A Roadmap to Implement Competency- Based Integrated In-service Refresher Training on Health Extension Packages

Federal Ministry of Health

Health Extension and Primary Health Care Directorate, FMoH

Draft

February, 2019

Addis Ababa, Ethiopia

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Abbreviations

AAP	Agreed Action Plan
ADDIE	Assess, Design, Develop Implement and Evaluate
ASK	Attitude, skill and Knowledge
CBT	Competency Based Training
ELC	Experiential Learning Cycle
FMHACA	Food, Medicine, Human Accreditation and Certification Agency
FMOH	Federal Ministry of Health
HC	Health Centre
HEP	Health Extension Program
HEp	Health Extension Professional
HEW	Health Extension Worker
HP	Health Post
HSDP	Health Sector Development Plan
HSTP	Health Sector Transformation Plan
IRT	Integrated Refresher Training
IST	In-service Training
IUCD	Intra Uterine Copper Device
KPS	Knowledge for Problem Solving
MDG	Millennium development Goal
M&E	Monitoring and Evaluation
MTR	Mid Term Review
NCD	Non-communicable Diseases
NTD	Neglected Tropical Diseases
PASDEP	plan for Accelerated and Sustained Development to End Poverty
PHC	Primary Health Care
PHCU	Primary Health Care Unit
QA	Quality Assurance/ Assessment
RHB	Regional Health Bureau
THO	Town Health Office
TNA	Training Need Assessment
TOT	Training of Trainers
UHEP	Urban Health Extension professionals
WHO	Woreda Health Office
ZHD	Zonal health Department

Content

1. Introduction

1.1 Background

Ethiopian government had formulated a series of HSDPs (HSDP I, II, III and IV) in line with the plan for Accelerated and Sustained Development to End Poverty (PASDEP) and to

achieve the health MDGs. Despite the gains that were made in the implementation of HSDP I, it became clear that basic health services had not reached those in need, owing to lack of Primary Health Care (PHC) services at the community level. In response to the health need of the community, thus, the government introduced accelerated expansion of PHC coverage and Health Extension Program (HEP) with the aim of creating a healthy society and reduce rates of maternal and child morbidity and mortality[1]

Based on the guiding principles of PHC, the HEP was first introduced during HSDP II in 2003 in rural parts of the country to reach the community with a set of essential promotive preventive and curative health services. Following the implementation of rural HEP, the training and deployment of HEWs expanded to the pastoral regions in 2007 and urban areas in 2010. So far, a total of 17187 HPs constructed and 39878 HEWs trained and deployed[2]
HEP is not a stand-alone program. Rather, it is part and parcel of Primary Health Care Unit (PHCU). PHCU, which is also known as primary level of care, comprises five surrounding satellite health posts (HPs), referral health center (HC) and primary hospital. PHCU is the point where majority of the PHC- services are being rendered.

1.2 Context of HEWs` training

After recruitment from their respective villages, in rural areas of the country, the female high school graduates received a one- year intensive theoretical and practical pre- service training on 16 health service packages, and become employee of the government as a level 3 HEWs with regular monthly salary and other benefits. While, UHE-ps are required from diploma holding nurses and deployed to work after having three-month pre- service training on common public health programs. Over all, by the beginning of 2018, reportedly a total of 39,878 HEWs were trained and deployed[3].

Integrated Refresher Training (IRT) was first introduced by mid- 2006 in rural areas based on the recommendations of *HEW and HP performance survey*[4]; with the aim of Improving the skills and knowledge of the HEWs and as a result to help them provide quality health service to the community. Likewise, the standardized Urban IRT started by mid- 2007 in urban settings of the country.

On the other hand the government has opened more opportunities for level 3 HEWs and genic entrants to join level 4 HEP- courses. These days, majority of the HEWs have had a level 4

Second generation HEP consists of advanced health system in terms of governance, human resource, service delivery, infrastructure and logistics. I.e. NCDs, Mental health, NTDs, Fistula care, Long term FP (IUCD and Implants), etc. are included in service packages. Three or more Level 4 plus HEWs are required to deliver such services in a standard new-model Health Posts which are designed to have more spaces and facilities to accommodate all extended facility – based services.

