Background

Scaling up health care services is not possible without significant investments in in-service training (IST) to build the capability of health workers to competently, safely, and efficiently provide quality services. While IST has been widely seen as an effective way to enhance health workers’ competencies, many IST programs in Ethiopia have been found to be weak, including poor planning, coordination, and quality.

This brief describes the methodology and results of a 2012 PEPFAR supported rapid assessment of IST provided to health care workers in Ethiopia between January and December 2011 undertaken by the Federal Ministry of Health (FMOH) and the USAID Health Care Improvement Project (HCI), with technical assistance from the FMOH IST Technical Working Group (TWG). The findings were used to identify the strengths, weaknesses, and best practices in IST and inform the development of: 1) a database to track IST training and 2) a strategy to standardize and institutionalize IST.

Study Objectives

The assessment sought to analyze the IST situation in Ethiopia and provide evidence to inform policy, planning, and implementation to: 1) improve IST effectiveness, efficiency, and sustainability; and 2) standardize and institutionalize the practices that caused such improvement. In specific, the assessment aimed to:

- Analyze Ethiopia’s IST situation;
- Analyze IST provider practices in training design; delivery; follow-up/monitoring; evaluation; capacity building; standardization and institutionalization; tracking the trainings of health care workers by training recipient; and linkages among health care workers, community health workers, paraprofessional workers, program managers, and policy makers;
- Identify the strengths, weaknesses, and best practices in IST;
- Inform the development of a database for health sector in-service trainings; and
- Inform the development of a strategy for the standardization and institutionalization of health sector in-service trainings.

Methods

A cross-sectional design was used to collect data from bodies providing IST (referred in this report as IST providers) and key stakeholders. All IST providers identified by the FMOH and IST TWG were invited to participate in the study. Thirty-four (34) of 63 (55%) respondents representing IST providers completed self-administered on-line surveys using SurveyMonkey software and analyzed using SPSS. Of the 34 IST program providers, 32% were from local NGOs; 30% were from international NGOs; 21% were from public sector entities; and 15% represented such institutions as professional associations, multilateral organizations, and academia. Face-to-face interviews, using a structured open-ended questionnaire, were conducted with 20 key stakeholders, including representatives from the FMOH, regional health bureaus, IST program providers, professional associations, donors, and the private sector. From the 34 IST providers responding to the survey, details of a total of 72 IST programs offered in 2011 were submitted.

Key Findings

The assessment found that local and international NGOs were the main IST providers in Ethiopia. Numerous types of IST programs are being offered in the
country: among the organizations surveyed about 29 different types of IST programs were provided in 2011. However, training staff and resources are lacking. Nearly half the IST program providers did not have competent full-time equivalent (FTE) staff for training. With regard to resources and infrastructure, most IST program providers surveyed had computers and Internet access available for their staff, but only about half said that these facilities were available to trainees. About half of the providers (56%) had access to journals, however only one-third (32%) had them available for trainees. Only one-fifth (21%) of surveyed IST providers reported they had halls and classrooms for training (rooms were accessed at hotels and other venues) (Figure 1).

Of the 72 IST programs offered in 2011, HIV and AIDS programs were provided most frequently (28%), followed by communication skills (22%), and family planning (17%). No IST program covered human resources management, injuries and violence, or social work and care.

The assessment highlighted that recipients of trainings were most frequently nurses, health officers, and physicians. Rarely was IST training provided to staff from information systems, lab personnel, health extension workers, and midwives. Most (79%) IST providers had used pre-determined eligibility criteria to select trainees most of the time or all the time, but the stakeholders interviewed expressed doubts about how routinely this was practiced.

The median length of program duration was 40 hours. The average training program had 38% of its curriculum delivered through workplace-based learning. Distance learning and self-study were uncommonly used training modalities. Adaptation was the most frequently cited method of developing learning materials and curricula.

Only one-third (33%) of IST providers consistently extended technical assistance to build local capacity to provide training. In addition, partnership with professional societies was very low in delivering IST (5%). Three-quarters (74%) of respondents said that their IST programs were evaluated most of the time or always. Of those that evaluated their training, most were through knowledge pre-tests and post-tests. Evaluating performance and learning outcomes and obtaining feedback from the trainee’s supervisor were less common (Figure 2).

The assessment looked into the 16 best IST provider practices, asking survey respondents about the frequency with which each engaged in each practice on a five-point scale (“rarely” to “always”). The best practices that were reported most frequently to be always practiced related to describing to trainees the purpose of training and its objectives (79%), ensuring compliance with national efforts (71%), and having programs be formally recognized (59%). Those least likely to be “always” practiced related to providing technical assistance to build the capacity of other IST providers (15%), identifying barriers to performance to assess performance needs before programs are conducted (29%), and following up with trainees after the training to assess whether performance has improved (27%).

The report also presents scenarios of ideal provider practices that had been selected from the IST Improvement Framework and that the stakeholders were asked to comment on. For example, many providers (responding to the survey) claimed to have been authorized/accredited, but (interviewed) stakeholders called for better authorizing mechanisms. Similarly, 65% of survey respondents said they submit IST information to a training-tracking mechanism all or most of the time, but stakeholders suggested that such mechanism should be strengthened.

**Recommendations**

In reviewing the findings of this assessment at a workshop to develop a national strategic framework to improve IST, stakeholders including FMOH, regional health bureaus, IST providers, donors and technical assistance partners agreed on the following priority actions over the next five years: 1) designing/implementing an IST strategy; 2) standardizing IST; 3) accrediting and licensing IST; 4) setting IST monitoring and evaluation guidelines; 5) establishing an IST database (tracking mechanism); 6) setting IST policy direction; 7) institutionalizing IST; 8) ensuring the accountability and commitment of trainees to share their knowledge; 9) linking IST to pre-service trainings; and 10) getting key partners to work together. They also recommended a focus on program impact, cost, approaches to curriculum standardization, alternatives to off-the-job training, potential assistance from higher education institutions, and the tracking of IST data.