

<p><b>STANDARD SECTOR INDICATOR CODE:</b> HE-181-PEPFAR</p> <p><b>PEPFAR CODE:</b> H2.3.D</p>	<p><b>Health Care Workers Completing In-service Training:</b> Number of health care workers who successfully completed an in-service training program.</p>	
<p><b>HEALTH SECTOR</b></p>	<p><b>Sector Schematic Alignment</b></p> <ul style="list-style-type: none"> <li>• <b>Project Area:</b> Health Systems Strengthening             <ul style="list-style-type: none"> <li>○ <b>Project Activity Area/Training Package:</b> Health Systems Strengthening</li> </ul> </li> </ul>	
<p><b>Type:</b> Short-term Outcome</p>	<p><b>Unit of Measure:</b> Health Worker</p>	<p><b>Disaggregation</b></p> <p><b>Sex:</b> Male, Female  <b>Age:</b> 15-17 years, 18-24 years, 25+ years  <b>Type of Health Worker:</b> Doctors, Nurses, Social Workers, Midwives, CHW/Para-social workers, Male Circumcision, Pediatrics, and Other</p>

**To be counted for this indicator the following criteria must be met:**

- The individuals must have received at least 1 hour of training or provision of services that had clearly defined goals and objectives **and**
  - Was based on sound behavioral and social science theory
  - Was focused on competencies in workers
  - Had activities that addressed the targeted training areas
  - Employed instructionally sound teaching methods
  - Provided opportunities to practice relevant in-service training skills
- The training or services must have been provided by the PCV or their partners in an individual or small group setting. If conducted in a group setting, research shows ideal group size is 25 individuals or less, although in some instances group size can be significantly larger.
- Training may include traditional, class-room type approaches to training as well as on the job or “hands-on” training such as clinical mentoring or structured supervision so long as it does have:
  - Training objectives are clearly defined and documented
  - Participation in training is documented (e.g. through sign in sheets, or some other type of auditable training)
  - The program clearly defines what it means to complete training (e.g. attend at least four days of a five-day workshop, achieve stated key competencies, score XX% on post-test exam, etc.)
- Provide opportunities to practice relevant in-service training skills
- Attendance in the session/s must be documented by the Volunteer or their partner

**Definitions:**

**Training-**This refers to training or retraining of individuals and must follow a curriculum with stated (documented) objectives and/or expected competencies.

**In-Service Training-** These training sessions are for practicing providers to refresh skills and knowledge or add new material and examples of best practices needed to fulfill their current job responsibilities. In-service training may update existing knowledge and skills, or add new ones. Care should be taken to base trainee selection on content and skill needs.

This can occur through structured learning and follow-up activities, or through less structured means, to solve problems or fill identified performance gaps. In-service training can consist of short non-degree technical courses in academic or in other settings, non-academic seminars, workshops, on-the-job learning experiences, observational study tours, or distance learning exercises or interventions. It requires a shorter, more focused period of time than pre-service education, and is often more “hands-on”. It can be a workplace activity (led by staff, peers or guest lecturers) or an external event. An in-service training program must meet national, international or other model standards and have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documents minimum requirements for course completion. The duration and intensity of training will vary by cadre. This indicator is distinct and separate from the indicator for pre-service training and education- a health care worker may be counted under both indicators ONLY if that worker has completed pre-service training and education distinct and separate from their in-service training in the same reporting period.

**Continuing Education**-This is a type of in-service training. Education/training offered to current providers to either update/add new knowledge and skills. In-service training is often limited to practitioners in the public sector and/or managed by the Ministry of Health (or similar entity). Continuing education is often used to describe education/training that is provided by other sources, such as professional associations, that reaches private sector practitioners and which can be linked to re-licensure and /or certification.

**On-the-Job Training**- This is a type of in-service training. Instruction in a specific task or skill is provided via mentoring by a practitioner using explanations, demonstration, practice and feedback. On-the-job training may be combined with academic or technical training to provide a practical experience component.