[1] Health Extension and Education Center 2017; Federal Ministry of Health (FM

[2] Proceedings: HEP Optimization Advocacy Workshop; FMOH

[3] Proceedings: HEP Optimization Advocacy Workshop, May 2018. FMOH

[4] Ethiopia Health Extension Program Evaluation Study, Center for National He (CNHDE- CU, 2011; CNHDE

qualification. In spite of all these, there have been a lack of core competencies in both rural and urban health extension professionals for un explained reasons[5],[6].

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1.3 Revisiting IRT: Why?

The HEP has been evolving over a period of time to become a flagship program and life saving for the community. Based on competency- based challenges observed during the implementation of the first generation HEP and the ever growing health needs of the community, FMOH has taken a step to advance the program by designing and implementing the Second Generation HEP since 2015. The second generation HEP was envisioned to address health and health related challenges due to demographical and epidemiological transitions mainly as a result of increased urbanization and socio-economic development[7].

As mentioned above, the second generation HEP is more advanced than the first generation HEP. Therefore, it is impossible to use the same in- service training materials and strategies in the second generation HEP. It is, thus, compelling to revisit the whole system of in- Service Training (IST) in accordance to the requirement of second generation HEP and National In-service Training Implementation Guide. Accordingly, the Health Extension and Primary Health care Directorate, FMOH has planned to revise the development of IRT based on the standard instructional design (analysis, Design, Development, and Evaluation (IDDIE)). This Road map is prepared to guide the development of Integrated in- service training (IRT) for Health Extension professionals (HEps) in the country. This road map can also be used as a communication and management tool.

1.4 Why Standardizing IST / IRT?

Standardizing IRT ensures training is need-based and has right approaches in delivering the training. It guarantees timely planning and effective coordination and implementation with proper monitoring and evaluation system. It helps create a system whereby training is linked to performance. Standardize training materials maintain the uniformity of the competency outcomes and quality of training. In general, standardizing training activities ensures the quality of training and as a result improves quality of health services

1.5 Concept of adult learning: Competency Based Training approach

Competency Based Training (CBT) aims to improve performance of the HE-Ps by equipping them with enabling attitude, skills and knowledge (ASK).

What is Competency?

[5] Proceedings: HEP Optimization Advocacy Workshop, May 2018. FMOH

[6] Health Sector Transformation Plan (HSTP) Mid Term Review, 2018. FMOH

7 Discussion Paper for Advocacy Workshop on HEP Optimization (unpublished). kebede Worku May, 2018; FMOH.

A competency is defined as knowledge, skill, or attitude that enables one to effectively perform the activities of a given occupation or function to the standards expected in employment[8]

The role of "ASK" in CBT

Attitudes may influence how we respond to people and situation cognitively (e.g. how we assess a situation), emotionally (e.g. how we judge people), and behaviorally (e.g. what we actually do). Attitudes play an important role in enabling or hindering desired outcomes, including performing job competencies effectively.
Skills encompass experience and practice. Therefore they involve cognitive abilities (thinking, reflecting, analyzing, drawing conclusions, etc.) as well as deciding how to apply knowledge to accomplish a desired outcome. Skills alone without knowledge for problem can be ineffective or even dangerous, because a person may assume that skill is all about following rules/instructions no matter what the context is. Such a "skilled" person may have no ability or capacity to respond to situations outside of what she/he perceives to be the "normal" conditions.
As one of the aims of training is to improve performance and quality, knowledge needs to be considered both as: Factual knowledge i.e. the required information to perform a task well; and Knowledge for problem-solving i.e. the capacity to apply knowledge adaptively in order to respond to the context.
Knowledge for problem-solving (KPS) means that the training develops ability to select from a menu of ASK and adapt how they can be used according to different scenarios, even if those specific scenarios were not practiced in training. Unless training develops this ability for KPS, performance of competencies will not be fully achieved

1.6 Developing IRT packages: Concept of Instructional Design

Instructional design is the systematic development of training using adult learning and design theories and techniques. This systematic approach ensures: There is a need for training; the learning events are well-designed; quality training materials are developed; learning events are implemented using appropriate strategies or approaches, and Learning events are evaluated to ensure that learning has taken place.

[8] Richey, Fields, & Foxon, 2001, p. 31.

