार्यक्रम विकास प्रयोजनका लागि मात्र प्रयोग गरिनेछन्। संकलित जानकारी अनुसन्धान/कार्यक्रमगत विश्लेषण बाहेक अन्य कुनै प्रयोजनका लागि प्रयोग गरिने छैन।

यस अध्ययनमा तपाईंको सहभागिता पूर्णतः स्वेच्छिक हो। तपाईंले कुनै पनि प्रश्नको उत्तर नदिन वा कुनै पनि समयमा सहभागिता रोक्न सक्नुहुनेछ। मैले माथि उल्लेखित तालिम आवश्यकता पहिचान प्रक्रियाको उद्देश्य, प्रकृति तथा मेरो सहभागिता सम्बन्धी जानकारी बुझिसकेको छु। म स्वेच्छिक रूपमा यस Google Form मा सहभागी भई आवश्यक जानकारी प्रदान गर्न सहमत छु।

** Indicates required question*

खण्ड १: व्यक्तिगत विवरण (Personal Information)

२. मोबाइल नं (Mobile Number)

३. नाम थर (अंग्रेजीमा)

४. लिङ्ग (Gender)

- ☐ पुरुष
- ☐ महिला
- ☐ अन्य

५. पुरा भएको उमेर (Age in completed years)

६. कार्यरत पद (Post/Position)

७. तह (Level)

- ☐ चौथो
- ☐ पाँचौँ
- ☐ छैटौँ
- ☐ सातौँ
- ☐ आठौँ
- ☐ नवौँ
- ☐ दशौँ
- ☐ एघारौँ

८. कार्यरत संस्थाको नाम (अंग्रेजीमा लेख्नुहोस्) *

९. सेवाको किसिम

- ☐ स्थायी
- ☐ करार
- ☐ अन्य

१०. नेपाल सरकारको स्वास्थ्यसेवामा कार्य अनुभव

- ☐ १ वर्ष भन्दा कम
- ☐ १ वर्ष
- ☐ २ वर्ष
- ☐ ३ वर्ष
- ☐ ४ वर्ष
- ☐ ५ वर्ष
- ☐ ६ वर्ष
- ☐ ७ वर्ष
- ☐ ८ वर्ष
- ☐ ९ वर्ष
- ☐ १० वर्ष
- ☐ १० वर्ष भन्दा बढी

११. पुरा गरेको माथिल्लो शैक्षिक योग्यता

- ☐ TSLC
- ☐ Diploma
- ☐ Bachelor (स्नातक)
- ☐ Masters (स्नातकोत्तर)
- ☐ PhD and above

१२. पुरा गरेको माथिल्लो शैक्षिक योग्यताको विषय उल्लेख गर्नुहोस्? (Eg: BPH)

१३. कार्यरत संस्थाको किसिम *

- ☐ संघीय तथा प्रादेशिक अस्पताल
- ☐ स्वास्थ्य निर्देशनालय / स्वास्थ्य आपूर्ति केन्द्र / जनस्वास्थ्य प्रयोगशाला / स्वास्थ्य तालिम केन्द्र / प्रादेशिक स्वास्थ्य प्रवर्द्धन केन्द्र
- ☐ आयुर्वेद चिकित्सालय / जिल्ला आयुर्वेद स्वास्थ्य केन्द्र / औषधालय / नागरिक आरोग्य केन्द्र
- ☐ जिल्ला अस्पताल
- ☐ स्वास्थ्य कार्यालय
- ☐ स्थानीय स्वास्थ्य शाखा
- ☐ स्थानीय अस्पताल / नगर अस्पताल / आधारभूत अस्पताल
- ☐ प्राथमिक स्वास्थ्य केन्द्र

- ☐ स्वास्थ्य चौकी
- ☐ आधारभूत स्वास्थ्य सेवा केन्द्र
- ☐ सहरी स्वास्थ्य केन्द्र
- ☐ सामुदायिक स्वास्थ्य केन्द्र
- ☐ अन्य

१४. कार्यरत जिल्ला *

- ☐ कन्चनपुर
- ☐ कैलाली
- ☐ डडेल्धुरा
- ☐ बैतडी
- ☐ दार्चुला
- ☐ डोटी
- ☐ अछाम
- ☐ बाजुरा
- ☐ बझाङ

पालिका छनौट (Municipality Selection)

१४.१ कन्चनपुर जिल्ला

- ☐ भीमदत्त नगरपालिका (Bhimdatta Municipality)
- ☐ बेदकोट नगरपालिका (Bedkot Municipality)
- ☐ कृष्णपुर नगरपालिका (Krishnapur Municipality)
- ☐ बेलौरी नगरपालिका (Belaury Municipality)
- ☐ पुर्नवास नगरपालिका (Punarbas Municipality)
- ☐ शुक्लाफाँटा नगरपालिका (Shuklaphanta Municipality)
- ☐ महाकाली नगरपालिका (Mahakali Municipality)
- ☐ बेलडाँडी गाउँपालिका (Beldandi RM)
- ☐ लालझाडी गाउँपालिका (Laljhadi RM)
- ☐ Other

१४.२ कैलाली जिल्ला

- ☐ धनगढी उप-महानगरपालिका (Dhangadi Sub Metro)
- ☐ घोडाघोडी नगरपालिका (Godagodi Municipality)
- ☐ गोदावरी नगरपालिका (Godavari Municipality)
- ☐ गौरीगंगा नगरपालिका (Gauriganga Municipality)
- ☐ लम्की चुहा नगरपालिका (Lamkichuha Municipality)
- ☐ टिकापुर नगरपालिका (Tikapur Municipality)
- ☐ भजनी नगरपालिका (Bhajani Municipality)
- ☐ कैलारी गाउँपालिका (Kailari RM)
- ☐ चुरे गाउँपालिका (Chure RM)
- ☐ बर्दगोरिया गाउँपालिका (Bardagoriya RM)
- ☐ जानकी गाउँपालिका (Janaki RM)
- ☐ जोशीपुर गाउँपालिका (Joshiapur RM)
- ☐ मोहन्याल गाउँपालिका (Mohanyal RM)

१४.३ डडेल्धुरा जिल्ला

- ☐ अमरगढी नगरपालिका (Amargadi Municipality)
- ☐ परशुराम नगरपालिका (Parshuram Municipality)

- ☐ आलिताल गाउँपालिका (Aalital RM)
- ☐ भागेश्वर गाउँपालिका (Bhageshor RM)
- ☐ नवदुर्गा गाउँपालिका (Navadurga RM)
- ☐ अजयमेरु गाउँपालिका (Ajaymeru RM)
- ☐ गन्यापधुरा गाउँपालिका (Gannyapdhura RM)

१४.४ बैतडी जिल्ला

- ☐ दशरथचन्द नगरपालिका (Dasrathchand Municipality)
- ☐ पाटन नगरपालिका (Patan Municipality)
- ☐ पुर्चौडी नगरपालिका (Purchudi Municipality)
- ☐ मेलौली नगरपालिका (Melauli Municipality)
- ☐ दोगडाकेदार गाउँपालिका (Dogadakedar RM)
- ☐ सुर्नया गाउँपालिका (Surnaya RM)
- ☐ सिगास गाउँपालिका (Sigas RM)
- ☐ शिवनाथ गाउँपालिका (Shivnath RM)
- ☐ पञ्चेश्वर गाउँपालिका (Panchesor RM)
- ☐ डिलासैनी गाउँपालिका (Dilasaini RM)

१४.५ दार्चुला जिल्ला

- ☐ महाकाली नगरपालिका (Mahakali Municipality)
- ☐ शैल्यशिखर नगरपालिका (Shailyashikhar Municipality)
- ☐ अपिहिमाल गाउँपालिका (Apihimal RM)
- ☐ दुहुँ गाउँपालिका (Duhu RM)
- ☐ नौगाड गाउँपालिका (Naugad RM)
- ☐ व्याँस गाउँपालिका (Byas RM)
- ☐ मारमा गाउँपालिका (Marma RM)
- ☐ मालिकार्जुन गाउँपालिका (Malikarjun RM)
- ☐ लेकम गाउँपालिका (Lekam RM)

१४.६ डोटी जिल्ला

- ☐ दिपायल सिलगढी नगरपालिका (Dipayal Silgadi Municipality)
- ☐ शिखर नगरपालिका (Shikhar Municipality)

- ☐ आदर्श गाउँपालिका (Aadarsh RM)
- ☐ बडीकेदार गाउँपालिका (Badikedar RM)
- ☐ बोगटान फुड्सिल गाउँपालिका (Bogatan Fudsil RM)
- ☐ के.आई. सिंह गाउँपालिका (K.I Singh RM)
- ☐ पूर्वीचौकी गाउँपालिका (Purbichauki RM)
- ☐ सायल गाउँपालिका (Sayal RM)
- ☐ जोरायल गाउँपालिका (Jorayal RM)

