'A conceptual framework for ToT interventions in global health'; executive summary

Background to the research

Many Health Partnership Scheme (HPS)-funded projects train health workers as trainers, an approach known as Training of Trainers (ToT). The aim is to set up a cascade of high quality, sustainable training in health systems. But does the ToT approach really work? Dr Maru Mormina, a Senior Lecturer at the University of Winchester, has looked at the evidence.

Introduction

The world faces a global shortage of health workers. As a result, many people across the globe have very limited access to health care, and the quality of the existing health care in many places is often below standard. The Health Partnership approach to strengthening health workforce capacity enables northern and southern partners to work together to exchange knowledge, skills and innovative approaches to medicine that can strengthen health systems, bring mutual benefits, and increase people's access to quality health care globally.

Health partnerships are relatively limited in both scale and time, and so they use approaches such as ToT to extend and sustain their impact on health systems. The aim of ToT is to start a training cascade: skills and knowledge are taught to a small group of health workers, usually in low and middle income countries (LMIC), who become trainers and go on to transfer those skills to others. However, training cascades can be hampered by external factors such as attrition, time constraints, or a lack of resources. The purpose of this research was first to identify how the ToT model is implemented within HPS-funded projects, and secondly to develop a framework for ToT interventions to help inform practice.

Methods

The researcher analysed narrative reports of fourteen Medium Paired Institutional Partnership grant-holders. These narrative reports had been submitted to THET in early 2016 as part of the partnership's contractual monitoring and evaluation. The analysis looked for common themes in their ToT interventions. A literature review was also carried out using keyword searches[1]. From this, an evaluative framework outlining essential components of the ToT model was developed.

Initial findings from the partnership reports

Many of the partnerships analysed focused on training of clinical or technical staff, rather than community health workers or leadership and management staff. For the most part, ToT represented a small part of the project and was conducted alongside a wider training plan; the curriculum focussed strongly on technical skills, although in most cases it also included some teaching skills. Generally, ToT was delivered at the start of the project by UK "master trainers", with the expectation that local trainers would begin training others before the end of the project. The degree to which

---

[1] Key word search included; 'training the trainer', 'training of trainers', 'cascade training', 'global health partnerships', 'international development'.

transfer of training was achieved varied and was largely dependent on the complexity of the skills taught but also on a number of other factors, particularly time and resources.

Factors found to influence the success of a ToT in Health Partnerships

- Time: after receiving ToT training, local trainers need some time off their normal duties in order to be able to continue the training cascade. It was found that in many cases, institutions struggled to release new trainers and provide cover whilst they are conducting training.
- Institutional support: Managers need to agree to staff taking time out of work to deliver training. Training cascades were more successful and sustainable when ToT was embedded at institutional level– see below.
- Adequate resources: To run a training course or session, trainers must have not just time but also adequate resources such as training materials, IT equipment or suitable training space, as well as the support from managers to promote the training and encourage others to attend. There is often an assumption that the LMIC institution will help cover recurring costs such as refreshments, equipment, travel expenses, etc., which may not always be realistic. The research found that most projects were unable to fully transfer training to local trainers before the end of the project, illustrating the complexity of embedding a ToT cascade in a real health institution.
-

The TRAIN Framework

In order to help with the design, implementation and evaluation of ToT interventions, the TRAIN framework (Talent, Resources, Alignment, Implementation, and Nurture & Development) was developed. . This framework could be useful for Health Partnerships to understand the complexities of embedding ToT into their projects, and the many factors they should consider when planning to use this approach.
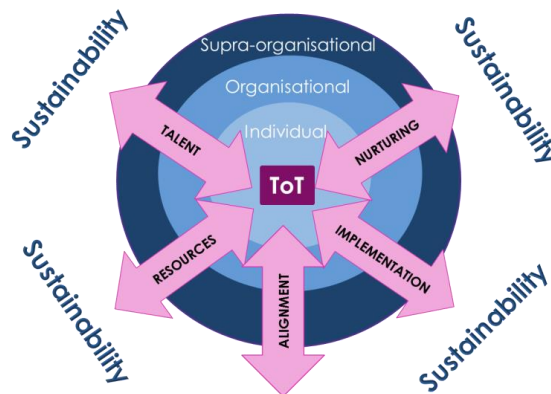

Figure 1. The 'TRAIN' framework

The TRAIN framework has two dimensions:

- The structural levels at which ToT should be embedded, which are the individual, organisational and supra-organisational levels, and are depicted in the diagram above by the three outer layers of the circle.
- Five constitutive elements of effective ToT which are represented in the arrows that extend across the three structural levels.