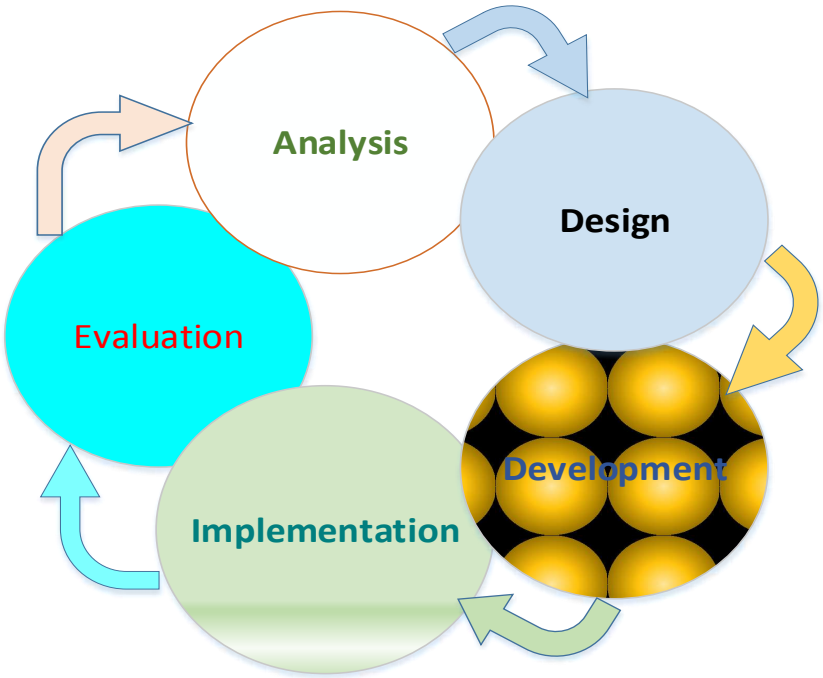

Figure 1: Model of instructional design (IDDE)[9]

1.7 Linking IRT to performance

The purpose of IRT is to contribute to the achievement of the goals of the health sector through improved performance of staffs in different categories of health care delivery units. Therefore linking training to on-the-job performances is very important as an ultimate goal is to improve performances through the application of learned skills and knowledge to the day-to-day health activities of HEps; and as a result, to improve satisfaction and health outcomes of the clients (figure 2), in order to achieve this (transferring knowledge and skills from training to performance), the following strategies can be used.

- Preparing an action plan at the end of the training
- Providing regular and continuous supportive supervision
- Post training follow-ups to carry out skill and knowledge reinforcement activities (coaching and mentoring)[10]

[9] https://online.seu.edu/instructional-design-models/

[10] National IST Implementation Guide for Health Sector. January 2014; FMOH

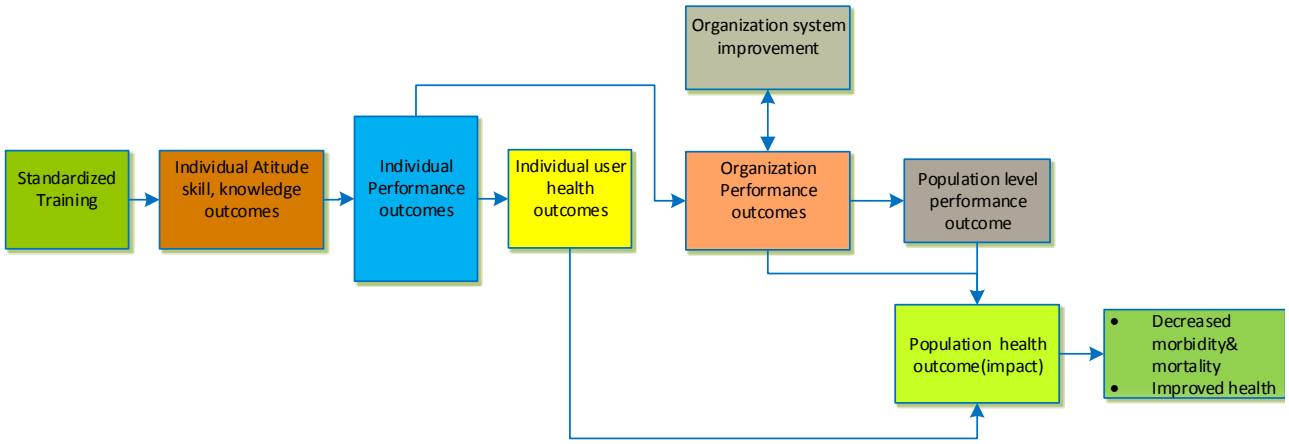

Figure 2: Training to performance linkage: conceptual framework

2. Guiding principle

The guiding principles of implementing IRT intervention are:

