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JHPIEGO, an affiliate of The Johns Hopkins University, builds global and local partnerships to enhance the quality of health care services for women and families around the world. JHPIEGO is a global leader in the creation of innovative and effective approaches to developing human resources for health.

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<table>
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<td>ART</td>
<td>Antiretroviral therapy</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>CTS</td>
<td>Clinical Training Skills course</td>
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<tr>
<td>EMS</td>
<td>Ethiopian Mailing System</td>
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<tr>
<td>HAPCO</td>
<td>HIV/AIDS Prevention and Control Office</td>
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<tr>
<td>HCT</td>
<td>HIV counseling and testing</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>IP</td>
<td>Infection prevention</td>
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<tr>
<td>MCH</td>
<td>Maternal and child health</td>
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<td>MOH</td>
<td>Ministry of health</td>
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<td>OST</td>
<td>On-site training</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PIHCT</td>
<td>Provider-initiated HIV counseling and testing</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission of HIV</td>
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<tr>
<td>VCT</td>
<td>Voluntary counseling and testing</td>
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EXECUTIVE SUMMARY

JHPIEGO, an affiliate of The Johns Hopkins University, works closely in Ethiopia with the U.S. Centers for Disease Control and Prevention (CDC), the Ministry of Health HIV/AIDS Prevention and Control Office (MOH/HAPCO), and all regional health bureaus in the areas of prevention of mother-to-child transmission of HIV (PMTCT); HIV counseling and testing (HCT), including both voluntary counseling and testing (VCT) and provider-initiated HIV counseling and testing (PIHCT); and infection prevention (IP). Since September 2003 JHPIEGO, like many other agencies that are implementing the President’s Emergency Plan for AIDS Relief (PEPFAR), has conducted training for health care providers in Ethiopia, using an off-site group-based workshop format.

After three years of implementing off-site training for small groups of providers (maximum five per site for all technical areas), JHPIEGO realized the limitations of its training approach in Ethiopia. The attrition rate of public-sector health care providers is very high in Ethiopia, causing interruptions in services when there are too few skilled and trained providers at sites. The high turnover of trained staff results in the need to train new providers to ensure the continuity of HIV/AIDS services, which is often costly and wastes valuable resources. Off-site training causes further gaps in service delivery when providers are called away from sites to attend training. In addition, because off-site training is held at long distances from the participants’ hospitals, participants often incur significant costs, including the cost of travel. JHPIEGO concluded that in order to implement appropriate IP practices or initiate a PIHCT program in a sustainable manner at a health care facility, a critical mass of providers from various departments should be trained on-site.

In response to the limitations of off-site training and the need for IP programs in Ethiopia’s public-sector hospitals, including some nongovernmental and military hospitals, JHPIEGO designed a pilot project for on-site training in IP and PIHCT. For the IP aspect of the project, up to 15 health care providers and hospital administrators from each of 39 hospitals were trained using in-country IP trainers. The trainers worked in teams of two and each team trained at two to five sites, primarily in their respective regions. For the PIHCT part of the project, up to 15 health care providers were trained at each of 97 public hospitals using in-country PIHCT trainers. The PIHCT trainers also worked in teams of two and trained at two to seven sites each, primarily in their respective regions.

The hospitals benefiting from on-site training were involved in the planning, preparation, implementation, and monitoring phases of all training. JHPIEGO’s PEPFAR university partners (ITECH/University of Washington, Columbia University’s ICAP program, the University of California San Diego, and the Johns Hopkins Bloomberg School of Public Health’s TEHAI program) assisted in the communication, materials transport, and coordination of on-site training (OST).

Planning for OST included informally discussing the program with representatives from the MOH/HAPCO and CDC; preparing and submitting a concept paper to the MOH/HAPCO at their request; introducing and discussing the on-site training issues at the stakeholders’ meeting; training the IP and PIHCT trainers and orienting them to OST; adapting the IP and PIHCT training materials to suit on-site training (adapting the content, training approach,
presentation graphics, course outline, and schedule); preparing kits of items required for training; making administrative and financial arrangements, including the preparation of reporting requirements by the trainers; and ensuring that feedback was obtained from hospital directors and all stakeholders visiting the training. Plans were also made for on-site supportive supervision for the trainers.

The first of the 39 on-site IP courses started on June 26, 2006, and the last one ended on August 26, 2006. Ninety-six PIHCT on-site courses were conducted, starting on June 9, 2006, and ending on November 20, 2006.

Major achievements of the on-site training program in IP and PIHCT included the following:

- A total of 605 participants from 39 hospitals (an average of 15 participants per hospital) were trained in infection prevention.
- A total of 1,349 participants from 97 hospitals were trained in PIHCT.
- Participants were selected from various departments in each hospital, thus promoting hospital-wide implementation and a team approach for both technical areas.
- All hospitals formed IP committees to guide and support the use of recommended IP practices and to review and resolve related problems. In addition, participants developed action plans to be implemented after training.
- OST trainers provided corrective feedback to participants during practical sessions and feedback to hospital management regarding supplies management and program planning to ensure immediate implementation.
- All participating hospitals were satisfied with OST and suggested that the OST model be replicated in other HIV-related training programs.
- Trainers were committed and determined to make OST a success, despite many challenges.
- Demand for IP and PIHCT training, supplies, and assistance has increased in all sites.

Major challenges of the on-site training program in IP and PIHCT included the following:

- Difficult travel and materials transport conditions
- Difficult communication with sites, due to lack of infrastructure
- Lack of electricity in some sites
- Participants sometimes called from the training to attend to patients
- Rigorous and complicated training schedule

Recommendations:

- With detailed planning and coordination, OST can be replicated for other settings and programs.
- OST should be continued and adapted for other HIV/AIDS programs.
- Close follow-up of trained providers should be undertaken to ensure sustainability and program implementation.
INTRODUCTION AND BACKGROUND

JHPIEGO, an affiliate of The Johns Hopkins University, works closely in Ethiopia with the U.S. Centers for Disease Control and Prevention (CDC), the Ministry of Health HIV/AIDS Prevention and Control Office (MOH/HAPCO), and all regional health bureaus in the areas of prevention of mother-to-child transmission of HIV (PMTCT); HIV counseling and testing (HCT), including both voluntary counseling and testing (VCT) and provider-initiated HIV counseling and testing (PIHCT); and infection prevention (IP). Ethiopia’s system for HIV services has been implemented in waves in public, uniformed hospitals and a few nongovernmental hospitals. Twenty-two hospitals were brought into the system in the first cohort, 55 in the second, and 89 in the third. Since 2003 JHPIEGO has been providing technical assistance in Ethiopia in the areas of training and site-level implementation of PMTCT and VCT services in the three hospital cohorts. Recently, however, JHPIEGO’s mandate has changed from an implementing role to a national-level role of providing assistance for training and human capacity building. JHPIEGO is funded to organize and conduct high-quality competency-based training for the three cohorts and to produce competent clinical trainers in each region as part of building the capacity of the regional health bureaus. The clinical trainers in turn train other providers. JHPIEGO is also closely involved with various national-level technical working groups that are developing national guidelines and training packages for HCT, PMTCT, and IP.

JHPIEGO’s PEPFAR university partners (ITECH/University of Washington, Columbia University’s ICAP program, the University of California San Diego, and the Johns Hopkins Bloomberg School of Public Health/TSEHAI program) lead the implementation of antiretroviral therapy (ART), PMTCT, IP and VCT service delivery at the hospital level. Whereas JHPIEGO conducts training for PMTCT, VCT, and IP at the national level, its university partners are responsible for service delivery at the site level.

Based on two years of program experience with training health care providers in Ethiopia, JHPIEGO recognized the serious problem of attrition of staff at the hospital level and the resulting problems with interruptions in services. One temporary solution to this problem is to train service providers at the site level so that the site has a critical mass of skilled providers. Having more trained providers reduces the chances of service interruption and also generates interest in and momentum for starting new services. To achieve the goal of training more providers, JHPIEGO changed its strategy for IP and PIHCT training from an off-site, group-based training approach to an on-site, group-based approach. In collaboration with the MOH/HAPCO and other stakeholders, JHPIEGO piloted an on-site training program in which 39 hospitals were trained in IP and 97 hospitals were trained in PIHCT.

This report describes the rationale for piloting the on-site training program; the project planning, implementation, and monitoring and evaluation processes; and the lessons learned.
WHAT IS ON-SITE TRAINING?

On-site training means taking the training to the sites where the participants are working. The on-site training approach makes it possible to hold training in the context of the workplace, which makes it easier to train a critical mass of providers at the site and enables participants and trainers to identify the challenges in implementing newly introduced or updated practices at their hospitals. For the most part, in-service training in Ethiopia has not been offered regularly and has consisted of off-site, group-based training for a few participants.