The notion of sustainability underpins all aspects of the TRAIN framework, and the sustainability of the training cascade is facilitated if these elements are implemented in conjunction with each other.

Constitutive elements of a successful ToT

- Talent:

Effective ToT includes training in technical skills but also training in teaching skills, since the capacity to learn technical skills does not automatically translate into the capacity to teach them to others. At the individual level, the attributes required of master and local trainers include patience, insight, confidence, communication skills, leadership, self-reflection, propensity to give constructive criticism, motivation and ability to help others. At the organisational and supra-organisational level, policies and incentives can be introduced to help talent recruitment and retention, such as professional accreditation, benefit packages or progression paths.

- Resources:

Consideration should be given to the resources needed to attend and deliver training for both master and local trainers as well as future trainees. These resources include time away from normal duties, fitting volunteering around annual leave, an institution's ability to replace staff who have taken time off normal duties, capacity to reimburse travel expenses or pay for refreshments, and any material resources needed such as internet access or hand-outs. The importance of financial contributions to the success of a ToT cannot be understated. Therefore, shared responsibility with clear commitments and transparent financial arrangements can help reduce barriers to access and avoid imposing undue resource burden on partners.

- Alignment:

Staff attrition is a barrier to the training cascade because when a trainer leaves, so too do their skills. Trainer retention could be enhanced by better aligning training duties with professional goals. Embedding trainer duties as part of career path and recognising it as a key element of career progression, rather than as an extra responsibility, may contribute to reducing attrition of local trainers, although more research into this would be needed.

Technical aspects of training should also be aligned to organisational, local and national priorities to avoid contradicting local guidance, which can confuse health workers and compromise the quality of patient care.

- Implementation:

As well as learning skills from a master trainer, local trainers – and their institutions – should take ownership of the training programme. As such, a clear implementation strategy should be set out at the start, with input from key stakeholders to identify responsibilities.

- Nurture and development:

Whilst technical skills can be tested, it is much harder to measure the acquisition of soft skills, which are also important trainer attributes. Soft skills can be developed by giving local trainers the opportunity to carry out training under the supervision of master trainers, an opportunity that is rarely available. There should also be measures in place to avoid de-skilling over time.

Based on this research, sustainable ToT is achievable if the project addresses the five TRAIN elements, and is implemented at all three structural levels.

TRAIN and the Health Partnership model

Although undoubtedly this research is valuable to the Health Partnership community, in practice some partnerships may find it difficult to implement TRAIN in its entirety. Of the five constitutive elements, it may be more feasible to address Talent, Implementation and Nurture and Development as these are more heavily reliant on the UK partner taking action. However, Resources and Alignment are much more demanding because they require ToT to be embedded at individual,

organisational and supra-organisational level. For example, the further along the training cascade, the less probable it is that trainers will have access to resources, as funds may run out and there may be less enthusiasm about training as a whole. Similarly, Alignment may be difficult because ToT often constitutes just a small part of Health Partnership projects, which in turn work within the much broader context of a health institution. This means that projects may not have the scope to influence decision making at a level that can integrate training into a career pathway.

Conclusion

The research highlights some limitations present in some examples of ToT within current Health Partnerships, which can prevent the ToT model from being both effective and sustainable. By using the TRAIN framework as a blueprint against which ToT interventions can be mapped, it offers a structure of requirements at various levels that allow individual capabilities and opportunities for training to translate into the achievement of a long-term training cascade.

Next steps in this ToT project

As part of the HPS Presentation Series, THET held a webinar on Training of Trainers. The presentations explored health partnerships' experiences of training trainers, what went well, what didn't, and how they achieved the transfer of training responsibilities from UK volunteers to local teams. This research framework was also presented.

Find the webinar here: https://www.youtube.com/watch?v=IHQzegYlo4s

We encourage Health Partnerships to try and apply to TRAIN framework as far as possible, and we welcome any comments you may have on this model of training and the evaluative framework.

Further reading

Scotland Malawi Partnership. (2014). *Practical guidance and support on per diems.* Available: http://www.thet.org/health-partnership-scheme/resources/tools-guidance/practical-advice-support-on-per-diems

Suzanne Edwards, Dan Ritman, Emily Burn, Natascha Dekkers and Paula Baraitser. (2015). *Towards a simple typology of international health partnerships.* Available: http://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-015-0132-x

THET. (2015). *Volunteer Support.* Available: http://www.thet.org/health-partnership-scheme/resources/tools-guidance/volunteer-support

THET. (2015). *Innovative training in Zambia.* Available: http://www.thet.org/health-partnership-scheme/resources/case-studies-stories/health-partnership-scheme-case-studies/innovative-training-in-zambia