- Need-based
- Standardization
- Institutionalization
- Competency- based design
- Learner- centered approach
- Efficiency and Effectiveness
- Acceptance
- Participatory partnership

3. Goal and Objectives

3.1 Goal

The goal of implementing this IST (IRT) is to expand HEps` competences in order to help them provide comprehensive and quality health services to their community as part of contributing to the achievement of a bigger goal of the health sector

3.2 Objectives

Implementing IST (IRT)is increasingly seen as being vital for HEP planners/ managers and front-line implementers specifically HEps as there have been a number of changes to the program itself and the providers. Thus, the following specific objectives are set to make the implementation effective and successful. They are;

- To generate evidences on performance gaps and training need of the providers (HEps)
- To develop standard training modules that are thought to address attitude, skills and knowledge gaps of the trainees.
- To secure all required resources (human, finance, goods, time)
- To organize live training sessions (TOT, roll out training) and training facilities
- To monitor the quality of the training during and after the training sessions
- To assess the achievement of learning objectives and learner`s satisfaction
- To evaluate learning outcomes and impacts

4. IRT Implementation Strategy

In order to implement IRT intervention effectively, the following key strategies will be deployed.

- Make use of evidences on HEP performance gap due to lack or limited competency for purposeful implementation of IRT
- Organize different advocacy platforms to mobilize resources such as finance, materials and human expertise for successful implementation of the IRT
- Work closely with both internal and external key stakeholders and development partners
- Build capacity of IRT course developers, IRT- coordinators, course supervisors, master and roll-out trainers
- Standardize IRT materials in terms of helping the learners address their attitude, skills and knowledge gaps that have been identified during TNA.
- Institutionalize IRT
- Formulate strong IRT planning, Implementation, monitoring and evaluation frameworks
- Design and utilize effective IRT communication and documentations strategies

5. Steps and Activities

5.1 Steps

The following are key steps to successfully implement IRT interventions

- Planning
- Training Need Assessment
- Design and Development
- Implementation
- Evaluation

Figure 3: Steps of IRT implementation

Step 1: Planning

The main purpose of planning training Interventions is to clearly define performance problem and its causes and making sure that the problem can be addressed through a training intervention. If training intervention is found to be a remedy, to ensure that it is tailored to the needs of the learner and the learner's work situation. The HEPHCD has already planned to implement IRT- intervention in consultation with other Directorates. This Operational Roadmap will guide the process of implementing the said training intervention

Step 2: Training needs assessment (TNA)

This assessment is usually done to identify the occurrence of performance gaps and whether the said gaps are due to lack of competences. If so, to analyze which domain/ s of competency are required in order to improve performances and meet the need of a business (provision of quality services that satisfy the client).

Step 3: Design and Development

Instructional designers need to develop or revise IRT instructional design based on the curriculum of level 4 HEP to addresses the learning need or performance gap identified in the TNA. They also need to reassure the developed training materials could enable the

facilitators and trainers to actively engage in the learning process and help the learners develop the required attitude, skills and knowledge.

Step 4: Implementation

Implementation of training intervention consists of three phases: pre-preparations, running training and post training follow- ups.
Preparation: The main purpose is to ensure successful logistical and technical implementation of training interventions as well as to prepare learners, trainers, and supervisors for their roles before, during, and after the training intervention to ensure successful transfer of learning.

Running training: The organizers, supervisors and facilitators need to ensure that a learning intervention is carried out as planned and runs smoothly; skills and knowledge are being transferred according to the curriculum; and trainers and learners are actively engaged in the learning process.
Post- training fallow- ups: The supervisors need these follow-ups to make sure learners have the tools, opportunities, and support to apply new skills and knowledge on the job.

Step 5: Evaluation

An evaluation is the systematic and objective assessment of an ongoing or completed project, program or policy, its design, implementation and results. The main objectives are to:

- determine whether the objectives of the training were achieved;
- see how the knowledge and skills learned in the training are put into practice;
- assess the results and impacts of the training programs;
- assess the effectiveness of the training programs;
- and identify major problems of the training programs and solutions for improvement.