RATIONALE FOR THE PILOT PROJECT

During the second and third years of JHPIEGO’s program in Ethiopia (2004–2005), JHPIEGO provided technical assistance in the areas of PMTCT, VCT, and IP to 55 first and second cohort public hospitals. At least five health care providers (one physician, two nurses/midwives from antenatal care or labor and delivery, one laboratory technician, and one environmental health worker) were trained in IP; five health care providers were trained in PMTCT; and six health care providers were trained in providing VCT as well as counseling pregnant mothers. PIHCT training began in Ethiopia as a pilot project involving eight sites where only a few providers were trained. The PIHCT program was very popular at the sites and dramatically increased the numbers of clients and patients counseled and tested for HIV. Thus, the demand for training grew and JHPIEGO received more requests to train providers.

High Turnover of Trained Staff

Ethiopia suffers from a high turnover rate among physicians, nurses/midwives, and laboratory technicians in all technical areas. The high turnover rate is the result of providers pursuing higher education, migrating to the private sector, and migrating out of the country. In order to implement services successfully, particularly for counseling and testing and IP, a critical mass of trained providers should always be available at service delivery sites. JHPIEGO’s on-site training program addressed both the challenge of improving IP practices and the difficulty of maintaining continuity of services at first and second cohort sites.

Huge Demand for Training

Several new approaches and recommendations in IP practices have been developed since the emergence of HIV/AIDS in the early 1980s, but most health care workers in Ethiopia do not have adequate access to information about the new practices. The lack of knowledge of current practices was evident in participants’ pre-test scores at JHPIEGO’s IP training courses and in the comments that participants made on their course evaluations. At the end of the training, participants often realized and expressed that they had not updated their IP knowledge and skills and that they had been following routine, traditional, and outdated practices. With the introduction of new IP practices to health care staff in Ethiopia and increased opportunities for IP training, hospitals now increasingly request IP training for more staff and on a more frequent basis to ensure the sustainability and expansion of appropriate practices. In addition,
participants who have learned and experienced the benefits of PIHCT at the facility level have pushed for more providers to be trained across the board.

**Infection Prevention Programs Need a Critical Mass of Providers**

In order to reduce the magnitude of nosocomial (health facility-acquired) infections, health facilities need to implement recommended IP practices in every unit. Health facilities should have enough trained providers to establish IP committees in every unit to bring about the desired change in IP practices. With the acute shortages and the high turnover rate of health care workers in Ethiopia, especially in public hospitals, JHPIEGO recognized the need to train a large number of providers at each site. Due to funding levels, however, only 39 hospitals were selected for IP training using the OST approach.

**PIHCT Services Require Training All Clinicians**

Identifying and recruiting patients who are eligible for ART for HIV/AIDS has been a challenge in Ethiopia. To increase the number of patients receiving ART, the MOH in Ethiopia recently adopted a PIHCT approach in all public hospitals that provide ART. This action was taken as a result of pilot testing of PIHCT in the tuberculosis clinics at eight hospitals in the country. In order to effectively implement a hospital- and department-wide PIHCT program, a group of clinical service providers had to be trained. In response to the urgent need to identify more patients in need of HIV clinical care and treatment, plans were made to train 97 hospitals (the 89 third cohort hospitals and several others) under Ethiopia’s ART support system. Training in two of the 97 hospitals is still pending.

**On-Site versus Off-Site Training**

It is not possible or advisable to train a large number of providers from one health care facility during one off-site, group-based training event. The health care workforce is limited at most sites, and an off-site training approach would strain the continuity of service delivery. In addition, off-site, group-based training is time-consuming and more expensive than on-site training because of travel and other costs (e.g., renting training facilities). OST is designed to help training participants practice newly learned skills immediately on the job, and trainers can provide immediate supportive supervision and coaching to ensure effective transfer of learning in an environment that is familiar to the health care providers. In addition, traditional off-site IP training uses simulated settings with ideal supplies for skill practice. Often participants are overwhelmed when they return to their sites after off-site training, because the majority of the supplies they need for IP practices are not available. On-site training allows trainers and participants to be innovative in finding solutions that will assist their sites in setting priorities and planning to ensure that supplies are always available. Further, OST creates awareness among all staff of the training that is occurring in their hospital, so they are more likely to learn from the trained providers after the training is over.
PLANNING AND PREPARATION FOR ON-SITE TRAINING

JHPIEGO’s planning for on-site training for IP and PIHCT in Ethiopia started with an informal discussion with the HIV/AIDS department of the MOH/HAPCO and the CDC in Ethiopia. A concept paper was developed at the request of the MOH and was approved with some changes. An agreement was made to limit the OST to IP and PIHCT as a pilot test. IP on-site training was planned for 39 hospitals and PIHCT on-site training was planned for 98 hospitals. Major activities carried out during the planning and preparation phase are described below.

Identifying Major Stakeholders

The first step in the planning process was to identify major stakeholders. The stakeholders for OST included the following:

- The health care facilities
- PEPFAR university partners (University of Washington, Columbia University, University of California San Diego, and Johns Hopkins University)
- Regional health bureaus
- The HIV/AIDS department of MOH/HAPCO
- CDC in Ethiopia
- IP and PIHCT trainers

Stakeholder Buy-In

In collaboration with the HIV/AIDS team at the MOH/HAPCO, JHPIEGO organized a two-day stakeholders’ meeting at the Christian Relief and Development Agency in Addis Ababa on May 15–16, 2006. The purpose of the meeting was to share JHPIEGO’s and the university partners’ fiscal year 2006 plans and activities, and to get participants’ feedback.

The participants were from the MOH/HAPCO, the regional health bureaus, third cohort hospitals, and the U.S. university partners that provide technical assistance in IP, PMTCT, and HCT services at the hospital level. An invitation letter was sent to the participants; it included detailed information on training dates, site preparation, and supplies needed for the training.

At the meeting, on-site training strategies for IP and PIHCT were introduced and discussed in detail using a participatory approach. Dr. Afework Kassa, of the HIV/AIDS department of the MOH, emphasized the need for decentralized in-service training and requested that the regional health bureaus and the hospital medical directors extend their full support for making on-site training in IP and PIHCT successful.

Following the meeting, the MOH sent out a letter requesting that an HIV/AIDS focal person or regional health bureau representative attend one of the on-site training events in their region and provide feedback. The proceedings of the stakeholders’ meeting, including a copy of the trainer development pathway, an
on-site training schedule, a list of trainers by region and technical area, and a feedback form for on-site training, were enclosed with the letter.

Not all medical directors from the planned OST hospitals were able to attend the stakeholders’ meeting, so JHPIEGO program staff contacted those who were not able to attend and introduced them to the IP and PIHCT on-site training approach.

Technical and Program Preparation

**IP training materials**

The MOH has continued to use JHPIEGO’s generic IP training package, which has been used internationally for more than five years and is mainly geared toward off-site, group-based training. The training package was reviewed to see if the content and instructional design would be applicable to the on-site IP training approach. Several changes were made to the content, training methodologies, and schedule. Presentations on avian influenza and IP in antenatal care and labor/delivery were added to the course. The training methodology included interactive classroom presentations using an overhead projector, demonstration and re-demonstration of IP skills, small-group activities, and IP video shows. Following each of these activities, participants implemented and practiced IP skills on the job, and trainers provided coaching and immediate feedback.

Consumable supplies for IP training were put together in kits. Items that could be borrowed from the hospital site were identified, and sites were informed of the needed supplies at the stakeholders’ meeting.

**PIHCT training materials**

The national-level HCT Technical Working Group, which was created by the MOH, adapted a PIHCT training package that had been used for a three-day off-site, group-based training. The training package required only minor changes for use in the on-site training.

For both IP and PIHCT on-site training, JHPIEGO’s presentation graphics were reviewed and revised for the on-site context. Each team of trainers received a set of presentation graphics and an overhead projector. The course schedule, course outline, course evaluation form, and pre- and mid-course questionnaires were revised to suit the on-site training, and additional topics were incorporated. A standardized end-of-course reporting form and a schedule for supportive follow-up were also designed. Plans were made to send the training materials to the sites well ahead of the training dates.

**Trainer preparation**

Having competent trainers is vital to any successful training intervention. In order to develop in-country capacity for training, JHPIEGO held a two-week Clinical Training Skills (CTS) course in May and June 2006 to prepare trainers to conduct IP and PIHCT training courses using competency-based, participatory training methods.