१४.७ अछाम जिल्ला

- ☐ मंगलसेन नगरपालिका (Mangalsen Municipality)
- ☐ कमलबजार नगरपालिका (Kamalbazar Municipality)
- ☐ साँफेबगर नगरपालिका (Safebagar Municipality)
- ☐ पञ्चदेवल विनायक नगरपालिका (Panchdewal Binayak Municipality)
- ☐ चौरपाटी गाउँपालिका (Chaurpati RM)
- ☐ ढकरी गाउँपालिका (Dhakari RM)
- ☐ तुर्माखाँद गाउँपालिका (Turmakhad RM)
- ☐ बान्नीगढी जयगढ गाउँपालिका (Bannigadi Jayagad RM)
- ☐ मेल्लेख गाउँपालिका (Mallekh RM)
- ☐ रामारोशन गाउँपालिका (RamaRoshan RM)

१४.८ बाजुरा जिल्ला

- ☐ त्रिवेणी नगरपालिका (Triveni Municipality)
- ☐ बडीमालिका नगरपालिका (Badimalika Municipality)
- ☐ बुढीगंगा नगरपालिका (Budiganga Municipality)
- ☐ बुढीनन्दा नगरपालिका (Budinanda Municipality)
- ☐ जगन्नाथ गाउँपालिका (Jagannath RM)
- ☐ खप्तड छेडेदह गाउँपालिका (Khaptad Chededaha RM)
- ☐ हिमाली गाउँपालिका (Himali RM)
- ☐ गौमुल गाउँपालिका (Gaumul RM)
- ☐ स्वामीकार्तिक खापर गाउँपालिका (Swamikarthik Khapar RM)

१४.९ बझाङ जिल्ला

- ☐ जयपृथ्वी नगरपालिका (Jayprithivi Municipality)
- ☐ बुंगल नगरपालिका (Bungal Municipality)
- ☐ सुर्मा गाउँपालिका (Surma RM)
- ☐ छबिसपाथिभेरा गाउँपालिका (Chhabispathivara RM)
- ☐ केदारस्युँ गाउँपालिका (Kedarsyu RM)
- ☐ खप्तडछान्ना गाउँपालिका (Khaptadchanna RM)
- ☐ मष्टा गाउँपालिका (Masta RM)
- ☐ थलारा गाउँपालिका (Thalara RM)
- ☐ बित्थडचिर गाउँपालिका (Bitthadchir RM)
- ☐ दुर्गाथली गाउँपालिका (Durgathali RM)
- ☐ टालकोट गाउँपालिका (Talkot RM)
- ☐ साइपाल गाउँपालिका (Saipal RM)

खण्ड २: तालिम आवश्यकता पहिचान सम्बन्धी प्रश्नावली

यस खण्डमा तालिम आवश्यकताको पहिचान गर्नका लागि तयार गरिएका प्रश्नहरू समावेश गरिएको छ। यसमार्फत सहभागीहरूको वर्तमान ज्ञान, सीप, कार्यअनुभव तथा आवश्यक देखिएका तालिम र प्राथमिकताहरूको व्यवस्थित रूपमा आकलन गरिनेछ।

२.१. तपाईंले हालसम्म प्राप्त गर्नु भएका तालिमहरू छनौट गर्नुहोस्। (अहिलेसम्म लिनु भएका सबै तालिमहरूमा टिक (✓) लगाउनुहोस्) *

- ☐ Acute Respiratory Distress Syndrome Management (ARDS)
- ☐ Adolescent and Sexual Reproductive Health (ASRH)
- ☐ Advanced Skilled Birth Attendance (ASBA)
- ☐ Ambulance Driver Training
- ☐ Basic Burn Care (BBC)
- ☐ Basic Critical Care Training for Nurses (BCCT-N)
- ☐ Basic Emergency Care
- ☐ Basic Fever Profile Diagnostic
- ☐ Basic Health Logistic Management (BHLM)
- ☐ Basic Immunization
- ☐ Basic Leprosy
- ☐ Basic Life Support
- ☐ Basic Malaria Microscopy
- ☐ Basic Oral Health
- ☐ Basic Training on Medical Oxygen System
- ☐ Burn Care Management
- ☐ Cervical Cancer Screening and Prevention (CCSP)
- ☐ Cervical Cancer Screening Program (VIA) Second Tier
- ☐ Child and Adolescent Mental Health (Module 3)
- ☐ Climate Change and Health Impact
- ☐ Climate Resilient-Water Safety Plan (CR-WSP)
- ☐ Clinical Coach/Mentor Development Training on MNH Service
- ☐ Clinical Training Skills (CTS)
- ☐ Cold Chain Equipment Repair and Maintenance
- ☐ Comprehensive Abortion Care (CAC)
- ☐ Comprehensive Family Planning (COFP) and Counseling
- ☐ Comprehensive Newborn Care (CNBC)

- ☐ Continuous Ambulatory Peritoneal Dialysis (CAPD)
- ☐ Comprehensive Nutrition Specific Intervention (CNSI Training)
- ☐ Disability Management and Rehabilitation
- ☐ Essential Critical Care (ECC)
- ☐ Eye, ENT/Oral Health
- ☐ Ksharsutra and Surgical Skill Training
- ☐ Field Epidemiology Training Program (FETP) Frontline
- ☐ General Training Skills
- ☐ Geriatric Healthcare for Medical Officer
- ☐ Health Administration and Management Training
- ☐ Healthcare Waste Management
- ☐ Health Management for Local Level
- ☐ Health Response to Gender-Based Violence
- ☐ Helping Babies Breath (HBB)
- ☐ Helping Mother Survive – Bleeding After Birth and Helping Babies Breath
- ☐ Hemodialysis
- ☐ Hemodialysis Machine Maintenance
- ☐ HFOMC (TOT)
- ☐ Hospital Preparedness for Emergency (HOPE)
- ☐ Implant
- ☐ Infection Prevention and Control (IPC) Blended/Advance
- ☐ Intrauterine Contraceptive Device (IUCD)
- ☐ Kangaroo Mother Care (KMC)
- ☐ Malaria, Dengue, Kala-azar, Scrub Typhus, Chikungunya and Emerging Disease
- ☐ Medical Abortion (MA)
- ☐ Mental Health for Prescriber
- ☐ Mid Level Practicum (MLP)
- ☐ Minilap
- ☐ Minimum Initial Service Package (MISP)
- ☐ No Scalpel Vasectomy
- ☐ Occupational Health and Safety (OHS)
- ☐ Operation and Maintenance of Healthcare Waste Treatment Technologies
- ☐ Operation Theatre Techniques and Management (OTTM)
- ☐ Package of Non-Essential Communicable Disease (PEN)/PEN plus
- ☐ Pediatric Nursing Care (PNC)

- ☐ Post-Partum Intrauterine Contraceptive Device (PPIUCD)
- ☐ Pre-Hospital Care Training
- ☐ Primary Burn Care Management
- ☐ Primary Emergency Care (PEC)
- ☐ Primary Trauma Care and Basic Life Support
- ☐ Psychosocial Counseling
- ☐ Primary Trauma Care/Basic Life Support (PTC/BLS)
- ☐ Rural Obstetric Ultrasound (ROUSG)
- ☐ Safe Abortion Service (SAS)
- ☐ Site Based Essential Critical Care Training
- ☐ Social Accountability for the Health Sector
- ☐ Supplementary Course for Psychosocial Counseling
- ☐ Vector Borne Disease Treatment and Management
- ☐ IMNCI Training
- ☐ पूर्वकर्म पञ्चकर्म तालिम
- ☐ PAMS V2
- ☐ District Health Information System-2 (DHIS-2)
- ☐ Prevention of Mother-to-Child Transmission (PMTCT)
- ☐ Health Management Information System (HMIS)
- ☐ Visual Inspection with Acetic Acid (VIA) for Cervical Cancer Screening
- ☐ Skilled Birth Attendant (SBA)
- ☐ Integrated Management of Acute Malnutrition (IMAM)
- ☐ Other: _____

२.२. तपाईंले तालिमको क्रममा प्राप्त ज्ञान र सीपलाई कार्यमा प्रयोग गर्दा तपाईंको आत्मविश्वासमा वृद्धि भएको छ।

- ☐ अत्यन्त सहमत
- ☐ सहमत
- ☐ मध्यम
- ☐ असहमत
- ☐ अत्यन्त असहमत

२.३. तालिम/प्रशिक्षणपछि तपाईंको आफ्नो कार्य सम्पादनमा सुधार भएको छ।

- ☐ पूर्ण रूपमा असहमत
- ☐ असहमत

- ☐ तटस्थ
- ☐ सहमत
- ☐ पूर्ण रूपमा सहमत

प्राथमिकताका आधारमा आवश्यक तालिमहरू

तपाईंको पदअनुसारको कार्य सम्पादन गर्नका लागि तपाईंलाई आवश्यक पर्ने पाँचवटा तालिमहरू प्राथमिकताका आधारमा क्रमसँग उल्लेख गर्नुहोस्।
कृपया आवश्यक तालिमहरू अंग्रेजीमा प्राथमिकताको आधारमा लेख्नुहोस्। (Eg: PMTCT)

२६. पहिलो प्राथमिकतामा रहेको तालिम *

२७. दोस्रो प्राथमिकतामा रहेको तालिम *

२८. तेस्रो प्राथमिकतामा रहेको तालिम *

२९. चौथो प्राथमिकतामा रहेको तालिम *

३०. पाँचौँ प्राथमिकतामा रहेको तालिम *

खण्ड ३: सेवा अवरोध सम्बन्धी प्रश्नावली

यस खण्डमा सेवा प्रवाहका क्रममा देखिएका अवरोध सम्बन्धित प्रश्नहरू समावेश गरिएको छन्।