HEP leaders, managers and supervisors all need to carry out training evaluation to obtain scientific evidences in terms of the above- mentioned objectives

5.2 Major Activities

5.2.1 Planning

- Establish IRT- Task force
- Assign IRT intervention adviser
- Conduct resources and stakeholder mapping
- Secure all logistical input including budget
- Develop the roadmap

- Develop micro plan[11]

5.2.2 Training Need Assessment

- Develop a brief proposal and data collection tools for the TNA
- Carry out TNA in the field
- Conduct desk review (Optional)
- Compile, organize and analyze and report data
- Share the report with or present it to executive bodies for approval

5.2.3 Design and Development

- Identify core CBT and Instructional designers and reviewers
- Provide orientation on CBT and instructional design;
- Review documents such as TNA, First generation HEP IRT modules, Level 4 HEP curriculum, second generation HEP implementation guide and packages, etc.;
- Identify IRT areas to be maintained, modified or newly developed
- Define IRT course syllabus and develop course out-line (Annex 1)
- Assign IRT module writers and reviewers
- Draft standard IRT modules (Participants manual and Facilitators` guide) based on National IST Courses Standardization Checklist.pdf
- Organize a series of IRT- modules review platforms
- Field test the modules
- Produce final IRT- modules
- Print the modules and make them ready for distribution

5.2.4 Implementation

5.2.4.1 Preparation

- Prepare training implementation guide[12]
- Develop CBT- facilitation skill guideline
- Prepare training quality assurance checklist
- Develop post- training follow-up checklist
- Identify human resources needed for running the training (training coordinators, master trainers and supervisors facilitators, support staffs, etc)
- Identify trainees
- Identify and secure training venues (must be public Health Science Colleges)

[11] Micro plan includes detain IRT implementation processes and timeframe with budget breakdown. Reasonably, RHBs, Zonal and Towns health Dept./ offices need to do such plan to cost their activities and secure budget ahead of the commencement of the trainings

[12] This guideline may include the IRT planning and implementation techniques, from preparation up to post- training follow-ups. It will have a section for role and responsibilities of training organizers and coordinators, facilitators, supervisors and participants. It also incorporates a paragraph and template describing about the agreed action plan of the participants (see Annex 2).

- Allocate and distribute budget for the training
- Develop and share the standard training- materials check list
- Distribute training materials to regions [training modules (Participants manual and Facilitators` guide), standard PPt especially for master TOT and regional TOTs, reference materials, samples training methods, course evaluation forms etc. as per the checklist].
- Assign training supervisors
- Organize IRT advocacy workshop in integration with other forums

5.2.4.2 Running the training

- Make sure all training materials and facilities, facilitators and supervisors are made available by level of training
- conduct national master TOT based on training schedule and sessions
- conduct regional TOTs based on training schedule and sessions
- Organize roll- out IRTs based on training schedule and sessions
- Supervise the undertakings of the training at all levels using training implementation guide and training quality assurance checklist to make sure the training- learning processes are according to the instructional design outlined in facilitators guide
- By the end of the training make sure that the participants have been able to develop agreed action plan for improvement
- Produce accomplishment report

5.4.2.3 Post training follow-ups

- Revise routine supportive supervision tools to assess the translation of acquired/ improved ASK in to practices
- Conduct trainees satisfaction survey
- Conduct separate knowledge/ skill reinforcement assessment within 6-8 weeks of the recent training to see how better the HEps practicing their learning objectives from the IRT
- Based on the findings plan the required mentorship or coaching supports
- Document all processes of post- training interventions

5.2.5 Evaluation

- Develop/ revise IRT evaluation guide
- Plan IRT evaluation activities
- Mobilize the required resources
- Empower regions to conduct IRT evaluation on them selves
- Conduct IRT formative (behavior) evaluation
- Conduct IRT impact evaluation
- Produce and share report on each evaluation results
- Document all processes of IRT evaluations

5.3 Milestone of IRT implementation

- **By March 31st, 2019**

  - FMOH is having approved IRT implementation Roadmap
  - RHBs are having approved micro plans
  - FMOH and RHBs establish IRT- intervention taskforce

- **By April 30th, 2019**

  - FMOH generates evidence on training need of the HE-ps and share it with the stakeholders.