JHPIEGO and the MOH/HAPCO identified and invited 25 IP participants and 27 PIHCT participants from the respective regions to the course. Providers were selected on the basis of their demonstrated proficiency in IP/PIHCT knowledge and
skills, active participation during previous IP/PIHCT provider courses, demonstrated efforts to implement IP/PIHCT practices at a facility following IP/PIHCT training, willingness and availability to conduct OST, and interest in training other health care providers. Before the CTS course, the participants were informed of their potential roles and responsibilities as on-site IP or PIHCT trainers.

The first week of the CTS course focused on strengthening participants’ skills in delivering interactive classroom presentations using participatory training methods and in demonstrating skills. Trainers received coaching from master trainers while they practiced the skills either in the classroom or on the job. During the second week, participants taught an IP/PIHCT on-site training course using their training materials and acquired skills. They practiced using the overhead projectors and transparencies that they would be expected to use when conducting IP/PIHCT on-site training. The presenters were allowed to express their feelings about their peer trainers’ presentation styles, and participants were also given time to give positive feedback and suggest approaches and skills that the presenter could improve. The master trainers also provided positive feedback and suggestions for improvement at the end of each session.

Along with the CTS, trainers participated in a three-day orientation to OST, which included information on the technical, financial, and administrative processes involved in OST. The orientation introduced trainers to the OST approach, schedule, logistics, and materials and trained them to become trainers in the OST approach. The benefits of on-site training were reviewed in detail. Orientation also included a role-play on how participants would ensure the full support of hospital management at the training site.

Participants were informed about their contracts, the need to take leave and fill out various forms, and the need to take materials (kits, payment forms, registration and attendance sheets, and so on) with them to the training sites. In order to increase the number of trainers available and trained for OST, six additional former IP/PIHCT trainers attended the orientation. One trainer left the training at the beginning because he did not get his first choice of sites.

At the completion of the training for trainers, participants received copies of all presentations and a draft trainers’ guide, on-site training materials (including an overhead projector), and administrative and financial reporting forms. They were informed of their schedules, grouped into teams, and given the contact information of JHPIEGO staff and IP/PIHCT trainers for support during the on-site training. All participants signed a contract for providing services as trainers during the IP or PIHCT on-site courses. Based on the geographical proximity of each of the sites and the trainers’ workplace/regions, a total of 14 IP training teams and 15 PIHCT training teams were formed.

The formats of the two types of training were different. On-site training in IP was planned in a back-to-back format, which allowed trainers to take continuous leave from their jobs rather than several separate leaves. Each IP team conducted four consecutive trainings at four different sites. The PIHCT training courses were held on weekends, and hospitals were scheduled for training over several weeks in close geographic proximity to the trainer teams. This allowed trainers to provide training on weekends and then return to work during the week. At the conclusion of the OST project, trainers noted that they preferred the IP approach.
Training site preparation
The stakeholders’ meeting and regular follow-up communication helped to set the tone for successful on-site training at the hospitals. Each site was contacted by letter in advance of the training and asked to prepare in the following ways (see Annex A):

- **Participant selection for IP training.** Each site was asked to select a maximum of 15 participants from key departments of the hospital. Hospitals received a list of suggested areas or units from which participants could be selected. JHPIEGO encouraged the selection of participants from antenatal care and labor and delivery, but the hospital’s preference was given priority.

- **Participant selection for PIHCT training.** For the PIHCT training, priority was given to the selection of clinical care providers who had direct contact with patients with advanced HIV disease. These providers—particularly general practitioners, nurses, and midwives—were chosen regardless of their professional qualifications. The maximum number of participants was set at 15.

- **Training room.** The hospital management at each site was asked to arrange for a training room or space big enough to hold the number of health professionals attending the training. Hospital managers were asked to identify an off-site training facility, if the hospital did not have an in-house training space.

- **IP supplies.** A list of the IP supplies needed for practical demonstrations during the training was prepared in advance. JHPIEGO procured overhead projectors and consumable IP supplies, and hospitals provided some nonconsumable items that were returned to the respective department at the end of the training (see Annex A). The list was given to the medical directors at the stakeholders’ meeting and was also sent to sites prior to the start of the training. Follow-up calls were made to the sites to remind them to prepare the supplies. Provisions were made for the trainers to buy some materials from local markets if their materials did not arrive on time.

In order to ensure that the medical directors were aware of the training dates and assistance needed from the sites, JHPIEGO staff called the sites immediately after the letters were sent and again one week before the training to ensure receipt of the letter and to remind them of site-level needs.

Administrative and Finance Preparation for On-Site Training
Like all other implementing partners, JHPIEGO follows the U.S. Government’s financial rules and regulations for PEPFAR funding. An extensive discussion was held with the MOH regarding payment for OST participants. Payment for off-site training is seen as an incentive for health care providers. Participants receive a per diem, get to travel outside of their workplace, and meet and share experiences with other health care professionals from different sites around the country. However, because the OST project was a pilot program, participants were paid a small stipend for the extra hours of work instead of a per diem. The stipends for the trainers (consultancy fee and per diem) were based on rates set by the PEPFAR implementing partners to ensure consistent pay rates for all trainers in different technical areas.
The OST trainers were asked to sign contracts with an agreed-upon consultancy fee, their scope of work, and clearly defined deliverables (Annex B). In keeping with U.S. Government financial regulations, the trainers were required to take annual leave while they were training, so they were asked to arrange their leave before signing the contractual agreement for the assigned training period.

One member of each team was designated as a lead trainer. The lead trainer was expected to take responsibility for the following:

- Payment of training-related costs (participant payments and other miscellaneous costs incurred during training)
- Ensuring that all required forms were completed and attached to the training report
- Timely submission of training reports to the JHPIEGO office at the end of training, with accompanying financial and other forms completed
- Taking care of the IP kit and the overhead projector

The following reporting forms were developed and distributed to the trainer teams at the orientation meetings:

- Participant registration forms
- Daily attendance sheets
- Training report template
- JHPIEGO contact list
- List of hospitals scheduled for training
- List of IP supplies and training materials, by site and team
- List of demonstration materials to be prepared by hospitals
- Instructions for the overhead projector

An OST financial policy was developed to guide lead trainers on the rules and regulations for payments made for OST (see Annexes C and D). This policy was signed and agreed upon by all lead trainers. Project and personal travel advance forms were developed and individually tailored to each trainer’s circumstances (differentiating the responsibilities of the lead trainer and co-trainer).

The lead trainer was required to submit all training-related payment receipts and other program deliverables to the JHPIEGO office before consultancy payment was made. He or she was paid an extra fee per day for this additional responsibility.

The following forms were developed to ensure accurate financial reporting:

- Copies of the consultancy contract
- Leave agreement form
- Bank wire information form
- Project advance reconciliation form
- Travel advance reconciliation form
- Participant payment sheet
- Daily attendance sheet
- JHPIEGO receipt for goods and services obtained for which no receipt was issued by the vendor

JHPIEGO made arrangements in advance to send money to the training sites. The majority of sites had a bank where money was transferred in the lead trainer’s name. For IP, money was wired in bulk before the training started; for PIHCT, money was wired before each training weekend. JHPIEGO staff created a schedule to ensure that money was transferred well in advance of training, and they made every effort to be responsive to emergency needs for extra funding.

**On-site supportive supervision during training**

The JHPIEGO technical advisors for IP and PIHCT conducted visits to the trainers at least once during the OST to provide supportive supervision. At least one visit was planned for each of the 14 IP teams. Two of the teams were visited twice because of geographic proximity and the need for more technical assistance, and three teams were not visited at all because of other commitments or priorities. Visits to the PIHCT trainers were conducted by site and not necessarily by team. The JHPIEGO technical advisor for PIHCT visited 27 of the 97 hospitals that received training. All hospitals and teams were contacted by phone to ensure training preparedness.

**Monitoring and evaluation**

The nature of on-site training prevents the continuous presence of a master trainer. Having a strong monitoring and evaluation system helps to ensure the quality of training at all levels and provides lessons for future training efforts. In the OST project, efforts were made to get feedback on all aspects of training from as many sources as possible, including the following:

- **Pre- and mid-course questionnaires.** In each of the training courses, pre-course questionnaires were administered at the beginning of the course to assess individual and group knowledge of IP or PIHCT principles and practices. The purposes of the pre-course questionnaire were to help participants identify their own level of knowledge and areas they needed to focus on during training and to help trainers identify the topics that they should give more time to during the training. The pre-course questions were true-false; hence, the chance of getting the correct answer on any question was 50 percent. The mid-course questionnaire consisted of multiple-choice questions and was designed to assess the knowledge that participants had gained during the training.

- **Feedback from participants.** Throughout training, participants were encouraged to give feedback to the trainers, both individually and as a group, in order to improve the course.