३१. तपाईं कार्यरत संस्थामा तालिम नपाएकाले कुनै सेवा संचालनमा अवरोध भएको छ? *

☐ छ

☐ छैन

३२. तपाईं कार्यरत संस्थामा तालिम नपाएकोले कुन कुन सेवा अवरोध भएका छन्? उल्लेख गर्नुहोस्।

खण्ड ४: तालिमको प्रभावकारिताको अध्ययन प्रश्नावली

यस खण्डमा यस स्वास्थ्य तालिम केन्द्रबाट सञ्चालन गरिएका विभिन्न तालिमहरूको प्रभावकारिता मूल्याङ्कन गर्ने उद्देश्यले जानकारी संकलन गरिनेछ। यो अध्ययन विशेष रूपमा SBA, IMNCI, Implant तालिम लिइसक्नुभएका स्वास्थ्यकर्मीहरूका लागि लक्षित गरिएको हो।

उक्त तालिमहरू लिइसक्नुभएका सहभागीहरूले मात्र यस खण्डका प्रश्नहरू भरी फारम पेश गर्नुहुन अनुरोध छ।

यदि तपाईंले यस स्वास्थ्य तालिम केन्द्रबाट SBA, IMNCI, Implant नलिनुभएको भए, कृपया “छैन” विकल्पमा चिन्ह लगाई फारम पेश गर्नुहुन अनुरोध छ।

४.१ SBA तालिमको प्रभावकारिताका लागि

३३. तपाईंले SBA तालिम लिनु भएको छ?

- ☐ छ
- ☐ छैन

यस खण्डमा SBA तालिमको प्रभावकारिता मूल्याङ्कन गर्नका लागि सम्बन्धित प्रश्नहरू समावेश गरिएको छन्, जसबाट तालिमपछि सहभागीहरूको ज्ञान, सीप, व्यवहारमा आएको परिवर्तन तथा सेवा प्रवाहमा परेको प्रभावको आकलन गरिनेछ।

SBA सम्बन्धी तल दिएका कथन ठीक लागेन भने “पूर्ण रूपमा असहमत”, केही हदसम्म ठीक लागेन भने “असहमत”, न सहमत न असहमत जस्तो अनुभव भएमा “तटस्थ”, कथन ठीक र उपयोगी लाग्यो भने “सहमत” र कथन पूर्ण रूपमा ठीक, पर्याप्त तथा अत्यन्त उपयोगी लाग्यो भने “पूर्ण रूपमा सहमत” विकल्प रोज्नुहोस्।

३४. तपाईंले SBA तालिम कहिले प्राप्त गर्नुभएको थियो? (E.g. २०८१)

३५. के तपाईं हाल आफ्नो स्वास्थ्य संस्थामा SBA सम्बन्धी सेवा प्रदान गर्दै आउनुभएको छ?

- ☐ हो, नियमित रूपमा
- ☐ कहिलेकाहीँ
- ☐ छैन

३६. तालिममा गरिएको व्यावहारिक अभ्यास पर्याप्त र उपयोगी थियो।

- ☐ पूर्ण रूपमा असहमत
- ☐ असहमत
- ☐ तटस्थ
- ☐ सहमत
- ☐ पूर्ण रूपमा सहमत

३७. SBA तालिमपछि प्रसव व्यवस्थापन र मातृ तथा नवजात शिशु स्वास्थ्यसँग सम्बन्धित मेरो ज्ञान र सीप सुधार भएको छ।

- ☐ पूर्ण रूपमा असहमत
- ☐ असहमत
- ☐ तटस्थ
- ☐ सहमत
- ☐ पूर्ण रूपमा सहमत

३८. SBA तालिमपछि प्रसव व्यवस्थापन र मातृ तथा नवजात शिशु स्याहारमा आत्मविश्वास बढेको छ।

- ☐ पूर्ण रूपमा असहमत
- ☐ असहमत
- ☐ तटस्थ
- ☐ सहमत
- ☐ पूर्ण रूपमा सहमत

३९. SBA तालिमपछि मेरो मातृ तथा नवजात शिशु स्वास्थ्यको जटिलताहरू समयमै पहिचान गर्ने क्षमता सुधारिएको छ।

- ☐ कति पनि सुधारिएको छैन
- ☐ थोरै पनि सुधारिएको छैन
- ☐ सामान्य रूपमा सुधारिएको छ
- ☐ धेरै सुधारिएको छ
- ☐ अत्यन्त सुधारिएको छ

४०. SBA तालिमले गर्भवती महिलाको हेरचाह (ANC सेवा) र प्रसवपछिको हेरचाह (PNC सेवा) को गुणस्तर सुधार गरेको छ।

- ☐ कति पनि सुधार गरेको छैन
- ☐ थोरै पनि सुधार गरेको छैन
- ☐ मध्यम सुधार गरेको छ
- ☐ धेरै सुधार गरेको छ
- ☐ अत्यन्त सुधार गरेको छ

४१. समग्रमा, SBA तालिम कतिको प्रभावकारी रहेको छ?

- ☐ प्रभावहीन
- ☐ कम प्रभावकारी
- ☐ मध्यम प्रभावकारी
- ☐ प्रभावकारी

☐ अत्यन्त प्रभावकारी

४२. औसतमा SBA तालिमपछि तपाईंले अहिलेसम्म कतिओटा प्रसूती (delivery) गर्नुभयो?

४.२ Implant तालिम प्रभावकारिता सम्बन्धी प्रश्नावली

यस खण्डमा Implant तालिमको प्रभावकारिता मूल्याङ्कन गर्नका लागि सम्बन्धित प्रश्नहरू समावेश गरिएको छन्, जसबाट तालिमपछि सहभागीहरूको ज्ञान, सीप, व्यवहारमा आएको परिवर्तन तथा सेवा प्रवाहमा परेको प्रभावको आकलन गरिनेछ।

४३. तपाईंले Implant तालिम लिनु भएको छ?

- ☐ छ
- ☐ छैन

४४. के तपाईं हाल आफ्नो स्वास्थ्य संस्थामा Implant सम्बन्धी सेवा प्रदान गर्दै आउनुभएको छ?

- ☐ हो, नियमित रूपमा
- ☐ कहिलेकाहीँ
- ☐ छैन

४५. Implant तालिम मेरो दैनिक कार्यसँग सान्दर्भिक छ।

- ☐ पूर्ण रूपमा असहमत
- ☐ असहमत
- ☐ तटस्थ
- ☐ सहमत
- ☐ पूर्ण रूपमा सहमत

४६. तालिममा गरिएको व्यावहारिक अभ्यास पर्याप्त र उपयोगी थियो।

- ☐ पूर्ण रूपमा असहमत
- ☐ असहमत
- ☐ तटस्थ
- ☐ सहमत
- ☐ पूर्ण रूपमा सहमत

४७. Implant तालिमपछि Implant प्रयोग विधि र सम्बन्धित स्वास्थ्यसेवासँग सम्बन्धित ज्ञान र सीप सुधार भएको छ।

- ☐ कति सुधार भएको छैन
- ☐ थोरै पनि सुधार भएको छैन
- ☐ मध्यम सुधार भएको छ
- ☐ राम्रो सुधार भएको छ
- ☐ अत्यन्त राम्रो सुधार भएको छ

४८. Implant तालिमपछि Implant सेवा प्रदानमा मेरो आत्मविश्वास बढेको छ।

- ☐ कति पनि बढेको छैन
- ☐ थोरै पनि बढेको छैन
- ☐ मध्यम रूपमा बढेको छ
- ☐ राम्रोसँग बढेको छ
- ☐ अत्यन्त बढेको छ

४९. तालिमपछि Implant राख्दा हुने जटिलताहरू समयमै पहिचान गर्ने मेरो क्षमता सुधारिएको छ।

- ☐ कति पनि सुधार भएको छैन
- ☐ थोरै पनि सुधारिएको छैन
- ☐ मध्यम रूपमा सुधारिएको छ
- ☐ धेरै सुधारिएको छ
- ☐ अत्यन्त सुधारिएको छ

५०. Implant तालिमले Implant सेवाको प्रयोगदरमा सुधार भएको छ।

- ☐ कति पनि सुधार भएको छैन
- ☐ थोरै सुधार भएको छ
- ☐ मध्यम सुधार भएको छ
- ☐ धेरै सुधार गरेको छ
- ☐ अत्यन्त सुधार गरेको छ

५१. समग्रमा, Implant तालिम कतिको प्रभावकारी रहेको छ?

- ☐ प्रभावहीन
- ☐ कम प्रभावकारी
- ☐ मध्यम प्रभावकारी
- ☐ प्रभावकारी
- ☐ अत्यन्त प्रभावकारी

५२. Implant तालिमपछि तपाईंले अहिलेसम्म कति जना महिलालाई Implant सेवा प्रदान गर्नुभएको छ?

४.३ IMNCI तालिम प्रभावकारिता सम्बन्धी प्रश्नावली

यस खण्डमा Integrated Management of Neonatal and Childhood Illness (IMNCI) तालिमको प्रभावकारिता मूल्याङ्कन गर्नका लागि सम्बन्धित प्रश्नहरू समावेश गरिएको छन्, जसबाट तालिमपछि सहभागीहरूको ज्ञान, सीप, व्यवहारमा आएको परिवर्तन तथा सेवा प्रवाहमा परेको प्रभावको आकलन गरिनेछ।

५३. तपाईंले Integrated Management of Neonatal and Childhood Illness (IMNCI) तालिम लिनु भएको छ?