- **By May 31, 2019**

  - FMOH assigns IRT personnel (designers, developers, reviewers, supervisors and advisor).
  - FMOH designs the standard IRT packages (modules)
  - FMOH in consultation with RHBs produce draft IRT modules and supplementary documents and pilot test them

- **By June 30, 2019**

  - FMOH in consultation with RHBs finalize all IRT modules and supplementary documents

- **By August 31st , 2019**

  - FMOH and RHB select IRT institutes (Nursing/ Science colleges)
  - FMOH prints the required quantity of IRT modules and supplementary documents
  - FMOH prepares for organizing IRT master training

- **By October 1st, 2019**

  - FMOH organizes national master TOT
  - FMOH distributes IRT modules and supplementary documents
  - All RHBs prepares for cascading regional TOT and roll-out training

- **By November 30, 2019**

  - FMOH transfers the required budget to the regions
  - FMOH conduct IRT quality assessment
  - All RHBs complete Regional TOTs

- All RHBs distribute IRT modules and supplementary documents to training sites

- **By December 31st, 2019**

  - Half of the regions provide roll out training

- **By March 31st 2o20**

  - ZHDs/ W/THO of all regions organize roll-out training
  - FMOH and RHBs conduct IRT quality assessment
  - FMOH carry out trainees satisfaction survey
  - All ZHDs/ W/THO produce accomplishment report
  - All regions produce consolidated regional accomplishment report and share it with FMOH
  - FMOH produce consolidated national accomplishment report and share it with relevant stakeholder
  - FMOH and RHBs document the overall processes of implementing IRT intervention

- **By May 31st 2020**

  - FMOH and RHBs conduct post- IRT follow-up visits

- **By September 30, 2020**

  - FMOH carry out IRT out-come evaluation

- **By January 31, 2022**
- **By January 31, 2025**

  - FMOH in collaboration with RHBs and other stakeholders/ partners carryout outcome and impact evaluation on two and half and five years after the commencement of IRT

6. Resources

6.1 Human

In the implementing processes, the availability of human resource in the required number and quality is very crucial. The critically needed HR categories are as follow;

- IRT adviser (national level)

- IRT intervention planners, managers/ coordinators at all levels
- IRT implementation taskforce (National and regional levels)
- IRT course designers
- IRT course developers and reviewers (national)
- IRT master trainers (national)
- IRT course supervisors at all levels
- IRT regional trainers
- IRT post training supervisors (National and regional)
- Training outcome and impact evaluators
- logisticians
- Support staff

6.2 Materials/ goods

- IRT modules (Facilitator guide and participants manual)
- A set of reference materials as per the checklist
- IRT course outline
- IRT implementation guide
- IRT training quality assurance checklist
- Training evaluation guide
- CBT- facilitation skill guideline
- A set of PPT as required
- IRT training materials for each module as per the standard checklist
- Electronic Devices (Lap tops, Tabs, Sound recorders, LCD projectors, printers, cameras and other gadgets)
- Stationaries
- Vehicles
- Others

6.3 Training Implementation Cost (see budget section; Annex 3)

- IRT planning cost (national)
- TNA Cost
- IRT designing and development cost
- IRT advisor`s cost (national)
- Training cost
  - Master TOT
  - Regional TOT
  - Roll- out training
- On-training supervision cost
- Post training assessment cost
- Post training-supervision cost
- Training evaluations cost

6.4 Detailed time frame

Table I: **Detailed Timeframe for Implementing HEP- IST**

Steps and Activities	2019											2020												2022 2025			Respon-sible	Budget
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
1. Planning	Plan																											
Establish IRT- Task force																												
Assign IRT adviser																												
Conduct resources mapping																												
Secure all logistical inputs including budget																												
Develop the roadmap & micro plan																												
2. TNA		TNA																										
proposal & data collection tools																												
Carry out TNA in the field																												
Conduct desk review																												
Compile analyze and report data and get it approved																												
3. Design and Development			Design& development																									
Identify CBT designers and reviewers																												
Provide orientation on designing IRT packages																												
Review documents																												
Design course syllabus																												
Assign IRT module writers and reviewers																												
Draft standard IRT modules																												
Organize modules` review platforms																												
Field test the modules																												
Produce final IRT- modules and supplementary materials																												
Print the modules and get them ready for distribution																												