- **Feedback from hospital directors.** The medical directors were considered a very important source of feedback. Specific questions were added to the PIHCT and IP training reporting template to help them provide objective feedback about the training. Medical directors were asked to monitor the training and review the training report before providing feedback and signing the report.

- **End-of-day meetings.** Trainers also reviewed their own performance. Each training team was expected to meet at the end of every training day. The daily
meetings helped trainers reflect on their performance, provide and receive feedback, and plan for the next day. JHPIEGO technical officers also attended some of these meetings.

- **End-of-course evaluation.** An end-of-course evaluation tool was developed to assess all aspects of training, including classroom arrangements, training materials, training methodology, timing, and content. Participants were also asked to give suggestions for improving future training.

- **Feedback from stakeholders and partners.** Each trainer was given an evaluation tool to use for soliciting feedback from visiting stakeholders and partners. Possible visitors included regional health bureau staff, MOH staff, and U.S. university partners. The university partners were kept in the loop right from the beginning; they not only assisted with on-site training but also provided feedback.

- **Debriefing meeting.** A debriefing meeting for trainers was scheduled early in the planning process to get comprehensive feedback on training, identify advantages and limitations of OST compared to off-site group-based training, share experiences, and solicit input for the final report. Because the Ethiopian government halted PIHCT training activities in order to scale up ART services, the PIHCT trainer debriefing was not held.

## IMPLEMENTATION OF ON-SITE TRAINING

The first IP on-site training kicked off on June 26, 2006, and all 39 sites were covered by August 26, 2006. PIHCT training courses started on June 9, 2006, and finished on November 20, 2006. In all, 97 public hospitals were trained in PIHCT.

The IP training teams took leave from their workplaces for up to one month. The trainers noted that they appreciated the schedule because it required them to take leave only once. The sessions were held from Tuesday to Saturday, with Monday reserved as a trainer set-up day. The IP course was scheduled during the week so that practical sessions could be held during hours when client care was being provided, enabling trainers to provide constructive feedback to the participants (see Annex E).

PIHCT training courses were held over a longer time period, with the team conducting the training going back to work and then returning to train again about two weeks later. This schedule reduced the amount of time that the trainer had to spend away from his or her workplace at any one time. In addition, training on the weekends reduced the disruption to client care, enabling the participants to maintain continuity of services at their sites.

**Mobilizing Trainers**

The trainers were informed in advance about the dates of training, the names and locations of the sites, and how to get money for traveling, so it was easy for them...
to arrive at the training site a day or two before the course. They were expected
to make their own travel arrangements and to use public transportation whenever
possible. Trainers were able to use public transport (air and road) to reach 35 of
the 39 training courses; in four cases, they needed JHPIEGO’s assistance with
arranging transportation. In several places no private lodging accommodations
were available, so medical directors assisted trainers in making lodging
arrangements, either in the hospital guest houses or in private houses. Five teams
reported challenges in getting private accommodations in the town, but not a
single course was cancelled for this reason. Some trainer teams reported difficulty
in locating the hospital when they arrived in the city and requested maps and
directions from JHPIEGO for the next round of training.

During the implementation phase of the training, the trainers were instructed to
contact the hospital director as soon as they reached the respective hospitals to
prepare for the set-up of the training. The hospital directors were expected to
provide the participant list, training materials, and a training room. Hospital
matrons were responsible for providing the requested nonconsumable IP
supplies for the trainers. The trainers spent one day arranging the training room
and preparing for the training event.

On the first day of the course, hospital managers and participants were asked to
select the best time (morning or afternoon) to hold the classroom portion of the
training. This allowed participants to partially continue to provide services in
order to reduce the gap in routine service delivery.

**Mobilizing Training Materials**

JHPIEGO program assistants and IP and PIHCT technical advisors identified
various options for mailing materials to each of the sites. Packages were mailed
using the regular mail system if sites had more than three weeks until the beginning
of their course. The Ethiopian Mailing System (EMS) was used to send training
materials to sites that had less than three weeks until the training started. For sites
that were not covered by the EMS, university partners assisted with sending the
materials. In several instances, trainers agreed to assist in carrying materials to sites.
The program assistants made frequent follow-up telephone calls to ensure that the
packages arrived at the sites long before the training started. Training materials did
not arrive on time at three of 39 IP sites, and trainers had to purchase several items
locally, including stationery and some IP materials.

**Mobilizing Funds for Training**

The lead trainer was expected to make per diem payments to participants and
handle all expenses. Each lead trainer therefore signed a project advance
agreement form and received wired funds to pay for participants’ costs. In
addition, advances for travel were given to each trainer. Trainers were required to
settle all costs before reimbursements and consultancy payments were made.

One week before a trainer’s travel or the start of a training, the JHPIEGO finance
team wired transferred funds (both project and travel funds) to banks with a
branch in the towns where trainers lived or where on-site training events were to
be conducted. Trainers were given funds only for the next training session so that
they would not be put in danger by carrying a large amount of cash.
Allowed OST costs included but were not limited to participant per diem, stationery (pens and notepads), photocopies of training materials, money for generator fuel, and transport, per diem, and incidental expenses for trainers. (Annex C shows the relevant financial forms.)

Mobilizing Sites for Training

The JHPIEGO/Ethiopia OST team communicated with sites frequently to ensure that they were ready for training, had received training materials, had arranged for the room, and had identified participants for training.

In spite of all of the efforts made to ensure that the OST went smoothly at all sites, several training events had to be rescheduled because (1) trainers did not reach the training sites on time due to transportation or communication problems, (2) the travel time from one site to another was underestimated, (3) sites were not prepared for the training, or (4) sites had conflicting priorities, such as needing to respond to a disease outbreak and other training activities.

Thirteen of the 39 IP on-site training courses were rescheduled because trainers needed more travel days than expected to reach the next training site. Since PIHCT training was scheduled with more time between each training event, the PIHCT courses were held as planned and did not need to be rescheduled.

Mobilizing Partners and Other Stakeholders

Beginning in the planning phase and continuing through implementation, partners and stakeholders were encouraged to visit the training events and provide feedback and suggestions for improvement. The detailed schedule consisting of the names of sites, training dates, and names of the trainers was sent to all partners and stakeholders before the beginning of the training. Of the 39 IP training events, one was visited by a regional health bureau and none were visited by the university partners or other stakeholders. However, regional health bureaus and/or university partners visited 16 of the 97 PIHCT training courses.

While every effort was made to encourage the participation of regional health bureaus and other stakeholders in the training process, it is understandable that they were not able to attend frequently. Other demands on the stakeholders—for example, implementation of Ethiopia’s ART program—were significant and did not allow for visiting the training.

On-Site Support from JHPIEGO during Training

JHPIEGO technical advisors visited 12 of the 14 IP training teams at least once. The only teams that did not receive a follow-up visit in person were those with a team leader who had already been supervised while training another team. Follow-up visits were made to only 27 of the 97 PIHCT sites, so the other teams were called in to provide support to the teams that didn’t receive follow-up visits. The main purposes of the follow-up visit were to assist the trainers technically, to monitor the training, and to
provide immediate feedback on the trainers’ skills or their performance as a whole. For the IP training, assistance during the follow-up visit included helping sites to develop action plans for implementing IP practices, developing IP committees, and reorganizing the use of IP supplies in the hospital. Plans were developed and contact information for JHPIEGO staff was shared to ensure that trainers had frequent contact with the JHPIEGO IP technical advisor, program assistants, and finance staff.

MAJOR OUTCOMES OF THE ON-SITE TRAINING PROJECT

Tables 1, 2, and 3 show the numbers of participants in the pilot IP and PIHCT on-site training courses by cadre, gender, and region.

Infection Prevention
A total of 605 participants from 39 public hospitals received on-site training in IP. Of the 39 on-site training courses that were planned, 38 were conducted. Because of security concerns, trainers did not travel to Deghabur in the Somali region adjacent to the eastern border of the country. The participants from these hospitals were reassigned to courses at Harar Police and Harar Misrak Arbenoch hospitals.

The Harar regional health bureau was the only bureau to send an HIV/AIDS focal person to one of the IP training courses. That participant attended the training at Harar Misrak Arbenoch Hospital.

Provider-Initiated HIV Counseling and Testing
Of the 98 PIHCT on-site training courses planned, 97 were actually conducted. A total of 1,349 participants from the 97 public hospitals received the training. Due to the Ethiopian government’s rapid scale-up of ART services in late 2006, Humera and Lalibela did not receive the PIHCT training.