- ☐ छ
- ☐ छैन

५४. के तपाईं हाल आफ्नो स्वास्थ्य संस्थामा IMNCI सम्बन्धी सेवा प्रदान गर्दै आउनुभएको छ?

- ☐ हो, नियमित रूपमा
- ☐ कहिलेकाहीँ
- ☐ छैन

५५. IMNCI तालिम मेरो दैनिक कार्यसँग सान्दर्भिक छ।

- ☐ पूर्ण रूपमा असहमत
- ☐ असहमत
- ☐ तटस्थ
- ☐ सहमत
- ☐ पूर्ण रूपमा सहमत

५६. IMNCI तालिममा गरिएको व्यावहारिक अभ्यास पर्याप्त र उपयोगी थियो।

- ☐ पूर्ण रूपमा असहमत
- ☐ असहमत
- ☐ तटस्थ
- ☐ सहमत
- ☐ पूर्ण रूपमा सहमत

५७. IMNCI तालिमपछि नवजात शिशु र बालबालिकाको स्वास्थ्य, उपचार विधि तथा सम्बन्धित स्वास्थ्यसेवाको ज्ञान र सीपमा सुधार भएको छ।

- ☐ कति पनि सुधार भएको छैन
- ☐ थोरै पनि सुधार भएको छैन

- ☐ मध्यम सुधार भएको छ
- ☐ राम्रो सुधार भएको छ
- ☐ अत्यन्त राम्रो सुधार भएको छ

५८. IMNCI तालिमपछि नवजात शिशु र बालबालिकाका रोगहरूको व्यवस्थापन र उपचारका विधिहरूमा आत्मविश्वास बढेको छ।

- ☐ कति पनि बढेको छैन
- ☐ थोरै पनि बढेको छैन
- ☐ मध्यम रूपमा बढेको छ
- ☐ राम्रोसँग बढेको छ
- ☐ अत्यन्त बढेको छ

५९. IMNCI तालिमपछि नवजात शिशु र बालबालिकाका रोगहरूको जटिलताहरू समयमै पहिचान गर्न मेरो क्षमता सुधारिएको छ।

- ☐ कति पनि सुधारिएको छैन
- ☐ थोरै पनि सुधारिएको छैन
- ☐ मध्यम रूपमा सुधारिएको छ
- ☐ धेरै सुधारिएको छ
- ☐ अत्यन्त सुधारिएको छ

६०. IMNCI तालिमले नवजात शिशु र बालबालिकाको स्वास्थ्यसेवाको गुणस्तर र हेरचाहमा सुधार गरेको छ।

- ☐ कति पनि सुधार गरेको छैन
- ☐ थोरै पनि सुधार गरेको छैन
- ☐ मध्यम सुधार गरेको छ
- ☐ धेरै सुधार गरेको छ
- ☐ अत्यन्त सुधार गरेको छ

६१. IMNCI तालिम कतिको प्रभावकारी रहेको छ?

- ☐ प्रभावहीन
- ☐ कम प्रभावकारी
- ☐ मध्यम प्रभावकारी
- ☐ प्रभावकारी
- ☐ अत्यन्त प्रभावकारी

६२. IMNCI तालिमपछि तपाईंले अहिलेसम्म कति नवजात तथा बालबालिकाहरुलाई सेवा प्रदान गर्नुभयो?

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तपाईंको अमूल्य सहभागिताको लागि धन्यवाद

Annex 2: Qualitative Data collection tool

सुदूरपश्चिम प्रदेश
सामाजिक विकास मन्त्रालय
स्वास्थ्य तालिम केन्द्र
धनगढी, कैलाली

Training Need Assessment प्रश्नावली

(जिल्ला स्वास्थ्य कार्यालय प्रमुख / स्वास्थ्य शाखा प्रमुख / कार्यक्रम फोकल पर्सन लाई लिईने
अन्तर्वाताको लागि)

S. N.	मूल प्रश्न	Follow up प्रश्न	Probing प्रश्न
1	कुन कुन कार्यक्रमहरूमा सेवा दिन / लक्ष्य हासिल गर्न कठिनाई भइरहेको छ ?	कुन कुन तालिमलाई आगामी आ.व. मा प्राथमिकतामा राख्नु पर्छ ?	आफू मातहत रहेका स्वास्थ्यकर्मीहरूलाई आवश्यक पर्ने कुनै ५ वटा तालिम List गर्नुहोस
२	कुन cadre (post) को स्वास्थ्यकर्मी (ANM, HA, Staff Nurse, Lab Technician, Public Health Inspector, PHO, Doctors आदि) लाई तालिम आवश्यकता बढी देखिन्छ ? (सेवा प्रवाहको आधारमा)		
३	हालको समयमा चुनौतिहरू के छन् जुन तालिमले पूर्ति गर्न सक्छन् वा तालिमकै अभावले हल गर्न सकिएको छैन ?		
४	हामीले प्राप्त गरेको individual level को HRH को need assessment अनुसार (यस्तो list) देखेका छौं, यहि तालिम किन आवश्यकता पर्यो ? (बढी आवश्यक देखिएको तालिमको उदाहरण दिने) जस्तो: • PAMS V2 • SBA • Mental Health • Implant	1. चलि आएका तालिम जस्तै SBA, IMPLANT, IUCD सम्बन्धी तालिम, CNSI, CBIMNCI हरू पनि फेरी धेरैले आवश्यक छ भन्नुको कारण के होला?	यी तालिमहरू के साँच्चै आवश्यक हुन् ? यदि होइनन् भने साँच्चै आवश्यक भएका तालिमहरू के हुन्?

धन्यवाद!

Annex:3

Health Training Center Dhangadhi, Kailali Training Need Assessment and Effectiveness Study Field Implementation Plan Sudurpashchim Province, Nepal- 2025

1. Purpose

This plan outlines the field activities, team assignments, data collection methods, and deliverable requirements for the Training Need Assessment (TNA) and Effectiveness Study across nine districts of Sudurpashchim Province.

2. Study Sites

Each team will visit the following facility types in their assigned districts:

- Health Office (HO)
- District/Provincial Hospital
- At least one local health and facility per district: Health Post (HP), Basic Health Services Centre (BHSC), or Urban Health Centre (UHC)

3. Field Team Deployment

Group	Team Members	District(s)	Maximum Days	Facilities to Visit	Activities	Remarks
Group 1	Om Prakash Joshi Kamala Bist Santosh Pandey	Kanchanpur	4	HO, District Hospital/provincial hospital, one Local level, Health Facility per district (HP/BHSC/UHC)	Qualitative KII, TNA Quantitative Follow-up, Effectiveness Study Follow-up	• Depends on flexibility and time of members (6) • For Kailali Tikapur municipality
	Hem Raj Khadka Kamala Bist Binod Dhimi Maan Bahadur Madai	Kailali	4	HO, District Hospital/provincial hospital, one Local level, Health Facility per district (HP/BHSC/UHC)	Qualitative KII, TNA Quantitative Follow-up, Effectiveness Study Follow-up	
Group 2	Hem Raj Khadka Santosh Pandey Tilak Singh Karki/Binod Dhimi	Dadeldhura	5	HO, District Hospital/provincial hospital, one Local level, Health Facility per district (HP/BHSC/UHC)	Qualitative KII, TNA Quantitative Follow-up, Effectiveness Study Follow-up	
Group 3	Nirav Lekhak Samir Singh	Bajhang Baitadi Darchula	5	HO, District Hospital/provincial hospital, one Local level,	Qualitative KII, TNA Quantitative Follow-up, Effectiveness Study Follow-up	

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Scanned with CamScanner

Group	Team Members	District(s)	Maximum Days	Facilities to Visit	Activities	Remarks
	Sudip Okheda/Bhoj Raj Kalauni			Health Facility per district (HP/BHSC/UH C)		
Group 4	Som Raj Karki Dev Raj Jaishi Bhoj Raj Kalauni	Doti Accham Bajura	7 2	HO, District Hospital/provin cial hospital, one Local level, Health Facility per district (HP/BHSC/UH C) district (HP/BHSC/UH C)	Qualitative KII, TNA Quantitative Follow- up, Effectiveness Study Follow-up	

4. Data Collection

4.1 Key Informant Interviews (KIIs)

- Conduct interviews with the Health Office Chief, Medical Superintendent, and Local Level Health Coordinator for a minimum of two interviews per district.
- All interviews must be audio-recorded with prior verbal consent from the participant.
- Transcribe recordings verbatim in written Nepali without alteration or paraphrasing.

4.2 TNA Quantitative Follow-up

- Follow up with health workers to ensure complete submission of TNA Google Forms.
- Use in-person visits, phone calls, social media, stakeholders as needed.

4.3 Effectiveness Study Follow-up

- Conduct structured follow-up with health workers who attended prior training programmes using the standardized follow-up tool.