**Computer based training**- This is a type of in-service training. This includes an interactive learning experience in which the computer provides most of the stimuli, the learner responds, and the computer analyzes the responses and provides feedback to the learner. Components most often consist of drill-and practice, tutorial, or simulation activities offered alone or as supplements to traditional instruction. CBT is sometimes used as a component of a pre-service education course, as well.

**Distance Learning**-This is a type of pre-service training. Distance learning is characterized by a geographic separation of instructor and learner where learners work on their own. It uses a range of mechanisms such as self-guided lesson plans, mailings, radio, and computer based activities. Usually it is tied to an educational facility and uses sequential instructional material that is corrected by the instructor. Regardless of methodologies chosen, it requires motivation on the part of the learner and regular feedback on the part of the learning institution. This can also be used for pre-service education.

**Male Circumcision Training**-This includes persons who receive in-service training in one or more of the following functions in the delivery of Male Circumcision (MC) for HIV prevention service: 1) MC provider/surgeon (persons who surgically remove the foreskin, regardless of whether they are a physician, nurse, clinical officer, etc.) 2) surgical assistant 3) counselor (persons who provide education and counseling of clients on male circumcision 4) ancillary staff (persons who perform sterilization and preparation of surgical instruments/equipment). Programs should focus on compiling data on male circumcision training from Training Registers maintained by funded programs. MC for HIV prevention services in adolescents/adults is comprised of a minimum package of components that includes elective surgical MC using local anesthesia provided after education and consent and delivered in the context of comprehensive pre-operative HIV counseling and testing (offer of), pre-operative STI assessment (and treatment when indicate), post-operative HIV risk reduction counseling and abstinence/healing instructions, and provision of condoms. Training may be for infant or adolescent/adult MC surgical methods. Persons who receive training to perform multiple functions (i.e., as both counselor and surgical assistant), and persons trained in multiple methods (infant and adolescent/adult methods) should only be counted once.

**Pediatric Treatment Training**-This includes in-service training, which touches upon issues in pediatric treatment, dosing for children, adherence counseling for children and appropriate clinical monitoring of therapy. In-service training is in addition to traditional classroom training and workshops. People who fall into the pediatric treatment in-service training will fall into the following categories: nurse, counselor, clinical officer, physician, health surveillance advisor (HAS), pharmacist.

**PEPFAR Support**-This includes funding for full or partial support of an in-service training activity, including course development, training materials, trainer salaries, training site rental or renovation, participant per diem and travel costs.

**Rationale:** This data will tell us the number of health care workers who are available to support the mitigation of the HIV/AIDS epidemic each year as a result of full or partial PEPFAR support. It is widely acknowledged that the lack of trained health workers is a major barrier to scaling up HIV/AIDS services. The lack of sufficient workforce in the PEPFAR countries presents a serious challenge not only to HIV/AIDS programs but to every area of health.

This indicator will not be collected by OGAC by cadre of health care worker; however, if the data are available by cadre in country and reviewed along with survey or other human resources data, country teams could gain some understanding about whether the participants completing in-service training programs represent the correct ration of health care worker cadres and whether the 'mix' of health care workers is the correct 'mix' to meet the human resource demands of the health system, according to each country's epidemiological profile and other factors. Based on this data, countries can determine how to prioritize investments in the education and on-going training of health care workers to maximize workforce expansion and capacity building within the cadres of professionals that are most needed.

#### Measurement Notes:

1. **Sample Tools and/or Possible Methods (for Peace Corps staff use):** Volunteers should use data collection tools to measure progress against project indicators. For this Standard Sector Indicator, Peace Corps post staff can access a sample tool on the intranet page through [this link](#) and adapt it at the post level for their Volunteers' use. Once the tool has been adapted or a local version developed, post staff should have a few Volunteers and their partners pilot it, and then distribute and train Volunteers on its use.

You may also develop your own data collection tool, particularly for one-on-one, on-the-job training, and other forms of trainings. A data collection tool to measure this indicator could be based on the following standards:

- Provide basic information on the trainee(s), including name, title or type of health care profession (remember to include Male Circumcision, Pediatrics professionals), official contact information, sex, and age.
- Title of the training and a brief description of the objectives or content.
- Date(s) of training.
- Where appropriate, pre-and post-test scores.
- Any other information relevant for VRT reporting requirements.