Overall OST Statistics
- OST is less than one-third the cost, per participant, than off-site training.
- A total of 1,954 service providers were trained using the OST approach.
- Most participants were very pleased with the training approach and suggested that more training be offered in the same format.
- Increases in post-test scores (over pre-test scores) among the participants in IP on-site training were somewhat lower than those of participants in off-site training, most likely because non-service providers (e.g., cleaners), who might not have had a good command of English, were included in the on-site training.
  Table 4 shows the average pre-test and post-test scores for PIHCT participants.
Table 1. OST Participants by Cadre

<table>
<thead>
<tr>
<th>PROFESSIONS</th>
<th>NUMBER OF PARTICIPANTS TRAINED IN IP</th>
<th>NUMBER OF PARTICIPANTS TRAINED IN PIHCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>66</td>
<td>149</td>
</tr>
<tr>
<td>Nurse/Midwife</td>
<td>308</td>
<td>985</td>
</tr>
<tr>
<td>Lab Technician</td>
<td>61</td>
<td>0</td>
</tr>
<tr>
<td>Sanitarian</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Heath Officer</td>
<td>14</td>
<td>37</td>
</tr>
<tr>
<td>Administration</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>Health Assistant</td>
<td>57</td>
<td>159</td>
</tr>
<tr>
<td>Other</td>
<td>56</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>605</td>
<td>1,349</td>
</tr>
</tbody>
</table>

Table 2. OST Participants by Gender

<table>
<thead>
<tr>
<th>TRAINING TYPE</th>
<th>GENDER</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>IP</td>
<td>366</td>
<td>239</td>
<td></td>
</tr>
<tr>
<td>PIHCT</td>
<td>708</td>
<td>641</td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Number of OST Training Sites by Region

<table>
<thead>
<tr>
<th>REGION</th>
<th>SITES TRAINED IN IP</th>
<th>SITES TRAINED IN PIHCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addis Ababa</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Amhara</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>Bensingul Gumuz</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Harari</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Oromia</td>
<td>15</td>
<td>29</td>
</tr>
<tr>
<td>SNNPR</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Somalia</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Tigray</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Afar</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Dire Dawa</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Gambella</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>97</td>
</tr>
</tbody>
</table>

Note: Afar, Dire Dawa, and Gambella had no new sites during PEPFAR’s fiscal year 2006.

Table 4. PIHCT and IP Pre-test and Post-test Participant Scores (out of 100)

<table>
<thead>
<tr>
<th></th>
<th>PIHCT</th>
<th>IP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Pre-Test Score (out of 100%)</td>
<td>52.2%</td>
<td>47.6%</td>
</tr>
<tr>
<td>Average Post-Test (out of 100%)</td>
<td>68.6%</td>
<td>58.4%</td>
</tr>
<tr>
<td>% Improvement from Pre- to Post-Test</td>
<td>16.4%</td>
<td>10.8%</td>
</tr>
</tbody>
</table>

Financial Indicators for On-Site Training in Infection Prevention
Overall, the cost of on-site training for one participant was significantly lower than the cost of training a participant in an off-site training (Table 5). The calculations in Tables 5 and 6 are based on the assumptions listed below. Costs are averages in U.S. dollars and represent per training averages for all cost variables.

- **Participant costs** include per diems (travel days and training days), transport costs (if applicable), and hotel costs (if applicable). The per diem for OST was primarily for tea/coffee breaks, lunch, and transportation.

- **Materials/supplies** include participant stationery (pens and notepads), various training demonstration supplies, photocopies of the training materials and exercises, and shipping of the training materials to sites. It does not include overhead projectors.

- **Conference costs** include tea/coffee breaks and conference room rental.

- **Trainer costs** include per diems, travel, lodging, and consultancy fees.

<table>
<thead>
<tr>
<th>TYPE OF TRAINING</th>
<th>TOTAL AVERAGE COST</th>
<th>COST PER PARTICIPANT</th>
<th>MATERIALS/SUPPLIES COSTS</th>
<th>CONFERENCE COSTS</th>
<th>TRAINER COSTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP Off-Site</td>
<td>U.S. $11,064</td>
<td>U.S. $3,829</td>
<td>U.S. $1,677</td>
<td>U.S. $2,336</td>
<td>U.S. $1,880</td>
</tr>
<tr>
<td>IP On-Site</td>
<td>U.S. $2,634</td>
<td>U.S. $175</td>
<td>U.S. $328</td>
<td>0</td>
<td>U.S. $577</td>
</tr>
<tr>
<td>PIHCT On-Site</td>
<td>U.S. $1,533</td>
<td>U.S. $34</td>
<td>U.S. $125</td>
<td>0</td>
<td>U.S. $359</td>
</tr>
</tbody>
</table>

**Note:** Off-site and on-site have the same training duration (IP=5 days; PIHCT=3 days); the average number of participants was 15 in IP OST and 25 in IP off-site training. For PIHCT, the average number of participants was 12 in OST and 25 in off-site training.

The following results were obtained from our analysis of the costs and financial reporting of the pilot training:

- The maximum cost per IP OST training was U.S. $2,800; the minimum cost per IP OST training was U.S. $2,536.

- The maximum average cost per PIHCT training site was Ethiopian Birr (ETB) 16,474.77 and the minimum was ETB 11,048.19. The variation in cost is most likely the result of the different distances and thus the longer travel times from the trainers’ workplaces to the site or of the increase in the number of participants trained.

- The average transport cost per on-site training was U.S. $66. (Only trainers incurred transport costs.)

- The average time for trainers to reconcile training costs with JHPIEGO was four days (with a range from two to six days).

- Four of the 14 IP teams initially sent incomplete documents for reconciliation. However, all were finalized over time.

The main reasons for the cost variation in the on-site training events were the
additional participants, the lack of public transportation, the remoteness of the site, payment for fuel/generators for training purposes, and the purchase of stationery or copies on-site due to a delay in receiving packages from JHPIEGO.

Table 6. On-Site versus Off-Site Training Costs as Percentage of Total Project Costs

<table>
<thead>
<tr>
<th>IP ON-SITE TRAINING EXPENSE ITEMS</th>
<th>PERCENT OF TOTAL</th>
<th>IP OFF-SITE TRAINING EXPENSE ITEMS</th>
<th>PERCENT OF TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Per Diems</td>
<td>28.50%</td>
<td>Participant Per Diems</td>
<td>41.00%</td>
</tr>
<tr>
<td>Trainer Per Diems</td>
<td>13.54%</td>
<td>Trainer Per Diems</td>
<td>10.13%</td>
</tr>
<tr>
<td>Trainer Transport and Miscellaneous Costs</td>
<td>3.4%</td>
<td>Trainer Transport and Miscellaneous Costs</td>
<td>1.62%</td>
</tr>
<tr>
<td>Participant Transport</td>
<td>0%</td>
<td>Participant Transport</td>
<td>7.11%</td>
</tr>
<tr>
<td>Consultancy Fee</td>
<td>26.99%</td>
<td>Consultancy Fee</td>
<td>0.00%</td>
</tr>
<tr>
<td>Staff Per Diems</td>
<td>0%</td>
<td>Staff Per Diems</td>
<td>1.26%</td>
</tr>
<tr>
<td>Stationery Supplies</td>
<td>3.03%</td>
<td>Stationery Supplies</td>
<td>0.05%</td>
</tr>
<tr>
<td>Photocopy and Binding, Mailing Materials to Sites</td>
<td>9.46%</td>
<td>Photocopy and Binding, Meeting Costs</td>
<td>7.58%</td>
</tr>
<tr>
<td>Conference Package</td>
<td>0%</td>
<td>Conference Package</td>
<td>21.11%</td>
</tr>
<tr>
<td>Overhead Projector (one-time cost)</td>
<td>11.16%</td>
<td>Contractor Fee and VAT</td>
<td>10.14%</td>
</tr>
<tr>
<td>Office Miscellaneous</td>
<td>0.10%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Consultancy fee was also incurred with off-site training (at least two trainers at ETB 500 per day for five days have not been included in the overall percentage. VAT is value-added tax.

LESSONS LEARNED

A two-day debriefing meeting for all IP on-site trainers was held on September 25–26, 2006. The main purposes of the meeting were to review the different strategies, challenges, and benefits of on-site training, and to collect feedback on the OST and encourage trainers to share their experiences with each other and stakeholders. The meeting also provided an opportunity to recognize trainers’ performance and award them with certificates. Participants included staff from MOH/HAPCO, CDC, the U.S. university partners, and the Addis Ababa regional health bureau, and two hospital directors (from Alert and Ras Desta).

A trainer debriefing for PIHCT on-site training was not scheduled due to an MOH directive in late 2006 to halt all training activities in order to facilitate the scale-up of ART services around the country.

