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Replication of Training Designs

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Section A

Fidelity of a Training Design

Overview of Lecture 15

- In the preceding lectures and assignments we have worked on developing, implementing, and evaluating training curricula and guides
- We recognize that our training guides, once field tested, can be used in other settings
- This lecture addresses the issues surrounding "faithful" replication of training designs in order to guarantee comparable results

Continued

Overview of Lecture 15

- We will accomplish this by . . .
  - Examining the concept of "fidelity of implementation"
  - Reviewing a case study of Cascade Training in Nigeria
  - Listening to an interview on adapting training materials in Guatemala

Why Replication?

- Training may meet the need of a specific local program, but . . .
- Training is also a standard way of upgrading health workers and other development staff across countries and regions

Continued

Why Replication?

- A good example is WHO's Integrated Management of Childhood Illness (IMCI)
  - Basic treatment algorithms for pneumonia, malaria, and diarrhea, for example, need to be applied consistently
  - A standard training guide is useful to ensure that health workers treat these problems in a consistent and safe manner (although differences may exist in drug registration, resistance thus requires adaptation)

The Challenge of Replication

- "Surprisingly, many of the highest quality programs fail to take adequate steps to monitor and verify program integrity. This weakens the conclusions that can be drawn regarding the program outcomes and reduces the likelihood that replications will resemble the original program"
  - DHHS/SAMAHSA/CSAP 2002
- Thus the need for **fidelity**:
  - The extent to which delivery of a prevention program conforms to the developer defined parameters
  - A recipe for replicating the program
    - William Respress, Director of Research, Florida Institute of Education

Aspects of Fidelity

- Match or precision
- Purity or integrity
- Adherence or compliance
- Prescription, exposure, and dosage
- Quality implementation
- Reinvention—deviates from program standard

Fidelity Enhances Validity

- **Preserves internal validity** against
  - **Type I error**—significant treatment effect, but this arises because an unintended treatment ingredient was added to the intervention
  - **Type II error**—no treatment effect, but treatment wasn't actually administered as intended
- **Improves power** (research efficiency) by reducing unintended variability in treatment effect
- **Supports external validity** by allowing replication, dissemination
  - Bonnie Spring, University of Illinois Chicago

Ensuring Fidelity

- Writing implementation (training) guide or manual
- Training of trainers
- Monitoring/observing training implementation
  - Was the training delivered as intended?
  - Did trainees respond and comprehend as expected?
- Evaluating trainee performance

Fidelity versus Adaptation

- What are the core ingredients of the training design needed to achieve the desired result?
  - Training content
  - Training methods
  - Training context
- What are the flexible aspects of the design that should be considered for adaptation?
  - Language and culture
  - Literacy levels
  - Human relations and communication norms
  - Financial and logistical resources

A Case Study of Cascade Training from Nigeria

Photo: USAID, BASICS

- Basic Support for Institutionalizing Child Survival (BASICS)
- 1994–1999 worked with urban community based coalitions of community based organizations and private health facilities
- 2000–2004 transferred lessons on community participation to enhancing public sector primary care services

Catchment Area Planning and Action (CAPA)

- A community based approach
- Aim to strengthen essential services at local government primary health care (PHC) facilities within catchment areas (CAs)
- Through community participation and advocacy
  - —CAPA committees
- Health worker training
- Volunteer community health promoters (CHPs)

Catchment Area Planning and Action

- CAPA focused on primary level local government health facilities in three Nigerian states
- The aim was to involve community members in the catchment area of each facility in dialogue with facility staff
- To improve the quality of care and increase access to basic maternal and child health services such as . . .
  - Antenatal care
  - Immunization
  - Prompt treatment of childhood illness
  - Essential nutrition actions

