

<p><b>STANDARD SECTOR INDICATOR CODE:</b> HE-179-PEPFAR</p> <p><b>PEPFAR CODE:</b> HRH_PRE</p>	<p><b>Healthcare Worker Pre-Service Program:</b> Number of new healthcare workers who graduated from a pre-service training institution or program as a result of PEPFAR-supported strengthening efforts, within the reporting period, by select cadre.</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</li> <li>• <b>Project Activity Area/Training Package:</b> Health Systems Strengthening, HIV Care, Support &amp; Treatment</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>Type of Health Worker:</b> Doctors, Nurses, Midwives, Social service workers, Laboratory professionals, Other</p>

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

- **This indicator is ONLY to be used for GHSPs. If you are a PCV DO NOT use report on this indicator.**
- The individuals reporting on this indicator must have received professional training prior to the individual entering the health workforce in his/ her new position.
- The individuals must have graduated from an institution that is a university-based or affiliated school of medicine, nursing, public health, social work, laboratory science, pharmacy, or other accredited and nationally recognized pre-service program that is a requirement for the cadre’s entry into the workforce.
- The duration of the individuals’ training in the pre-service institution must meet or exceed a minimum of 6 months. The 6-month training period may consist of a combination of classroom and practical training. Health workers who receive a 3-month training course cannot be counted, and:
  - The pre-service training program must be nationally accredited, or at the minimum meet national and international standards.
  - The program must also have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion.
  - Successful completion of training may be documented by diploma, certificate, or other evidence of completion of the program and subsequent eligibility to enter service.
  - Employed instructionally sound teaching methods
- The training or services must have been provided by the GHSP or their partners in an individual or small group setting. Research shows ideal group size is 25 individuals or less, although in some instances group size can be significantly larger.
- Attendance in the session/s must be documented by the Volunteer or their partner

**Definitions:**

**Pre-Service Training-** The training of “new” health workers. All training must occur prior to the individual entering the health workforce in his or her new position. A health workers who advances to higher cadre (e.g., nurse completes medical school to become a doctor, clinical assistant completes training to become a clinical officer) shall be counted as a “new” health worker for the purpose of this indicator. The intent of the legislative goal is to expand the number of workers in the workforce and increase access to care this could occur through advancing current workers to higher level cadres through additional training and education.

**Pre-Service Training Institutions**-These institutions are university-based or affiliated schools of medicine, nursing, public health, social work, laboratory science, pharmacy, and other health-related fields. Non-professional or paraprofessional training would be any accredited and nationally recognized pre-service program that is a requirement for this cadre's entry into the workforce.

**Health Workers**-Individuals involved in safeguarding and contributing to the prevention, promotion, and protection of the health of the population (both professional and auxiliary-professionals). The categories below describe the different types of health workers to be considered under this indicator. These are merely examples, not an exhaustive list of all health workers and position titles may vary from country to country. The intent of the legislative goal is to expand the number of workers in the workforce and increase access to care this could occur through advancing current workers to high level cadres through additional training and education. A health worker who advances to a higher cadre (e.g., nurse completes medical school to become a doctor, clinical assistant completes training to become a clinical officer) shall be counted as a "new" health worker for the purposes of this indicator.

**Clinical Health Workers**-These workers play clinical roles in direct service delivery and patient care. These include clinical professionals and clinical officers (see below definitions).

**Clinical Professionals**-These include doctors, nurses, midwives, laboratory scientist, pharmacists, social workers, medical technologists, and psychologists. They typically have a tertiary education and most countries have a formal method of certifying their qualifications.

**Clinical Officers**-These include medical and nursing assistants, lab and pharmacy technicians, auxiliary nurses, auxiliary midwives, T&C counselors. These officers should have completed a diploma or certificate program according to a standardized or accredited curriculum and support or substitute for university-trained professionals.

**Non-Clinical Health Workers**-These workers do not play clinical roles in a health care setting but rather include workers in a health ministry, hospital and facility administrators, human resource managers, monitoring and evaluation advisors, epidemiologist and other professional staff critical to health service delivery and program support.

**Social Service Workers:** including social workers, child and youth development workers, social welfare assistants

**PEPFAR Direct Support**- This includes funding in the areas of curriculum development, teacher training and support, tuition/scholarships, infrastructure, material/equipment, and practical/internships. For example, full or partial support of student tuition or scholarships, teacher salaries, expansion/refurbishment or pre-service training facilities, and remuneration to recent graduates to 'bridge' the time period between graduation and hiring/development could all count under this indicator depending on if the investment meets the criteria for Direct. In order to be counted, partial support must substantially contribute to pre-service training, meaning that individual or collective PEPFAR contributions must comprise the predominate quantity of support or be critical to production of a health worker.