The following points were collected from comments from IP and PIHCT trainers, JHPIEGO staff, partners, and hospitals:
Advantages of On-Site Training

- More health care providers can be trained using an on-site approach than using off-site training.
- Routine hospital health care services were not compromised during the training.
- OST facilitates immediate implementation of newly learned knowledge and skills and opportunities for feedback from trainers.
- OST increased the awareness, motivation, and commitment of hospital management and providers to implement IP and PIHCT practices at their sites.
- OST fostered a team spirit among the trainees.
- OST was cost-effective, time-saving, and practical.
- The participants trained without going far from their families and workplaces.
- The OST experience will pave the way for OST implementation in other HIV/AIDS-related technical areas.
- OST will result in increased transfer of IP knowledge and skills, because training takes place in a practical and familiar environment with available supplies.
- Participants actively participated in identifying IP gaps and designed feasible strategies to close those gaps.
- Trainers identified gaps in IP practices and gave immediate feedback to participants and management about how to improve services.
- Involving hospital management in the training generated more commitment and initiation of IP. Medical directors and hospital administrators also conducted follow-up visits and provided support for immediate implementation of recommended IP practices.

Key Factors Contributing to the Success of Onsite Training

- Management staff from various hospitals were supportive and cooperative with regard to:
  - Identifying participants as suggested by JHPIEGO
  - Preparing/space for the training
  - Providing IP supplies for practical demonstrations
  - Allowing use of the hospital generator in case of interruption or lack of electric supply
  - Making opening and closing/remarks
  - In some cases, attending the whole training
  - Providing genuine feedback and comments for the trainers and about the training in general at the end of the course
  - Participants were interested and willing to immediately implement what they have learned.
  - Trainers were able to observe the IP gaps in the hospital, suggest possible solutions, and share their experience.
Trainers were equipped with adult learning principles, standard training materials, and audiovisual aids.

Hotels and bank services were available in most towns where the hospitals were located.

JHPIEGO technical advisors provided follow-up visits and feedback.

The JHPIEGO office responded and acted immediately when contacted.

Participants were motivated to know more about IP and post-exposure management, especially those who took post-exposure prophylaxis.

Limitations of On-Site Training

- Participants were sometimes called to attend patients during classroom and practical sessions.
- Opportunities were missed to share experiences among participants of other hospitals.
- OST created more work and longer hours for participants during training times.
- With training in the workplace, there was no relief from routine activities and the work environment.
- Some participants were hesitant to give comments and suggestions in general discussions in front of hospital management.
- At some sites, the selection of participants was not appropriate.
- Sometimes a short time was allocated for classroom learning because of workload.
- Five days is too short a time for comprehensive on-site IP training.
- JHPIEGO could not arrange vehicles for the trainers to travel from site to site.
- Some sites were not ready and providers could not participate actively in OST because they had not attended the stakeholders’ meeting or had other health emergency priorities.
- Topics like blood safety, laboratory safety, and surgical wound care were not included or addressed actively during IP training.
- In some areas there were language barriers between the participants and the trainers.
- Participant certification was not determined prior to starting on-site training.
- Difficulties in contacting some of the sites and poor mail services hampered communication. One site was not informed about training due to communication failure, and at two sites the staff who received the message did not communicate it to the medical directors, either out of neglect or purposefully due to personal conflict.
- Heavy rains made it difficult for the trainers to travel and arrive on time at some of the sites.
- The allocated extra budget did not cover all of the unforeseen expenses.
Challenges and Solutions

Interuption or absence of electric power supplies
A small generator rented from a hotel or a hospital generator was used in areas where the electrical supply was interrupted or not available at all. Other options included using flipcharts or having participants read aloud from transparencies. In one hospital the trainers had to rent a generator from the town in order to conduct the training. Trainers reported having frequent power outages in eight of the training courses. In those cases they used the hospital generator or a flipchart in place of an overhead projector. Among the 14 IP teams, three teams had two projector bulbs burn out, six teams had one bulb burn out, and four teams had no incidence of bulbs burning out. Fluctuations in power supply and frequent outages were the main reasons for the 12 incidents of burned out bulbs.

In one hospital there was no electric supply and no generator to be rented, but there was a public generator that worked only in the evening. Participants of this IP training opted to meet until 9:00 PM.

Inappropriate participant selection
Participant selection criteria should be emphasized during the stakeholders’ meeting, and medical directors, hospital management, and regional health bureaus should have clear guidelines on appropriate selection of participants. In the letters sent to hospitals, JHPIEGO recommended relevant departments for the training. Medical directors acted in the recommendations and rarely selected staff from irrelevant departments. However, not all hospitals will have the suggested number of professionals for training, and in this case they must make their own selections based on their needs. When hospitals did make inappropriate selections of participants, trainers would call the JHPIEGO technical advisors for instructions.

Training packages arriving late, not arriving completely, or not arriving at all
Trainers made copies of the training packages and purchased stationery (pens and notepads) on site. While waiting for the training packages to arrive, they used innovative approaches in their training. Because there were many training sites and events to coordinate, the program assistant was asked to ensure that training packages were complete before sending them and to send two extra sets of training materials to each site.

Trainers unable to complete the training within five days
Some of the hospitals had a high client load and a shortage of staff. In these cases the time allocated each day for the training was not adequate to cover all of the needed topics. In some situations, such as during the World Cup football season, participants were reluctant to attend classes after work hours. Thus, trainers and participants came to an agreement to use the weekend to cover the topics.

Trainers had to hand-carry training materials
Trainers were allowed to pay porters a reasonable amount of money to carry the training materials. In addition, lead trainers who were asked to carry the overhead projector and other key training materials were paid an extra fee per day.
IP supplies in the training kit leaked

Bleach was one of the consumable IP supplies procured by JHPIEGO and included in the IP training kit. Often the bleach leaked and spoiled the bag and other supplies, so the decision was made not to include bleach in the kit. Instead, trainers purchased bleach upon arrival at the training site.

Fading transparencies

JHPIEGO technical officers gave instructions to participants about how to keep the transparencies from fading. Permanent markers were provided and were used to rewrite faded letters on the transparencies. The suggestion was made that better-quality transparencies and printing machines be used for the next training. In addition, some of the transparencies were printed in color and were expensive and not easily visible when projected, so the decision was made to use only black ink when printing transparencies.

Lack of certificates for participants after training

On direction from the MOH, participant training certificates were not awarded until the completion of the pilot project. During the trainer debriefing meeting for the IP trainers, the MOH instructed JHPIEGO to prepare and deliver certificates to the participants.

Absence of television and VCR/DVD in some hospitals

Televisions and VCR/DVDs were obtained from participants and community members or rented from music shops in order to show the IP demonstration videos. Some of the IP video CDs were not functional. JHPIEGO program assistants were asked to check the CDs before putting them in the training package and to provide additional CDs and videos as reserves.

Difficulties of communication with some of the sites and/or trainers

Trainers were forced to travel to distant places to get telephone service. In some cases there was no communication with the JHPIEGO office until the end of the training. Some trainers requested that the JHPIEGO office provide prepaid phone cards. They were advised to make “missed calls” (calling the JHPIEGO office and allowing the phone to ring once) to JHPIEGO technical advisors and finance and administrative staff, so the JHPIEGO staff would know they had called and could call them back at JHPIEGO’s expense.

Absence of flipchart stands and projector screens

Flipchart stands made of wood were sometimes found in the hospital compound. If stands were not available, the trainers used IV stands to support the flipcharts or hung the flipchart on the wall. Muslin, which was used at some sites as a screen for projectors, was also purchased and included in the training package for some sites.
Overhead projector bulbs often burned out due to fluctuating power
Reserve bulbs were included in the training packages.

Training schedules were often not followed as planned, and training was delayed
Competing health priorities, conflicts between managers at the site level, and delays at the previous training site were all reasons for delays in starting the training and following the schedule. Sites were rescheduled, directors were called to reschedule the next sites, and all trainings were either rescheduled or canceled, depending on the circumstances.

Lack of hotels for trainers at some hospital training sites
Some of the hospitals provided guest houses for the trainers and/or provided vacant rooms in outpatient departments where trainers could stay free of charge.

Trainers faced difficulties in traveling between hotels and hospitals
Public transportation, rented cars, and office cars were used to transport trainers and training packages. Most hospital directors offered the hospital car to transport trainers from the hotel to the hospital and in some cases to the next hospital. The hospital management requested the cost of fuel and a per diem for the driver if the driver traveled to another hospital. In some places trainers traveled from the hotel to the hospital on foot or by horse-drawn cart.