Steps and Activities	2019											2020												2011			Respon-sible	Budget
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
4. Implementation								Implementation																				
4.1 Preparation																												
Prepare IRT implementation guide																												
Develop CBT- facilitation skill guide																												
Prepare training QA checklist																												
Develop training follow-up checklist																												
Identify IRT personnel																												
Identify trainees																												
Identify and secure training venues																												
Allocate and distribute budget for the training																												
Develop the training-materials check list																												
Distribute training materials																												
Assign training supervisors																												
Organize advocacy workshop																												
4.2 Running the training																												
Make sure all inputs are ready for running IRT																												
conduct master TOT																												
conduct regional TOTs																												
Organize roll- out IRTs																												
Supervise the undertakings of the IRT																												
Develop AAP																												
Produce report																												
4.3 Post- IRT follow-ups																												

Steps and Activities	2019											2020												2022 2025			Respon-sible	Budget
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Revise routine supportive supervision tools																												
Conduct trainees satisfaction survey																												
Conduct S/K reinforcement assessment																												
plan the required mentorship supports																												
Document all processes																												
5. Evaluation																	Evaluation											
Develop/ revise IRT evaluation guide																												
Plan IRT evaluation activities																												
Mobilize the required resources																												
Empower RHBs to conduct IRT evaluation																												
Conduct IRT formative (behavior) evaluation																												
Conduct IRT impact evaluation																												
Produce and share report on evaluation results																												
Document all processes of IRT evaluations																												

7. M&E frame work[13]

In-service training standardization and institutionalization is one of the priorities of the FMOH. It is believed that in-service training standardization and institutionalization will improve the quality of health care delivery through sustainable in-service training programs. However, these benefits will result if the IST (IRT) Intervention is properly planned and implemented. Monitoring and evaluation (M&E) of the Intervention will help to solve challenges in its implementation. The result of M&E will be used for taking corrective actions and identifying new strategies.

7.1 What to Monitor and Evaluate?

The major indicators for monitoring and evaluation of IRT include:

- Proportion of selected local training institutions who fulfill the criteria set in this Guide
- Number of local training institutions delivering in-service trainings
- Proportion of local training institutions who are accredited by FMHACA
- Proportion of standardized training curricula
- Percentage of in-service training financing contributed by local sources

7.2 When and How to Monitor and Evaluate the Program?

The in-service training program has to be monitored every 6 month at the regional and national level. The following modalities of monitoring can be used.

- Analysis of records and reports during supportive supervision
- Undertaking review meetings with relevant stakeholders
- Rapid assessment

Evaluation of the overall program shall be undertaken in 2 and half years' time and 5 years after formal launching of the standardization and institutionalization process. The following methods of evaluation can be used.

- Analysis of records and reports
- Qualitative studies like in-depth interviews and focus group discussions
- Surveys

7.3 In-service Training Data Base

A data base will be set up to capture and track information on in-service trainings. The in-service training data base in Ethiopia shall be linked to the human resource information system (HRIS). The IRT data base has to be developed and maintained at the level of training institutions, RHBs and FMOH. The data base will track trainees and trainers to

[13] National IST Implementation Guide for Health Sector. January 2014; FMOH

avoid duplication and select the right training for IRTs respectively. The national and regional IRT data bases shall be regularly revised by FMOH and/or RHBs and will be shared with training institutions.

7.4 Monitoring and Evaluation Logic Model

The M&E framework of institutionalizing in-service training consists of essential elements for the process of standardization and institutionalization. However, RHBs and training institutions should develop their own monitoring and evaluation tool based on the following M&E framework.