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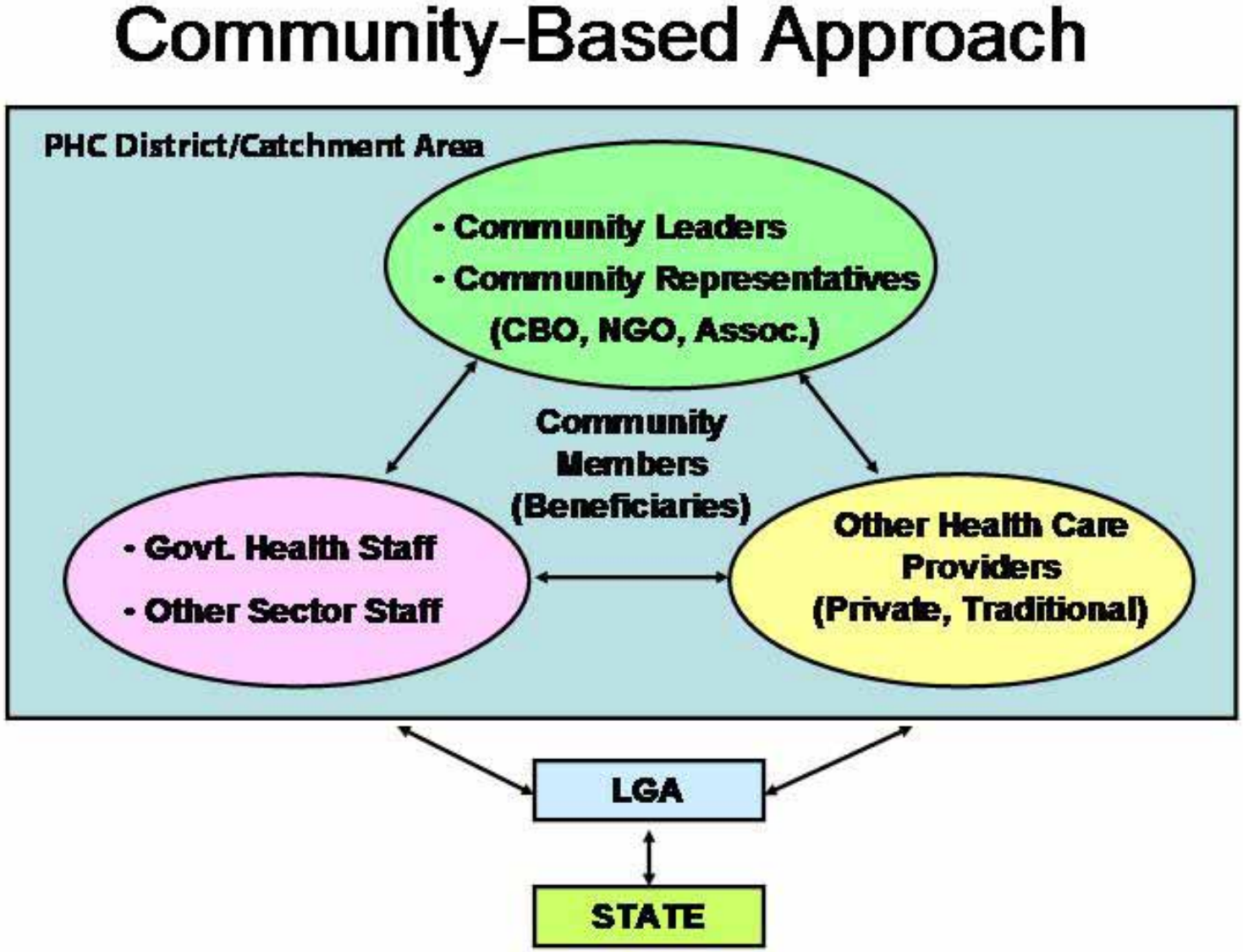