Requests for additional participants or payments beyond anticipated costs
If hospital directors asked for additional participants or payments, and if such requests were justifiable, JHPIEGO made exceptions and allowed additional participants to be accepted and additional payments for unexpected costs. Some participants shared a per diem in order to accommodate more participants. In two hospitals, medical directors insisted on payment for support staff, cleaners, and drivers who assisted in the training process. Requests were also made for extra participants, including laundry workers and housekeeping and kitchen staff, but sites making such requests were advised to include only health care professionals due to limited resources. Sites were advised to have the trained health care workers train other hospital staff.
Absence of camera for trainers
JHPIEGO was not able to provide cameras for trainers. However, some trainers used their own cameras or mobile phones to take photos.

Incomplete program and finance forms submitted for reimbursement
A few trainers submitted unclear or incomplete financial forms to the finance department. These trainers were called by phone, and the trainer debriefing meeting created an opportunity to meet with trainers and to have them clarify the forms.
Date

Medical Director
XX Hospital

Dear Medical Director,

Thank you for participating in the on-site training for Infection Prevention (IP) at your hospital. Two trainers will come to facilitate the on-site training that will occur at your hospital. The date of the on-site training is XX, 2006.

The IP training will consist of 5 half days of classroom training that will span from Tuesday to Saturday. This will help the providers to continue to provide routine services at your hospital and also practice some of the Infection Prevention skills in their work environment during the time when they are providing services. The trainers will arrive at your site on Monday to set up the training room and organize the training facilities.

JHPIEGO suggests the following cadre of health care providers should be selected for attending the training course. We strongly advise that most of the trainees come from the ANC and Labor and Delivery ward.

<table>
<thead>
<tr>
<th>Role</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP or ObGyn in ANC</td>
<td>1</td>
</tr>
<tr>
<td>Nurse/MCH Nurse</td>
<td>3</td>
</tr>
<tr>
<td>Physician in Labor and Delivery</td>
<td>1</td>
</tr>
<tr>
<td>Nurse/Midwife in Labor and Delivery</td>
<td>4</td>
</tr>
<tr>
<td>MD/Surgeon in OR/surgical unit</td>
<td>1</td>
</tr>
<tr>
<td>OR Nurse</td>
<td>2</td>
</tr>
<tr>
<td>Emergency Room/OPD</td>
<td>1</td>
</tr>
<tr>
<td>Sanitarian</td>
<td>1</td>
</tr>
<tr>
<td>Laboratory Personnel</td>
<td>2</td>
</tr>
<tr>
<td>Medical and Surgical Ward</td>
<td>3</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1</td>
</tr>
<tr>
<td>VCT</td>
<td>1</td>
</tr>
<tr>
<td>Matron</td>
<td>1</td>
</tr>
<tr>
<td>Person in Charge of CSR</td>
<td>1</td>
</tr>
<tr>
<td>Hospital Administrator</td>
<td>1</td>
</tr>
<tr>
<td>Medical Director</td>
<td>1</td>
</tr>
</tbody>
</table>

We kindly request you to select the appropriate participants for this training and to please ensure their availability for the training. We are also kindly requesting you to arrange for a training space that has chairs sufficient enough to hold the number of health professionals attending the training. We kindly ask you to limit the number of professionals trained to a maximum of 15 in number.
JHPIEGO is also kindly requesting some supplies from your hospital to conduct the on-site IP training. These items will remain at the hospital after the training. The items are as follows:

<table>
<thead>
<tr>
<th>Infection Prevention Items</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forceps (different types)</td>
<td>6</td>
</tr>
<tr>
<td>Needle holder</td>
<td>1</td>
</tr>
<tr>
<td>Suturing needles (preferably different kinds)</td>
<td>2</td>
</tr>
<tr>
<td>Cut gut</td>
<td>2</td>
</tr>
<tr>
<td>Cotton</td>
<td>small</td>
</tr>
<tr>
<td>Clean gauze squares</td>
<td>20</td>
</tr>
<tr>
<td>Calculator</td>
<td>1</td>
</tr>
<tr>
<td>Kidney dishes (preferably plastics)</td>
<td>3</td>
</tr>
<tr>
<td>Boots (plastic shoes)</td>
<td>1 pair</td>
</tr>
<tr>
<td>Plastic bowl (medium/small size)</td>
<td>2</td>
</tr>
<tr>
<td>Scissors</td>
<td>1</td>
</tr>
<tr>
<td>10- or 20-liter plastic buckets</td>
<td>3</td>
</tr>
<tr>
<td>Alcohol solution</td>
<td>half liter</td>
</tr>
<tr>
<td>Other supplies as needed</td>
<td></td>
</tr>
</tbody>
</table>

At the conclusion of the training, the trainers will produce a training report that we are kindly requesting you to review and approve. This is a way to ensure that the training is up to the standards and quality of the training JHPIEGO offers as well as that it fit the needs of your staff and hospital. There will also be a space on the report for you to provide comments for evaluation of on-site training.

Thank you in advance for your assistance in facilitating this on-site training, and we look forward to offering quality IP training to your hospital staff.

Sincerely,
ANNEX B: SAMPLE SCOPE OF WORK FOR ON-SITE TRAINERS

SCOPE OF WORK

Contractor’s Name: ____________________________________________

Contract Number: _____________________________________________

INDEPENDENT CONTRACTOR AGREEMENT

Scope of Work

Objective: Team 1: To conduct on-site training for hospital staff in Infection Prevention at:

<table>
<thead>
<tr>
<th>TEAM 1</th>
<th>SITES</th>
<th>REGION</th>
<th>TRAVEL</th>
<th>SET UP</th>
<th>TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gendeberat</td>
<td>Oromia</td>
<td>24–25 June</td>
<td>26-Jun</td>
<td>27 June–1 July</td>
</tr>
<tr>
<td></td>
<td>Gimbi</td>
<td>Oromia</td>
<td>2-Jul</td>
<td>3-Jul</td>
<td>4–8 July</td>
</tr>
</tbody>
</table>

Specific tasks for each training:
1. Arrive at site one day in advance of training to meet with medical director and prepare for the training.
2. Administer pre-test to participants.
3. Ensure that participants sign off on a daily AM/PM attendance and training payment sheet upon receiving payment.
4. Conduct training with hospital staff, using JHPIEGO training materials and training methods as taught at the Clinical Training Skills course.
5. Administer post-test to participants.
6. Ensure that all participants fill out the TIMS forms.
7. Draft brief training report based on the provided JHPIEGO template; have medical director review and sign the report.
8. Send all deliverables to JHPIEGO/Ethiopia within one week of the end of training.

Deliverables to be given to JHPIEGO no later than one week after the end of training:
1. Pre- and post-test results
2. Signed participant daily attendance and payment sheets
3. Completed TIMS participant form for each participant, and TIMS trainer and training course form
4. Brief training report signed by the medical director
5. Travel and project advance reconciliation form signed with appropriate and approved original receipts
6. Original bank wire receipt for project advance
ANNEX C: SAMPLE ON-SITE TRAINING WIRE AND PAYMENT INSTRUCTIONS

Name: ____________________________________________________________
Consultant profession: ________________________________________________
Lead trainer: _______________________________________________________
Team number: _______________________________________________________
Site to be trained: ___________________________________________________
Technical area to train in: _____________________________________________
Date of training: _____________________________________________________
Transport to be taken: ________________________________________________
Bank advance will be wired: ___________________________________________
Amount of money to be wired: _________________________________________

Wired money:
- Amount of money to be wired to sites is equivalent to the project and travel advance.
- Project advances are used to pay participant per diem and other miscellaneous expenses in connection with the training.
- Project advance should not be used to cover travel expenses.
- Allowable miscellaneous costs from project advance include: photocopies for training purposes, daily transport for trainer from hotel to hospital training site, purchase of replacement bulbs for overhead projector.
- Consultant should sign project and travel advance forms before receiving wire money.
- Project advance should be settled within 5 working days at the conclusion of on-site training by filling in Project Expense Report Form.
- Official receipts for miscellaneous expenses and payment form of participants shall be part of the Project Expense Report Form.

Participant per diem rates and instructions:
- Participants in the training will get paid 80 Birr per day if they attend a whole day training (proven by signature on the attendance sheet). This includes the cost for tea and coffee for breaks.
- No other payments will be made to the participants.
- Payments to participants will be made only at the end of the on-site training.
- Participants must sign on the Per Diem Payment Form and the names must be written legibly by the trainer in capital letters and will be submitted to JHPIEGO Ethiopia.
- Participants must sign a daily attendance sheet and submit it to JHPIEGO Ethiopia.
Payment for participants will be based on the daily attendance sheet: ETB 40.00 for half-day attendance and ETB 80.00 for full-day attendance.