5. Deliverables

All deliverables must be submitted to the study coordinator within 7 days of completing fieldwork:

- Audio recordings of all KIIs.
- Verbatim Nepali transcripts for each recording in editable digital format
- Field photographs from interview sessions and facility visits (minimum 3 per district)
- Travel order and all associated bills (transport, daily allowance)
- Completed Google Forms tracking log for all targeted health workers

6. Ethical Considerations

- Participation is voluntary; informed verbal consent must be obtained before recording.
- All data shall be stored securely and accessed only by authorised team members.

Group	Team Members	District(s)	Maximum Days	Facilities to Visit	Activities	Remarks
	Sudip Okheda/Bhoj Raj Kalauni			Health Facility per district (HP/BHSC/UH C)		
Group 4	Som Raj Karki Dev Raj Jaishi Bhoj Raj Kalauni	Doti Accham Bajura	7	HO, District Hospital/provin cial hospital, one Local level, Health Facility per district (HP/BHSC/UH C) district (HP/BHSC/UH C)	Qualitative KII, TNA Quantitative Follow- up, Effectiveness Study Follow-up	

4. Data Collection

4.1 Key Informant Interviews (KIIs)

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- Completed Google Forms tracking log for all targeted health workers

6. Ethical Considerations

- Participation is voluntary; informed verbal consent must be obtained before recording.
- All data shall be stored securely and accessed only by authorised team members.

Annex 4: Transcription of qualitative Interviews (sample transcript only included)

Transcription 1:

Q: पालिका स्तर बाट दिइने सेवाहरु वा कार्यक्रम को लक्ष्य हासिल गर्न केहि कठिनाई भएको छ ? समस्या हरु कुन कुन कार्यक्रममा भैरहेको छ ?

- खोप कार्यक्रमको target meet भैराको छैन , माथिल्लो तहबाट target बढेर आउँछ तर तल्लो तहमा achievement meet हुन सक्दैन अनि शत प्रतिशत delivery हुन गारो भैराको छ भौगोलिक कठिनाइले गर्दा अझै पनि home delivery भईराको छ , यो पालि पनि हाम्रो पालिका मा ८ वटा home delivery भएको छ |

Q: तालिमको अभावले समस्या भएको हो ? SBA को कमि हो ?

- SBA को कमि छैन ,एउटा संस्थामा २ जना overall हामी संग छन् , ७ वटा संस्थामा १४ जना SBA हुनुहुन्छ

Q: आउदो आर्थिक वर्षमा कुन कुन तालिमहरु आको भए हुन्थ्यो जस्तो लाग्छ ?

- तालिम मा MLP (Mid Level Practicum) ani CNSI अनि सेवाकालीन तालिम

Q: तालिम नभएकै कारणले कुनै सेवाहरु अवरुद्ध भयको छन् ?

- अरु त केहि छैन एउटा PAMS V2 मा चाही समस्या आइराको छ |

Q: Mental health ,NCDs को तालिम हरु कतिको आवश्यकता छ ?

- प्रत्येक संस्थाले mental healthको तालिम पाइसकेको छ अनि डाक्टर ले पनि तालिम लिनुभएको छ mental health को

Q: कुन जनशक्ति लाइ बढी तालिमको खाचो छ जस्तो लाग्छ ?

- Nursing र paramedics दुवै लाइ छ

Q: यो पालिकामा अरु केहि प्रमुख समस्या हरु ?

- Home delivery को नै बढी समस्या छ |

Q: Google form को result अनुसार PAMSV2, Mental health ,SBA ,Implant जस्ता तालिम चाहियो भन्नुभाको छ ,के यसको आवश्यकता साचिकै छ ?

- यसको आवश्यकता हो , अहिले PAMSV2 नया आएकाले यसको आवश्यकता छ

Q: पहिले देखि नै चली आएका तालिमहरु जस्तै CBIMNCI, IMPLANT,Mental health, CNSI जस्ता तालिमहरुको आवश्यकता छ भन्नु साचिकै आवश्यकता हो त ?

- यसको कारण चाहि सबै कर्मचारी ले तालिम पायो भने चै कुनै कर्मचारी बिदामा बस्यो भने अरु कर्मचारीले पनि सेवा दिन सक्नु भनेर हो

Q: तालिम केन्द्र बाट कस्तो अपेक्षा छ ?

- तालिम केन्द्र बाट राम्रै अपेक्षा छ ,राष्ट्रिय तालिम केन्द्र बाट तालिमहरु आइरको हुन्छन कहिलेकाही स्वास्थ्य कार्यालय बाट तालिमहरु आइरको हुन्छन अब PAMSV2 र MLP लाइ बिशेष focus गरिदिनुहोला पालिका तिर चै

Transcription 2: Health Office,

बैतडी मा कुन कुन कार्यक्रम मा लक्ष्य हासिल गर्न कठिनाई भैरहेको छ ?

- बैतडीमा कक्ष्य हासिल गर्न कठिनाई भैरहेको Neonatal mortality rate घटाउन सकिरहेको छैन अनि परिवार नियोजन सम्बन्धी जुन CPR(Contraceptive prevalence rate) छ जुन ६० पुर्याउन पर्ने छ त्यसमा पनि हामि चुकिरहेका छौं त्यसैगरी अन्य disease control and prevention को अनि mental health र NCD को जति Screening गर्नुपर्ने हो त्यति गर्न सकिरहेका छैनौं , RH morbidity , cervical cancer screening , breast cancer screening

,uterus prolapse screening र management सके अनुसार गर्न सकेको छैनौं अनि TB program को पनि जति case हरु identity गर्नुपर्ने हो त्यसको ५० प्रतिशत पनि target achieve गर्न सकिरहेको छैन

सेवा दिने सेवाप्रदायको कुन skill हरु meet गर्न हामीले तालिमहरु आयोजना गर्नुपर्ने देखिन्छ ?

- मुख्यतया हामीलाई clinical competency नै चाहिने हो , जस्तो cervical cancer को लागी pre canceral region identify गर्ने जनसक्ति चाहियो , TB screening को लागी अनि uterine prolapse screening को लागी ANM हरु चाहियो त्यसैगरी NMR घटाउन सम्पूर्ण Nursing staff लाई तालिमको आवश्यकता छ

बैतडी जिल्ला मा मुख्य रुपमा आवश्यक रहेका तालिम हरु कुन कुन हुन् ? कुनै ५ वटा तालिम

- Nursing staff को लागी SBA training, Medical Abortion training, CBIMNCI Training, (with refresher training) ,NCDs training (most important) , Geriatric Service Training अनि RH morbidity

कुन cadre को स्वास्थ्यकर्मी लाई तालिमको बाढी आवश्यकता छ ?

- Need चै बढी nursing कर्मचारी लाई नै बढी देखियो छ ,Nursing कर्मचारीको अभाव छ

Q: Google form बाट प्राप्त result अनुसार बैतडी जिल्ला मा PAMSV2, SBA , IMPLANT, Mental health, MLP, ASRH ,ENT,CSNI पनि छ , यो training haru कतिको समय सान्दर्भिक छ ?

- सबै ठिकै छ , Logistic management को लागी PAMSV2 आवश्यक छ CNSI training पनि नया आउनुभएको कर्मचारीले पाउनुभएको छैन , पायका हरुको पनि गुणस्तर भयको छैन , यो तालिम पालिका स्तर बाट चल्ने भयर त्यति गुणस्तरीय भएको छैन , यस्तो लामो तालिम हरुलाई स्थानीय मा भन्दा पनि जिल्ला मा आराखेको भए हुन्थ्यो होला , कुनै पनि तालिमहरुको refresher तालिम हुन पनि आवश्यक छ

Q: Regularly भईरहेको तालिम हरु मा पनि धेरैले आवश्यक छ भन्नुको कारण के होला ?

- तालिम सिकाइको कुरा पनि एउटा छ अनि अर्को भनेको आर्थिक हिसाब सित पनि जोडीएको छ | हामि सित कल्ले कति तालिम लियो भन्ने कुराको तथ्याडक पनि छैन ,TEAMS को Access पनि तालिम केन्द्र भन्दा भाहिर आएन ,त्यहि भएर कुनै स्वास्थ्य कर्मीले SAME तालिम incentive को रुपमा पनि लियोको भएर माग बढ्नु स्वाभाविक हो

Q: तपाईंको अरु के के सुझावहरु छ ?

- प्रमुख सुझावहरु भन्दा orientation जस्ता कार्यक्रम लाई digitalization गर्नुपर्छ ,यसो गर्दा कम resource बाट बढी outcome लिन सकिन्छ , अहिले NCDs को burden बढी भएकाले तालिम हरु पनि नसर्ने रोगहरु तिर बढी हुन आवश्यक छ , बोलाएर तालिम दिनभन्दा onsite coaching हरु पनि दिन सकिन्छ अनि हाम्रो दरबन्दी संरचना पनि परिवर्तन गर्न आवश्यक छ , दरबन्दी संरचना चै १: ४ को अनुपात मा हुन आवश्यक छ जस्तो कि चौथो तहको ४ जना भय भने पाँचौ को चाही १ जना हुन पर्छ , अनि तालिम हरु चै blended approach मा हुन आवश्यक छ अनि तालिममा सरकारले लगानी बढाउन आवश्यक छ अनि सबै स्वास्थ्य सम्बन्धी हुने तालिमको विवरण र तथ्यांक तालिम केन्द्र ले राख्नु पर्छ , अनि तालिम प्राप्त प्रशिक्षक पनि पहिचान गर्नु पर्दछ

Transcription 3: Bajura Health office

Q: यस बाजुरा जिल्लामा कुन कुन कार्यक्रममा सेवा दिन वा लक्ष्य हासिल गर्न कठिनाई भईरहेको छ ?