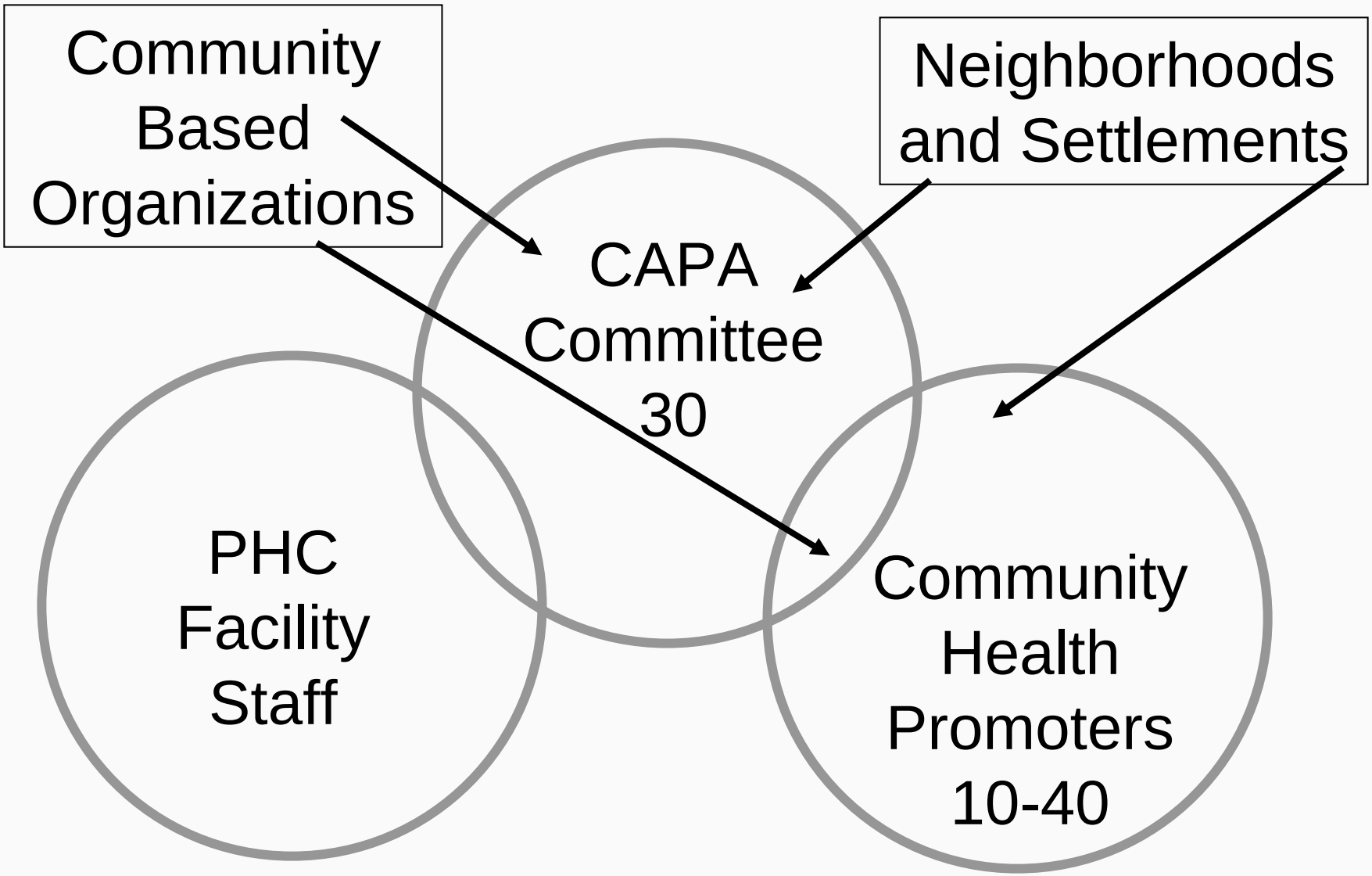
Catchment Area Planning and Action