Once a tool has been developed, post staff should have a few Volunteers and their partners pilot it, and then distribute and train Volunteers on its use. Also, share the tool with OGHH.

2. **General Data Collection for Volunteer Activities:** All Volunteer activities should be conducted with the intention of achieving outcomes – knowledge change (short-term), skills demonstration (intermediate-term), and behavioral changes (intermediate to long term) as defined by the progression of indicators within the objectives of a project framework. The progression of measurement for all Volunteer activities should begin with baseline data-collection being conducted prior to the implementation of an activity (or set of activities), followed by documenting any outcomes of the activities and then later at the appropriate time, measurements of specific

outcomes (see the bullet on “frequency of measurement”).

- 3. Activity-Level Baseline Data Collection:** Activity-level baseline data should be collected by Volunteers/partners before or at the start of their activities with an individual or group of individuals. It provides a basis for planning and/or assessing subsequent progress or impact with these same people. Volunteers should take a baseline of the number of health professionals trained in the skills to be addressed by the in-service training early in their work. The information for the baseline measurement will be the same or very similar to the information that will be collected after the Volunteer has conducted his/her training activities.

Because Volunteers are expected to implement relevant and focused activities that will promote specific changes within a target population (see the “unit of measure” above), taking a baseline measurement helps Volunteers to develop a more realistic snapshot of where individuals within the target population are in their process of change instead of assuming that they are starting at “0.” It also sets up Volunteers to be able to see in concrete terms what influence their work is having on the individuals they work with during their service. Please note that data collection is a sensitive process and so Volunteers will not want to take a baseline measurement until they have been able to do some relationship and trust-building with the person/people the Volunteer is working with, and developed an understanding of cultural norms and gender dynamics.

- 4. Frequency of Measurement:** For reporting accurately on this outcome indicator, Volunteers must take a minimum of two measurements with members of the target population reached with their activities. After taking the baseline measurement to determine the number of health professional already knowledgeable/skilled in the content to be addressed by the training, Volunteers should take at least one follow-on measurement during or after the training. Once Volunteers have measured that at least one individual has achieved the indicator, they should report on it in their next VRT.

In all cases, any additional data collection above the minimum expectation should be based on the time, resources, accessibility to the target population, and the value to be gained versus the burden of collecting the data. Following any additional measurements taken, Volunteers should report on any new individuals achieving the outcome in their next VRT.

- 5. Definition of change:** Outputs do not measure any changes. However, a minimum expectation for any HIV prevention skill to be counted for this indicator is that an individual or group must attend at least one (1) hour of training on HIV Prevention skills. This could include: behavioral approaches such as risk behaviors and risk reduction, biomedical approaches (condom use, adherence to treatment, VMMC), or structural approaches (availability of prevention services and social norms).
- 6. General Reporting in the VRT:** The “number achieved” (or numerator) that Volunteers will report on for this indicator in their VRT is the number of health care workers professionals) who have successfully completed the in-service training organized by the Volunteer/partner. The “total number” (or denominator) that Volunteers will report on for this indicator in their VRT is the total number of health professionals who are eligible for the in-service training.
- 7. Reporting on Disaggregated Data in the VRF:** This indicator is disaggregated by “Age” and “Sex” and “Type of Health worker”. When reporting in the VRF, a volunteer should disaggregate the total number of male individuals by 0-9 years, 10-14 years, 15-17 years, 18-24 years, 25+ years and the total number of female individuals by 0-9 years, 10-14 years, 15-17 years, 18-24 years, and 25+ years. The Volunteer will want to collect what type of health worker the individual is and note it in the following groups: Doctors, Nurses, Social Workers,

Midwives, CHW/Para-social workers, Male Circumcision, Pediatrics, and Other.

**Data Quality Assessments (DQA):** DQA are needed for each indicator selected to align with the project objectives. DQAs review the validity, integrity, precision, reliability, and timeliness of each indicator. For more information, consult the Peace Corps MRE Toolkit.

**Alignment with Summary Indicator:** Health Systems Strengthening