सेवाको कुरामा nutrition मा पनि समस्या नै छ ,training को पाटो मा CNSI को तालिम हरु पहिला सबै लिएको छ तर तालिम लिएर चै service provide भयको छैन केहि कुराहरु खाध्य बस्तुको अभाव सित जोडीएका छन् अनि अर्को family planning मा समस्या छ कुनै संस्थाहरु विस्तार हुदा खेरी कुनै trained manpower छोडेर गएको र संस्थाहरुले नया कर्मचारी recruit गरेको छ ,संस्था हरु धेरै छन् तर ५ वटै family planning कै device उपलब्ध गराउने संस्था हरु एउटा पनि छैन जस्तै implant iucd तालिम लेको manpower को कमि भयर service दिन सकेको छैन | पछिल्लो अबस्था मा यो SBA को पनि कमि छ पहिलेको SBA तालिम प्राप्त हरुले छोडीसक्नुभयो र अहिले SBA training कम हुने भयकाले नया recruit गरेकाले SBA तालिम पायको छैन अनि पछिल्लो समयमा यो HIV सम्बन्धी PMTCT को तालिम हरु पनि कमि भयको छ |

Q: अबको आर्थिक वर्षमा हेर्ने हो भने बाजुरा जिल्लामा कुन तालिमलाई प्राथमिकता मा राख्दा ठिक होला तालिम केन्द्रले ? SBA लाई पहिले प्राथमिकता मा राख्ने पर्ने देखिन्छ अनि family planning मा Implant र IUCD

Q: नसर्ने रोग र मानसिक रोग को आवश्यकता कतिको छ ?

त्यो एकदमै आवश्यक छ अहिले समस्या भनेकै गाउँ तिर र प्राय सबै बस्ति हरु तिर ४, ५ जना जति cancer को बिरामी हरु छन् अनि hypertension र diabetes को बिरामी हरु पनि बढिरहेका छन् अनि यता बाट जति औषधि दिएपनि पुग्दैन अनि psychiatric training पनि एकदमै आवश्यक छ अनि anxiety , depression मा पर्नेहरुको संख्या पनि बढिरहेको छ

Q: सेवाप्रवाहको आधारमा कुन तहको कर्मचारी लाई बढी तालिमको आवश्यकता छ कुन स्वास्थ्यकर्मी हरुले कम तालिम पायको छन् ?

Mid level को जनशक्ति लाई तालिमको बढी आवश्यकता देखिन्छ विशेष गरि आधारभूत स्वास्थ्यसेवा मा AHW, ANM ,HA ,staff nurse हरु लाई बढी तालिमको आवश्यकता छ र अनि Diagnostic पनि laboratory को पनि TB को तालिम को आवश्यकता छ जस्तो TB microscopy

Q: बाजुरा जिल्लाको हक मा त्यस्तो केहि चुनौती हरु छन् कुन तालिम दिएर समाधान गर्न सकिन्छ ?

तालिम दिएर समाधान गर्न सकिने भनेको एउटा psychiatric training आवश्यक छ

Q: Google form को result अनुसार PAMSV2, mental health , Implant को तालिम चाहियो भन्ने धेरै हुनुहुन्छ के साचिकै यहि तालिम हरु आवश्यक हो त ?

PAMSV2 directly स्वास्थ्यसेवा सित नजोडीए पनि आवश्यक छ र हाम्रो जिल्लामा सबै पालिका तिर यो सुरुवात भैसकेको छ हाम्रो सुब्बा साब ले पनि पालिकामै पुगेर PAMSV2 को तालिम दिरहुनु भएको छ र अरु mental health , implant र IUCD यी तालिम हरु चाही बढी आवश्यक छन् |

Q: IMPLANT, IUCD को तालिमहरु पहिला धेरै चोटी चलिआएको हो धेरै कर्मचारीले पाउनुभएको पनि हो , पाउनुभएकोले छोडेर नयाले मागेको होकी के छ यसमा ?

यसमा दुइटा कुरा छ पहिलो कुरा पाएको मान्छेले छोडेर नयाले माग्छन अनि अर्को कुरा कर्मचारीको विवरणमा पनि समस्या छ training लिन्छन training को विवरण हामीसित हुन दुइचार महिना पछी उसले training लिएको छैन भन्छ अनि कर्मचारीको वितरण पनि पालिकाले आफ्नै तरिकाले गरेको छ कुनै स्वास्थ्यकर्मीले कुनै पनि तालिम नलेको लाई पठाको छ भने कुनै मा चै एउटै स्वास्थ्य संस्थामा दुइ भन्दा बढी कर्मचारीले एउटै तालिम लेको छन्

Q: तालिम केन्द्र लाई के के सुझावाहरु दिन चाहनुहुन्छ ?

तालिम केन्द्रले कर्मचारीले कुन कुन तालिम लेको छ भन्ने कुराको विवरण राख्न पर्छ कुन तालिम कहिले र कसले लियो भन्ने कुराको विवरण राख्न पर्छ अनि दोस्रो कुरा हामिले मनोनयन गछौँ तर हामीले चिठी प्राप्त गर्नु भन्दा अगाडी नै व्यक्ति लाई खबर गैसकेको

हुन्छ यो कुरापनि तालिम केन्द्र ले समाधान गर्नु पर्यो अनि तालिम दिसकेपछि तालिमको result हेर्नुपर्यो उसले काम गरेको छ कि छैन अनि उ चै कस्तो संस्थामा छ त्यो कुरा पनि हामीले follow up गर्न पायो भने राम्रो हुन्थ्यो ।

धन्यवाद

Transcription 4: District Hospital Bajhang

I: यो अस्पतालमा कुन कुन cadre का स्वास्थ्यकर्मीहरु हुनुहुन्छ?

P: सबै किसिमका स्वास्थ्यकर्मीहरु हुनुहुन्छ, जस्तै डाक्टर, नर्स (P.C.L, B.N), paramedics तर्फ, HA, AHW, laboratory तर्फ सहायक, technician, officer, pharmacy, physiotherapy आदि हुनुहुन्छ।

I: हजुर, स्वास्थ्यकर्मीको ज्ञान वा सीपको कमीले गर्दा अस्पतालले दिने सेवामा कुनै कमी महसुस गर्नुभएको छ र सर?

P: सेवा दिने क्रममा कठिनाई त धेरै छैन, एक जना स्वास्थ्यकर्मीले दिने सेवा उहाँ नहुँदा अर्को स्वास्थ्यकर्मीले दिइरहेको अवस्था छ, कुनै एक जना स्वास्थ्यकर्मीको ज्ञान तथा सीपको कमीले गर्दा सेवा नै अवरोध हुने अवस्था त छैन, तर उहाको सट्टा बढी ज्ञान तथा सीप भएको स्वास्थ्यकर्मीबाट सेवा उपलब्ध गराइरहेका छौं। जो स्वास्थ्यकर्मीहरु तुलनात्मक रुपमा कमजोर हुनुहुन्छ, उहाँहरुको gap पहिचान गर्नलाई assessment पनि गर्ने गरेका छौं। हामीले यहि बैशाखमा एउटा tool बनाएका छौं, यहि बैशाख देखि नियमित रुपमा प्राविधिक स्वास्थ्यकर्मीहरु जस्तै नर्स, ल्याब, फार्मसीहरुको मासिक परिक्षण पनि गर्ने गरेका छौं। उहाँहरुले विभिन्न सूचांकमा स्व-मुल्यांकन पनि गर्नुहुन्छ र हरेक स्वास्थ्यकर्मीको supervisor ले पनि मुल्यांकन गर्छन्, र स्व-मुल्यांकन र supervisor ले गर्ने मुल्यांकनको आधारमा final score निकाल्छौं, र त्यसको आधारमा gap पत्ता लगाएर सो सम्बन्धी तालिम दिने हाम्रो योजना छ। र व्यक्तिगत तहमा क्षमता अभिवृद्धीका तालिमहरु आवश्यक छन्।

I: त्यो परिक्षणबाट केहि gaps पत्ता लाग्यो र सर?

P: हामीले यहि वैशाखबाट सुरु गरेको भएर अहिले नै त्यस्तो gap identify त भएका छैनन्। अब हामी हरेक महिनाको अन्तिममा परिक्षणलाई निरन्तरता दिने योजनामा छौं। र त्यसका आधारमा कुन-कुन पक्षमा gap देखियो, हामीले समाधान गर्न सकिने जस्तै परामर्श सेवा सम्बन्धी, recording-reporting सम्बन्धी, infection-prevention सम्बन्धी भए हामी आफै तालिम संचालन गर्नेछौं, र जटिल खालका भए त्यससम्बन्धी तालिमहरु माग गर्नेछौं।

I: हरेक cadre का लागि छुट्टाछुट्टै tool बनाउनु भएको छ कि सबैलाई एउटै tool छ?