- CAPA committees and trained volunteer community health promoters
  - Mobilized community interest and resources
  - Conducted advocacy with local policy makers

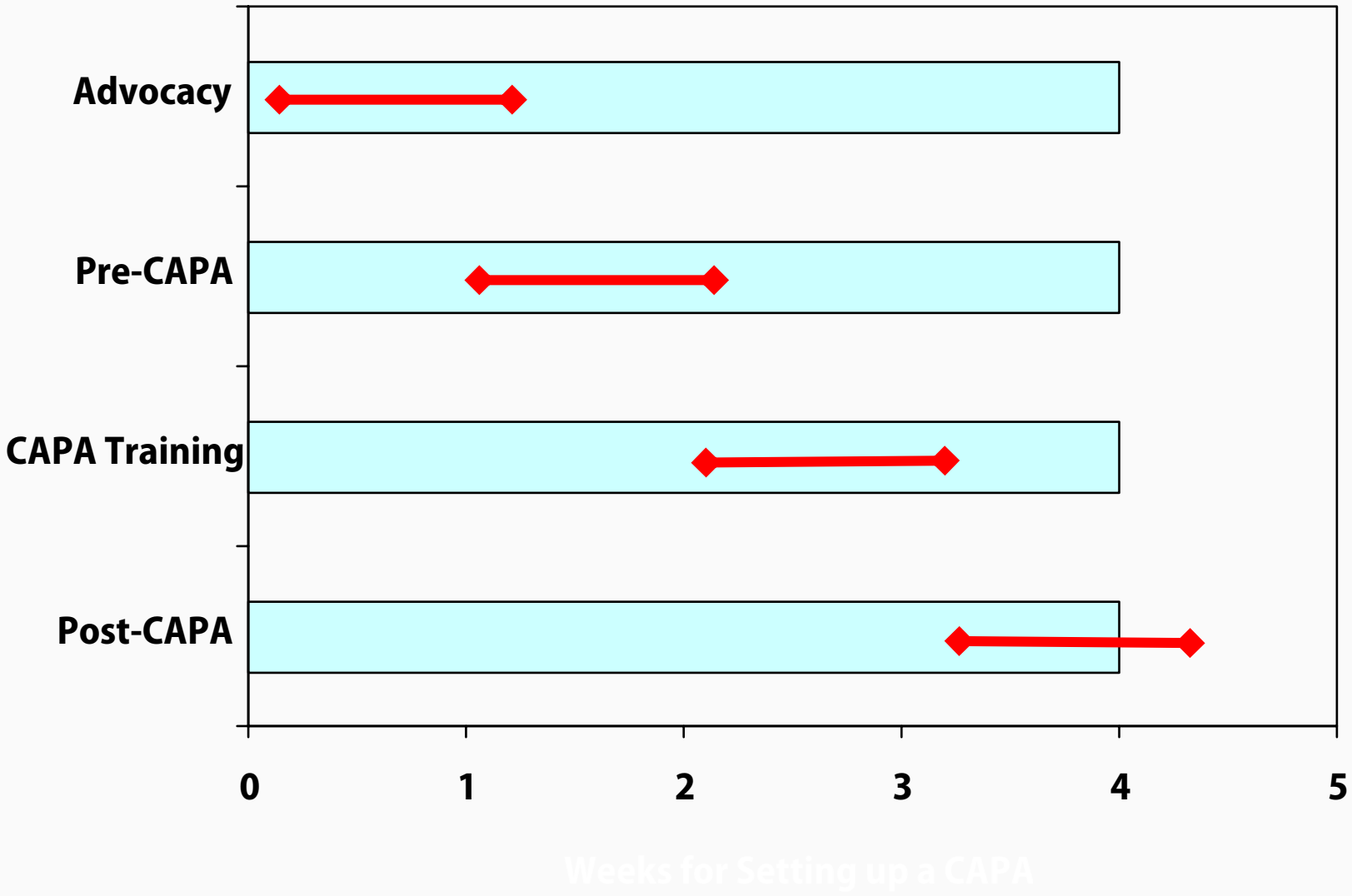
CAPA Uses a Community-Based Approach



Catchment Area Structure

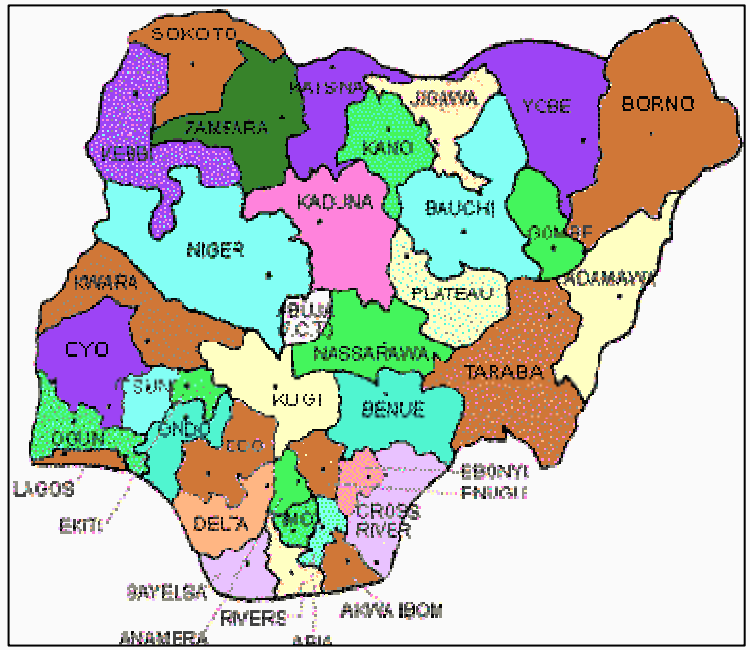


Establishing a CAPAC



CAPA Program Locations

State	Local Governments	Catchment Areas
Lagos	9	70
Kano	9	70
Abia	2	15
3	20	155
Cascade Training— The Need for Replication at Each Level		



More Information on CAPA

- Additional information on the CAPA process is available from BASICS
- The CAPA Handbook can be found at . . .
  - http://www.basics.org/publications/abs/abs_capatools_gen.html
- An documentation assessment of CAPA implementation can be obtained from . . .
  - http://www.basics.org/publications/abs/abs_capa2_gen.html