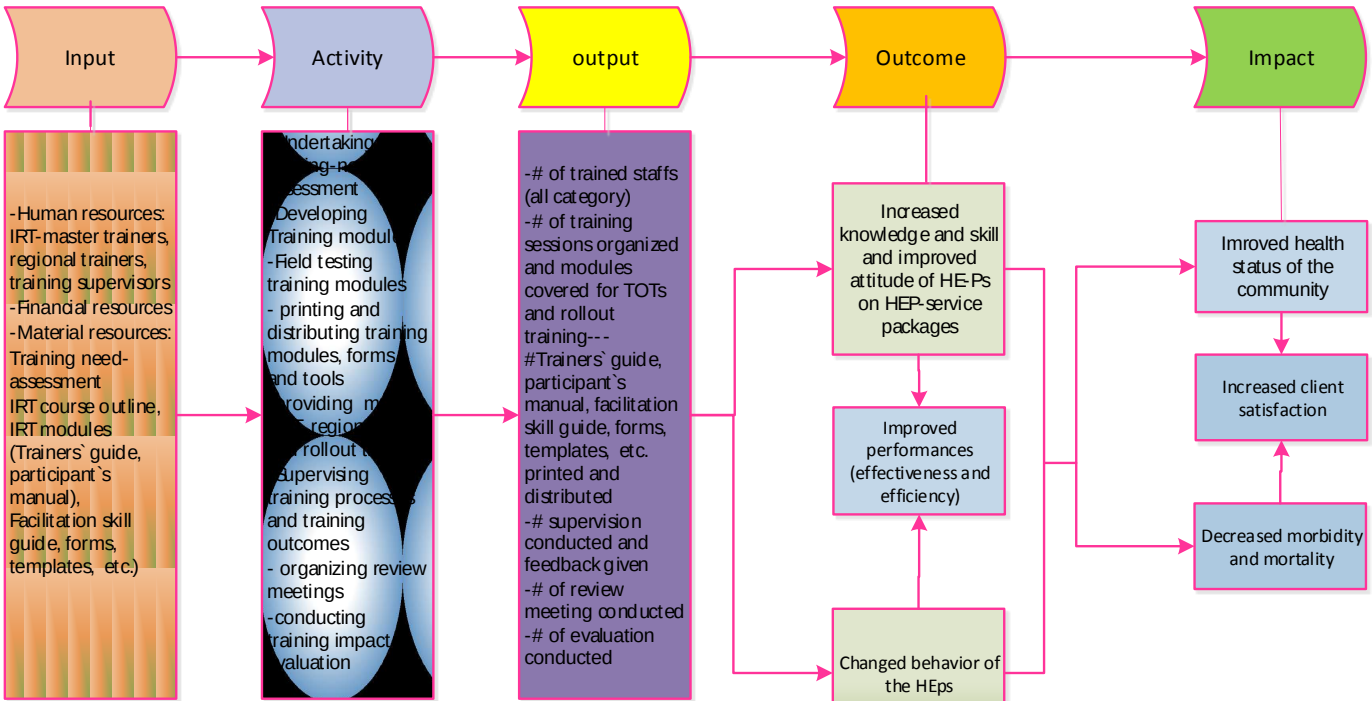

Figure 4: IRT M&E logical framework[14]

8 Annexes

Annex 1: IST/ IRT syllabus

[14] IRT M&E logical frame customized from National IST Implementation Guide for Health Sector.

The course syllabus provides a summary of the major components of a course. A syllabus usually contains the following information:

- Course description
- Course goals
- Participant learning objectives
- Description of training methods and materials
- Participant selection criteria
- Methods of course evaluation
- Course duration
- Suggested class size
- Course dates

Annex 2: IRT Implementation Guide outline

The IRT Implementation Guide outline may include but not limited to the following points.

- **Title**
- **Acknowledgement**
- **Abbreviations**
- **Content**

- **Introduction**
    - Background
    - Rationale
    - Concepts of Instructional design and CBT
    - Linkage of IRT to job performances
- **Goal and Objectives of IRT implementation**
- **Strategy**
- **Implantation steps and activities**
    - Planning
    - Assessment
    - Design (course syllabus)
    - Development
    - Implementation
        - Preparation
        - Running the training
        - Post training follow-ups
- **Evaluation**
- **Resources**
    - Human
    - Material/ goods
    - Finance
- **M&E framework**
- **Roles and responsibilities**
    - FMOH
    - RHBs and ZHD
    - W/THOs
    - Partners
    - Training Colleges/ Universities
- **Annexes**
        - Participants selection criteria
        - Training materials Checklist
        - POA/ Gannt Chart template
        - QA checklist
        - Daily/ end course evaluation tool and summary template

- Trainees profile and performance template (name, age, sex, level, prior IST, YoS, level of ELC in this training, SA result, pre& post test scores, etc.)
- AAP template
- Post- training client satisfaction survey checklist
- Post – training follow-up checklist
- Planning/Micro planning template
- Reporting template
- Other

Annex 3: IRT detailed budget breakdown