**Consultant fee and per diem rates and instructions:**

- Daily consultancy rate is ETB 500.00. This money will be paid only for working days while in training and the day preparing for training.
- Per diem includes hotel costs and meals and incidental expenses and is 200.00 ETB per day.
- Per diem is 100% (200 Birr) for all working days and is 75% (150 Birr) for travel days.
- Per diem advances will be given at a rate of 75% of the total budget.
- You must fill in a travel reconciliation form when you complete the travel and submit it to the JHPIEGO Ethiopia office by fax or in person no later than 5 working days after training, or your consultancy fee will be withheld.
- Consultancy fee will only be paid at the end of the training/service and you must submit an invoice to JHPIEGO Ethiopia (provided in your packet) detailing the training, dates, etc. and will only be paid upon receiving the deliverables set forth and agreed upon in the signed contract.

**Transport:**

- JHPIEGO will reimburse all public transportation used to reach a site. In order to get refunded, you must present a valid public transport receipt and report this expense with the receipt on your travel advance reconciliation format. In cases where public transport is not available, the use of rental and private transport will be taken on a case-by-case basis and must be discussed carefully with JHPIEGO Ethiopia staff. If flights are available for the site, the trainer must arrange for tickets and must present an official Ethiopian Airlines receipt and claim it on the expense report to JHPIEGO Ethiopia.

**General:**

- Consultants should contact JHPIEGO for any other financial matters occurring at sites before making any decisions. Contact persons are Yodit Fantahun at 091 1 64 53 22 for any financial matters and Marion McNabb at 091 1 86 48 69 and Yassir Abduljewad at 091 1 68 44 44 for administrative matters.

I hereby accept the above rules and regulations regarding payment of participants at the training as well as my per diem and consultancy fees:

______________________________
Consultant Name and Signature

______________________________
Date
ANNEX D: FINANCIAL PROCEDURES FOLLOWED FOR ON-SITE TRAINING

Before Advances:
- Contract agreement between consultant and JHPIEGO (including Leave Agreement Form)
- Sign Travel Authorization Request Form and Project Advance Request Form (these forms indicate the amount of per diem and transport advances for the total training)
- Sign Payment Instruction Form, indicate how to receive the money, and agree on payment terms
- Sign Property Issue Form for receipt of overhead projector

During Reconciliation:
- Fill in Travel Expense Report Form to reconcile per diem and transport advances for trainers and sign
- Summarize Participant Payment Sheet and receipts for other expenses in connection with the training by filling in the Project Expense Report and sign
- Fill in Consultant Invoice for completed sites and sign
- During delivery of the overhead projector, Property Turn-In Form will be filled out by the trainer and the trainer and the recipient of the material will sign on the form (original will be given to the trainer and copy retained for the office)
## ANNEX E: SAMPLE TRAINING SCHEDULE FOR ON-SITE TRAINING IN INFECTION PREVENTION

Infection Prevention Final On-Site Training Schedule
Updated: July 20, 2006

<table>
<thead>
<tr>
<th>TEAM</th>
<th>SITES</th>
<th>REGION</th>
<th>TRAVEL</th>
<th>SET-UP</th>
<th>TRAINING</th>
<th>TRAINER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team 1</td>
<td>Gendeberat</td>
<td>Oromia</td>
<td>24–25 Jun</td>
<td>26-Jun</td>
<td>27 Jun–1 Jul</td>
<td>Teshale Abamo</td>
</tr>
<tr>
<td></td>
<td>Gimbi</td>
<td>Oromia</td>
<td>2-Jul</td>
<td>3-Jul</td>
<td>4–8 Jul</td>
<td>Wondimnu Daniel</td>
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<tr>
<td>Team 2</td>
<td>Aira</td>
<td>Oromia</td>
<td>15–16 Jul</td>
<td>17-Jul</td>
<td>19–22 Jul</td>
<td>Alemayehu Negatu</td>
</tr>
<tr>
<td></td>
<td>Nejo</td>
<td>Oromia</td>
<td>24-Jul</td>
<td>25-Jul</td>
<td>26–30 Jul</td>
<td>Sr. Hiwot Tefera</td>
</tr>
<tr>
<td>Team 3</td>
<td>Shashamene</td>
<td>Oromia</td>
<td>5-Aug</td>
<td>6-Aug</td>
<td>7–12 Aug</td>
<td>Dr. Getahun Yenus</td>
</tr>
<tr>
<td></td>
<td>H/Mariam</td>
<td>Oromia</td>
<td>30-Jul</td>
<td>31-Jul</td>
<td>1–5 Aug</td>
<td></td>
</tr>
<tr>
<td>Team 4</td>
<td>Shambo</td>
<td>Oromia</td>
<td>5–6 Aug</td>
<td>7-Aug</td>
<td>8–12 Aug</td>
<td>Dr. Elias Gossa</td>
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<tr>
<td></td>
<td>Metehara</td>
<td>Oromia</td>
<td>13-Aug</td>
<td>14-Aug</td>
<td>15–19 Aug</td>
<td>Arage Kassa</td>
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<tr>
<td>Team 5</td>
<td>Gelemso</td>
<td>Oromia</td>
<td>5–6 Aug</td>
<td>7-Aug</td>
<td>8–12 Aug</td>
<td>Dr. Abiy Arefeaye</td>
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<tr>
<td></td>
<td>Deder</td>
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<td>13-Aug</td>
<td>14-Aug</td>
<td>15–19 Aug</td>
<td>Desta Samuel</td>
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<tr>
<td>Team 6</td>
<td>Bonga</td>
<td>SNNPR</td>
<td>24–25 Jun</td>
<td>26-Jun</td>
<td>27 Jun–1 Jul</td>
<td>Dr. Berhanu Amare</td>
</tr>
<tr>
<td></td>
<td>Jimma Military</td>
<td>Oromia</td>
<td>2-Jul</td>
<td>3-Jul</td>
<td>4–8 Jul</td>
<td>Nitishit Eniyew</td>
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<td></td>
<td>Limugenet</td>
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<td>9-Jul</td>
<td>10-Jul</td>
<td>11–15 Jul</td>
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<td>17-Jul</td>
<td>18–22 Jul</td>
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<tr>
<td>Team 7</td>
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<td>15–16 Jul</td>
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<td>18–22 Jul</td>
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<td>14-Aug</td>
<td>15–19 Aug</td>
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<td>21-Aug</td>
<td>22–26 Aug</td>
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<td>Amhara</td>
<td>24–25 Jun</td>
<td>26-Jun</td>
<td>27 Jun–1 Jul</td>
<td>Dr. Mahteme Bekele</td>
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<tr>
<td></td>
<td>Borumeda</td>
<td>Amhara</td>
<td>2–3 Jul</td>
<td>4-Jul</td>
<td>5–9 July</td>
<td>Abebebech Zeleke</td>
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<td>Akesta</td>
<td>Amhara</td>
<td>9–10 Jul</td>
<td>11-Jul</td>
<td>13–17 July</td>
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<tr>
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<td>Amhara</td>
<td>15–16 Jul</td>
<td>17-Jul</td>
<td>18–22 Jul</td>
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<td>Amhara</td>
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<td>26-Jul</td>
<td>27–31 Jul</td>
<td>Dr. Hiwot Degeneh</td>
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<td>TEAM</td>
<td>SITES</td>
<td>REGION</td>
<td>TRAVEL</td>
<td>SET-UP</td>
<td>TRAINING</td>
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<td>Amhara</td>
<td>5–6 Aug</td>
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<td>8–12 Aug</td>
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<td>13-Aug</td>
<td>14-Aug</td>
<td>15–19 Aug</td>
<td>Gobeze Negash</td>
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<td></td>
<td>Alamata</td>
<td>Tigray</td>
<td>20–22 Aug</td>
<td>22-Aug</td>
<td>23–27 Aug</td>
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<tr>
<td>Team 12</td>
<td>Ras Desta</td>
<td>Addis Ababa</td>
<td>25-Jun</td>
<td>26-Jun</td>
<td>27 Jun–1 Jul</td>
<td>Dr. Abdulasak Amare</td>
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<td>Pawe</td>
<td>Ben-Gumz</td>
<td>2–3 Jul</td>
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<td>Team 13</td>
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<td>26-Jun</td>
<td>27 Jun–1 Jul</td>
<td>Dr. Melesse Zeredawit</td>
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<td>Degabour</td>
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<td>Merged with Harar Pol and Mesrak Arb.</td>
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<td></td>
<td>Misrak</td>
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<td>2-Jul</td>
<td>3-Jul</td>
<td>4–8 Jul</td>
<td>Daniel Tadesse</td>
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