P: हजुर, हरेक cadre का लागि छुट्टाछुट्टै tool बनाएका छौं। र केहि major finding आए हामी स्वास्थ्य तालिम केन्द्र, धनगढीसंग पनि share गर्नेछौं।

I: यस अस्पतालमा कुन-कुन cadre का स्वास्थ्यकर्मीहरुलाई कुनै विशेष तालिमहरु आवश्यकता पहिचान गर्नुभएको छ र सर?

P: छ नि। हाम्रो अस्पतालमा सबैभन्दा तालिमहरु कम पाएका हाम्रो pharmacy मा कार्यरत स्वास्थ्यकर्मीहरु हुन्, उहाहरुलाई stock analysis, store management, disposal सम्बन्धी तालिम दिनुपर्ने जस्तो देखिन्छ। त्यसै गरी nursing लाई पनि तालिमहरु आवश्यक छन्, किनकि उहाँहरु विभिन्न खालका स्वास्थ्य समस्याहरु भएका बिरामीहरु जस्तै शल्यक्रियाहरु, मानसिक स्वास्थ्यका बिरामीहरु, trauma का बिरामीहरुलाई सेवा दिने भएका भएर सबैलाई rotation मा तालिमहरु दिने सके राम्रो हुन्थ्यो, जस्तै SBA

training, ICU training (हामीसंग MDGP, anesthesiologist छन् ICU का उपकरणहरु पनि छन्, तर nurses नभएका कारणले गर्दा ICU संचालन गर्न सकिरहेका छैनौं हामीले। पहिलो कुरा नर्सहरु कम छन्, झन् ICU तालिम पाएका नर्सहरु छैनन्। अब हामीलाई ICU तालिमको एकदमै आवश्यकता छ। त्यसै गरी स्वास्थ्य तथा जनसंख्या मन्त्रालयले जलन वार्ड स्थापना गर्ने, जलन उपचार केन्द्र संचालन गर्ने भन्ने नीति छ, त्यसका लागि जलनको तालिम नर्स तथा मेडिकल अफिसरहरुको लागि तालिम दिन आवश्यक छ। यसै गरी सरकारले मानसिक स्वास्थ्यलाई प्राथमिकतामा राखेको भएर नर्सहरुलाई मानसिक स्वास्थ्यसम्बन्धी र परामर्शसम्बन्धी तालिम पनि आवश्यक देखिन्छ। त्यसै गरी Infection-prevention को तालिम अस्पतालले आफैले संचालन गर्ने गरी व्यवस्था गरिनुपर्छ। त्यसैगरी ल्याबका स्वास्थ्यकर्मीहरुलाई blood transfusion तालिम चाहिन्छ, ER तिर trauma र Basic emergency care तालिम एकदमै आवश्यक छ। र मेडिकल अफिसरहरुलाई नयाँ थप्नुपर्ने ICU र जलनजस्ता तालिमहरु आवश्यक छन्।

I: त्यसै गरी जिल्ला तहमा आवश्यक पर्ने तालिमहरु पनि भनिदिनुहोस न।

P: जिल्ला तहमा कुरा गर्दा खेरि सबैभन्दा महत्वपूर्ण त SBA नै हो, अनि त्यसै गरी obstetrics सम्बन्धी onsite coaching & mentoring चाहिन्छ, स्थानीय तहमा कार्यरत स्वास्थ्यकर्मीलाई basic emergency care र trauma care training एकदमै आवश्यक छ,

I: तालिम केन्द्रलाई केहि सुझावहरु छन् र सर हजुरको तर्फबाट?

P: छ, एकदमै धेरै सुझाव छन्।

I: के-के छन्, भन्नुहोस न।

P: अहिले भइरहेका राम्रा प्रयासहरुलाई एकदमै तारिफ योग्य छ नै छन् जस्तै तालिमभन्दा अगाडी मनोनयन मान्ने, त्यसअनुसारले सहभागीहरुलाई तालिममा बोलाउने, त्यस्ता प्रयासहरुको लागि धेरै धेरै धन्यवाद। तर तालिममा सहभागी बोलाउँदा एउटा स्वास्थ्य संस्थाका सबै स्वास्थ्यकर्मीलाई संगै बोलाइदिने गर्नुहुन्छ कहिलेकाही, त्यस्तो गरिदिनु भएन, सकिन्छ भने स्वास्थ्य संस्थाहरुबाट पायक पर्ने समय लिएर तालिम संचालन गरौं, अब त्यो सम्भव भएन भने तालिम संचालन हुनुभन्दा केहि समय अगाडी खबर गर्दा राम्रो हुन्थ्यो, त्यसका लागि वार्षिक तालिका बनाएर हामीलाई दिनुभयो भने कुन cadre लाई कुन तालिम हुदैछ भन्ने थाहा भएपछी त्यहि अनुसार मानव संसाधन व्यवस्थापन गर्न सकिन्थ्यो, त्यसै गरी तालिम लिइसकेपछि सहभागीले आफैले कुनै तालिम संचालन गरेमा, CME संचालन गरेमा अथवा निर्धारित सेवा दिए पछी मात्रै तालिमको प्रमाणपत्र दिने व्यवस्थालाई एकदमै अनिवार्य गरिदिनुपर्छ। निर्धारित सेवा प्रदान गर्यो कि गरेन भनेर थाहा पाउनलाई key performance indicators बनाएर पनि थाहा पाउन सकिन्छ। र कृपया १/२ दिने तालिमहरु संचालन गर्नेपर्ने भए अरु तालिमहरु जोडेर गरिदिनुहोस्, यसले मानव संसाधन व्यवस्थापन गर्न सजिलो हुनुका साथै राज्यको खर्च पनि घटाउनमा मद्दत पुग्छ।

I: धेरै जानकारी आइसक्यो, त्यसका लागि यहाँलाई धेरै धेरै धन्यवाद।

P: धन्यवाद।

English translation of District Hospital Bajhang

I (Interviewer): Which cadres of health workers do you have in this hospital?

P (Participant): We have all types of health workers; for example, doctors, nurses (P.C.L, B.N), from the paramedics side: HA (Health Assistant), AHW (Auxiliary Health Worker), from the laboratory side: assistants, technicians, officers, as well as pharmacy, physiotherapy, etc.

I: Yes. Have you experienced any shortcomings in the services provided by the hospital due to a lack of knowledge or skills among the health workers, Sir?

P: There aren't many difficulties in the course of providing services. If one health worker who provides a service is absent, another health worker steps in to provide it. The situation is not such that services are disrupted due to a single health worker's lack of knowledge and skills; rather, we provide the service through another health worker who has more knowledge and skills instead.

For those health workers who are comparatively weaker, we also perform assessments to identify their gaps. Just this Baisakh (April/May), we developed a tool, and since this Baisakh, we have been conducting regular monthly testing for technical health staff such as nurses, lab, and pharmacy personnel. They perform self-evaluations across various indicators, and each health worker's supervisor also evaluates them. Based on the self-evaluation and the supervisor's evaluation, we calculate a final score. Our plan is to identify gaps based on that score and provide relevant training. At an individual level, capacity-building trainings are essential.

I: Did that testing reveal any gaps, Sir?

P: Since we just started this in Baisakh, such gaps have not been identified just yet. We now plan to continue this testing at the end of every month. Based on that, whatever gaps are visible across various aspects—if they are issues we can solve ourselves, such as those related to counseling services, recording-reporting, or infection prevention—we will conduct the training ourselves. If they are complex in nature, we will request relevant trainings [from higher authorities].

I: Have you created separate tools for each cadre, or is there a single tool for everyone?

P: Yes, we have developed separate tools for each cadre. If any major findings emerge, we will also share them with the Health Training Center in Dhangadhi.

I: In this hospital, have you identified specific training needs for any particular cadres of health workers, Sir?

P: Yes, I have. In our hospital, the health workers who have received the least amount of training are those working in our pharmacy. It appears necessary to provide them with training on stock analysis, store management, and disposal. Similarly, trainings are also required for nursing staff because they provide services to patients with various types of health issues, such as surgeries, mental health patients, and trauma patients. It would be excellent if we could provide them with trainings on a rotation basis—for instance, SBA (Skilled Birth Attendant) training and ICU training.

We have MDGPs (General Practitioners) and anesthesiologists, and we also have ICU equipment, but we haven't been able to operate the ICU due to a lack of nurses. First of all, nurses are in short supply, and moreover, there are no nurses who have received ICU training. Right now, we desperately need ICU training.

Similarly, the Ministry of Health and Population has a policy to establish burn wards and operate burn treatment centers; for that, it is necessary to provide burn management training to nurses and medical officers. Likewise, since the government has placed mental health as a priority, training related to mental health and counseling also appears necessary for nurses. In the same way, arrangements should be made so that the hospital itself can conduct Infection Prevention training. Additionally, laboratory health workers need blood transfusion training, and over in the ER, trauma and Basic Emergency Care training are highly necessary. For medical officers, newly added trainings such as ICU and burn management are required.

I: Along those lines, could you also mention the trainings required at the district level?

P: Speaking of the district level, the most important one is SBA itself. Then, similarly, onsite coaching and mentoring regarding obstetrics is required. Basic emergency care and trauma care training are extremely necessary for health workers working at the local level.

I: Do you have any suggestions for the training center from your end, Sir?

P: Yes, I have quite a lot of suggestions.

I: What are they? Please share them.

P: The current good initiatives are certainly highly commendable—such as requesting nominations before a training and inviting participants to the training accordingly. Thank you very much for those efforts.