**New health worker graduates of pre-service training institution or program will be counted as PEPFAR supported when:** PEPFAR is supporting the training of new health worker graduates, including:

- Tuition and fees - At least 50% of the students' tuition and fees were or will be provided by PEPFAR for at least six months of their education
- Curriculum development - The students received or will receive training where PEPFAR curriculum development was essential to qualify them for their trained role

- Infrastructure - The students received or will receive six months or more of education at an institution that could not have supported their education without PEPFAR-supported infrastructure improvements (classrooms, dormitories, utilities)
- Faculty support - The students received or will receive six months of more of education at an institution that could not have supported their education without one or more faculty members present and qualified due to PEPFAR support
- Practica / internship support - The students would not have received or will not receive adequate practica or internship training without PEPFAR support (including transportation to or sufficient resources at the practicum facility)
- Materials / equipment - The students would not have received or will not receive education without materials or equipment (including books and supplies) provided by PEPFAR
- PEPFAR educational programs (for non-university-based training institutions) - The students received or will receive their education in a PEPFAR-funded, non-university-based education program for one or more courses without which they would not graduate or be qualified for the intended role
- Please refer to the HRH flowchart and worksheet for further information (<https://www.pepfar.net/twg/hrh/SitePages/Home.aspx>)

**Rationale:** This indicator is meant to capture the spirit of PEPFAR legislation and will be used in conjunction with other indicators and measures to report to congress on PEPFAR contributions to the national health workforce. It is widely acknowledged that the lack of trained health workers is a major barrier to scaling up HIV/AIDS services. The lack of a sufficient workforce in the PEPFAR countries presents a serious challenge not only to HIV/AIDS programs but to every area of health. PEPFAR's legislative goal for new health workers is intended to support the production of health workers in each country through pre-services training. The data will tell us the number of new health workers who are available to enter the health work force each year as a result of full or partial PEPFAR support.

#### 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. A data collection tool to measure this indicator could be a survey of institutions or second-hand data gathering and should include:
  - Provide basic information on the trainee(s), including name, title or type of health worker, institution's contact information, sex, and age.
  - Type of credential awarded and/or a brief description of the objectives or content.
  - Date(s) of training/year of intake.
  - Duration of training.
  - Participants/students whose graduation is delayed.
  - Any other information relevant for VRT reporting requirements.

For more information on the suggested methods, please see [Appendix I in the MRE Toolkit](#). Also be sure to check [this link](#) on the intranet page as sample tools are regularly uploaded for post use. 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.
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 being conducted prior to the implementation of an activity (or set of activities), followed by documenting

any outputs 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 measurement regarding the outcome(s) defined in this data sheet. Volunteers should collect baseline information early in their work with students/trainee health workers.

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 (described above), Volunteers should take at least one follow-on measurement with the same individual(s), typically after completing one or more activities focused on achieving the outcome in this indicator and once they have determined that the timing is appropriate to expect that the outcome has been achieved. Please note that successful documentation of a behavior change or new practice may not be immediately apparent following the completion of activities and may need to be planned for at a later time. Once Volunteers have measured that at least one individual has achieved the indicator, they should report on it in their next VRT.
- 5. Definition of Change:** The minimum change to report against this indicator is an individual graduated from a pre-service training institution. In the case of this indicator, if as a result of working with the Volunteer/partner, an individual successfully completes his/her training program as evidenced by the receipt of a diploma or certificate, that would count because the Volunteer’s work influenced adding value to an existing product.  
**Please Note: Any student/trainee whose graduation is delayed should be noted and reported.**
- 6. General Reporting in the VRT:** The “number achieved” (or numerator) that Volunteers will report against for this indicator in their VRTs is the number of individuals who have successfully completed their training program as evidenced by the receipt of a diploma or certificate after working with the Volunteer/partner. The “total number” (or denominator) that Volunteers will report on for this indicator in their VRTs is the total number of individuals who participated in the training program. PCVs should also report the number of unlicensed/unregistered graduates.
- 7. Reporting on Disaggregated Data in the VRT:** This indicator is disaggregated by “type of health professional.” When reporting in the VRT, a Volunteer should disaggregate the individuals who successfully complete the pre-service training based on Doctors, Nurses, Midwives, Social service workers, laboratory professionals, or Other. They should also report the number of unlicensed or unregistered graduates by health care worker type (doctors, nurses, midwives, social service workers, laboratory professionals, 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