However, when inviting participants for training, sometimes you end up calling all the health workers from a single health facility at the same time; that should not be done. If possible, let's conduct trainings by taking convenient timing from the health facilities. Now, if that is not possible, it would be better to inform us some time before conducting the training. For that, if you could prepare an annual calendar and give it to us, we would know which cadre is undergoing which training and could manage our human resources accordingly.

Furthermore, after completing a training, the system of issuing a training certificate must be made absolutely mandatory only after the participant conducts a training themselves, conducts a CME (Continuing Medical Education), or provides the designated service. To know whether they provided the designated service or not, it can also be tracked by creating Key Performance Indicators (KPIs).

And please, if 1 or 2-day trainings must be conducted, please package them together with other trainings. This will not only make human resource management easier but will also help reduce state expenditure.

I: A lot of information has been provided, thank you very much for that, Sir.

Transcription 5 : Health Office Bajhang

I: बझाङ जिल्लाको संदर्भमा आम जनताले कुन-कुन सेवाहरू प्राप्त गर्नमा कठिनाई महसुस गर्नुभएको छ यहाँले, ती सेवाहरू मानव संसाधनको ज्ञान तथा सीपमा भएको कमीले गर्दा कठिनाई भएका हुन् कि अथवा अन्य कुनै कारणले हुन्, र ती कठिनाईलाई सम्बन्धन गर्न कुन कन तालिमहरूको आवश्यकता होला सर?

P: यसमा, प्राथमिक तहमा परिवार नियोजनसम्बन्धी तालिमहरू जस्तै minilap, vasectomy जस्ता तालिमहरू आवश्यक देखिन्छन्, किनकि तालिम लिएका स्वास्थ्यकर्मीहरू केहि समय राम्ररी सेवा गर्न नपाएर छिटै turnover भएर जान्छन्। SBA तालिम पनि आवश्यक छ, समुदायमा मानसिक स्वास्थ्य सेवाहरू पनि विस्तार गर्न सकिएको छैन, जसकारण मानसिक स्वास्थ्य सम्बन्धी तालिम चाहिएको छ। Mid-level practicum तालिम (२ हप्ता) पनि जरुरी छ जिल्लामा। Essential skills को तालिमहरू चलाउन आवश्यक छ। ज्येष्ठ नागरीक तालिम, परिवार नियोजन, PEN तालिम पनि प्रदान गर्नुपर्नेछ।

I: यस कार्यालयबाट कुन-कुन तालिमहरू संचालन हुने गर्छन्?

P: यहाबाट खोपको आधारभूत तालिम, CBIMNCI तालिम, क्षयरोगको modular तालिम, ENT, Basic Health Services, SORMAS, DHIS-२ तालिम संचालन गर्ने गर्छौं।

I: हाम्रो बझाङ जिल्लाको संदर्भमा थप कुन-कुन आवश्यक पर्ने देखिन्छ त?

P: हामीलाई पोषणको तालिम चाहिएको छ, किनकि indicators सन्तोषजनक छैनन् पोषणका।

I: यहाँको तर्फबाट तालिम केन्द्रलाई केहि सुझाव छ भने भन्नुहोस् न।

P: कहिलेकाही सेवा दिने स्वास्थ्यकर्मीहरू (cadre) र त्यस सेवासम्बन्धी तालिम प्राप्त गर्ने स्वास्थ्यकर्मीहरू (cadre) फरक हुन्छन्, र त्यसै गरी स्वास्थ्यकर्मीको क्षमता मुल्यांकन गर्ने व्यवस्था पनि छैन। तालिमहरू पनि दरबन्दीलाई मध्यनजर गरेर संचालन गर्नुपर्छ। एउटा सुधारार्थ कुरा के छ भने स्वास्थ्यकर्मी तालिम लिएर आए पनि vein open गर्न नजान्ने पनि हुन्छन्, उहाहरूको ज्ञान तथा सीप निरन्तर रूपमा परिक्षण गरिनुपर्छ। हाम्रो सुदूरपश्चिमको सन्दर्भमा मिल्ने तालिम सामग्री बनाउन अवश्यक छ, यहाँको specific gap पत्ता लगाएर। तालिमहरू design गर्दा हाम्रो प्रदेशका issue मा आधारित हुनुपर्छ, data-driven हुनुपर्छ, evidence based हुनुपर्छ, जुन-जुन संघबाट स्वीकृत हुन्छन्, ती मात्रै संचालन गर्नुपर्छ भन्ने छैन। तालिम संचालन गर्दा case-study present पनि गर्नुपर्छ। त्यसै गरी अनुभव share गर्ने पनि गराउनु पर्छ, performance appraisal पनि गर्ने गर्नुपर्छ। तालिमहरूलाई SDGs संग पनि जोड्नुपर्छ। स्थानीय तहले कुन-कुन तालिम संचालन गर्ने भनेर छट्टाउनु पर्छ। तालिमका प्रशिक्षकले पनि सिकेका कुराहरू आफ्नो व्यवहारमा लागु गर्नुपर्नेछ। तालिमहरूले देशको राजस्व बढाउन सक्नु हुनुपर्छ।

I (Interviewer): In the context of Bajhang district, what specific services have the general public experienced difficulty in accessing, according to your observation? Are these difficulties due to a lack of knowledge and skills in human resources, or are they due to some other reasons? And what specific trainings would be required to address these difficulties, Sir?

P (Participant): Regarding this, at the primary level, family planning trainings such as minilap and vasectomy appear to be necessary, because the trained health workers get turned over quickly without getting to provide services properly for a reasonable duration. SBA (Skilled Birth Attendant) training is also necessary. Mental health services have also not been expanded in the community, due to which training related to mental health is required. A mid-level practicum training (2 weeks) is also essential in the district. It is necessary to conduct trainings on essential skills. Senior citizen training, family planning, and PEN (Package of Essential Non-Communicable Diseases) training also need to be provided.

I: What specific trainings are usually conducted by this office?

P: From here, we conduct basic immunization training, CBIMNCI (Community-Based Integrated Management of Neonatal and Childhood Illness) training, tuberculosis modular training, ENT, Basic Health Services, SORMAS (Surveillance Outbreak Response Management and Analysis System), and DHIS-2 (District Health Information Software 2) training.

I: In the context of our Bajhang district, what additional [trainings] seem to be required then?

P: We need nutrition training because the nutrition indicators are not satisfactory.

I: Do you have any suggestions for the training center from your end? Please share them.

P: Sometimes, the health workers providing the services (cadre) and the health workers receiving the training for those services (cadre) are different. Similarly, there is no system in place to evaluate the competency of health workers. Trainings also need to be conducted keeping the sanctioned posts (darbandi) in mind. One area that needs improvement is that even after returning from training, some health workers do not know how to insert an IV line; their knowledge and skills must be continuously tested.

In the context of our Sudurpashchim [Province], it is necessary to develop matching training materials by identifying the specific gaps here. When designing trainings, they must be based on our province's issues, must be data-driven, and must be evidence-based; it shouldn't be that we only conduct those that are approved by the federal level. Case studies must also be presented while conducting training. Likewise, experience sharing should be facilitated, and performance appraisal should also be conducted. Trainings must also be linked with SDGs (Sustainable Development Goals). The local levels must clearly separate which specific trainings they will operate. Training instructors must also apply the things they have learned into their own practice. Ultimately, trainings must be able to increase the country's revenue.

Annex 3: Contributor List

Name	Position	Organization
Narendra Singh Karki	Director General	Health Training Center, Dhangadi Kailali
Kumari Kamala Bist	Nursing Administrator	Seti Provincial Hospital, Kaillai
Hem Raj Khadka	Health Education Administrator	Health Training Center, Dhangadi Kailali
Om Prakash Joshi	Public Health administrator	Health Training Center, Dhangadi Kailali
Dev Raj Jaishi	Senior Account Officer	Health Training Center, Dhangadi Kailali
Bhoj Raj Kalauni	Public Health Officer	Health Training Center, Dhangadi Kailali
Nirav Lekhak	Public Health Officer	Health Training Center, Dhangadi Kailali
Sudeep Okheda	Public Health Officer	Health Training Center, Dhangadi Kailali
Santosh Pandey	Public Health Inspector	Ministry Of Social Development
Samir Singh	Public Health Officer	Health Training Center, Dhangadi Kailali
Som Raj Karki	Public Health Officer	Health Training Center, Dhangadi Kailali
Binod Dharni	Public health officer	Health office, kailali
Tilak Singh Karki	Health education technician	Health Training Center, Dhangadi Kailali
Maan Bahadur Madai	Public Health Inspector	Health Training Center, Dhangadi Kailali

Annex 4: Glimpses of field Visit



Photo: 1 Panchadewal Binayak Accham during Follow Up



Photo 2: Interview with Health Section Coordinator, Panchadewal, Accham



Photo 3: After Interview in Purbichauki Municipality, Doti





Photo : Follow up visit in District Hospital Bajura



Photo: Badimalika Municipality Health section Team, Bajura



Photo: Follow up in District Ayurvedic Hospital, Bajura



Photo: Follow up Visit in Health Institution of Bajura



Data Collection and Follow up in Darchula



Data Collection In Health office, Bajhang



Follow up Visit in Darchula





Follow up Visit in Baitadi



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