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Section B

A Case Study of Cascade Training

Need for Cascade Training

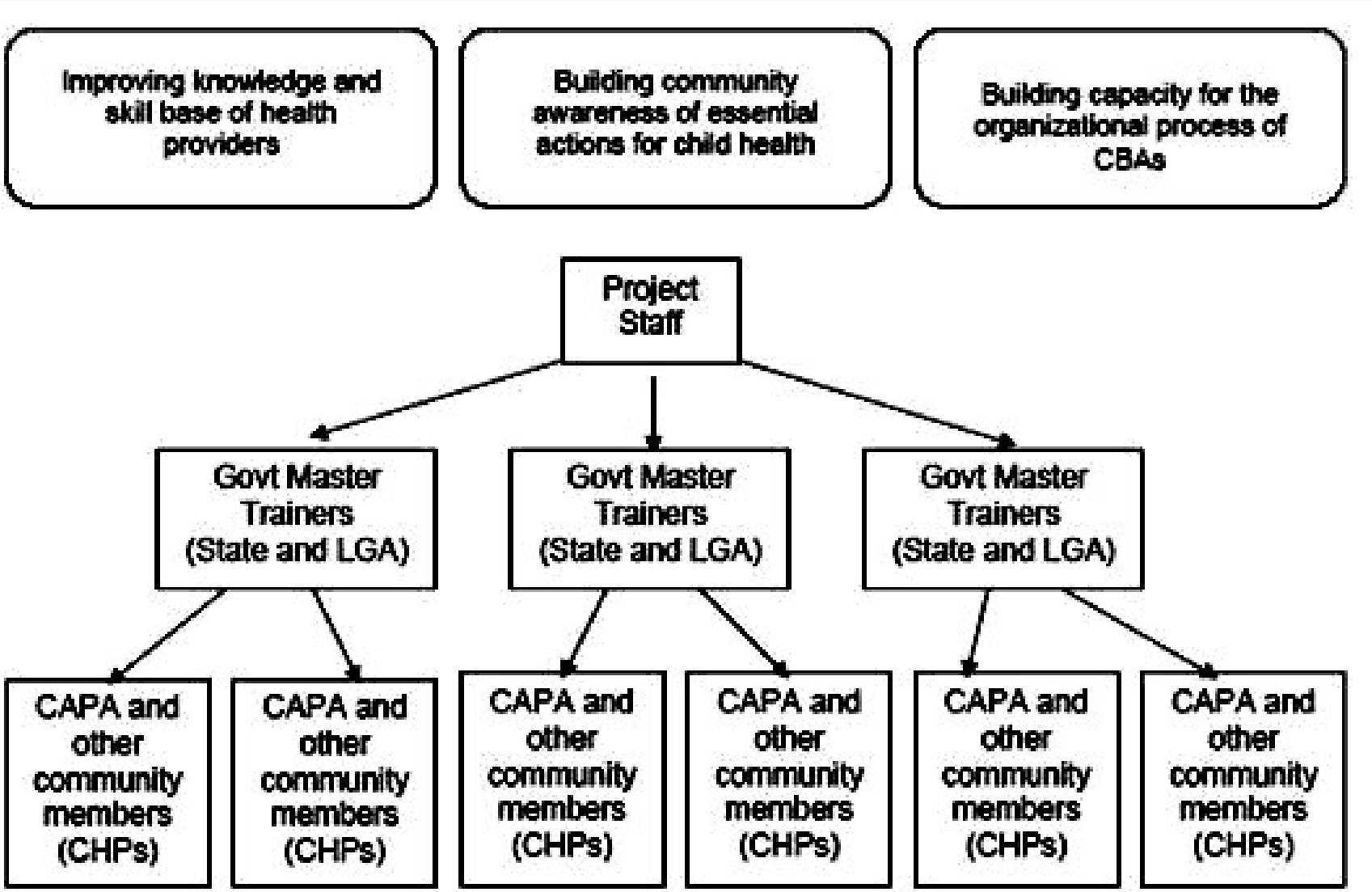
- To prepare community members for their **new roles as promoters, advocates, planners, and monitors** in the most expedient manner, CAPA adopted a **cascade training approach** that rapidly transfers responsibility from project staff to government master trainers and to community members
- Some training efforts are directed at **improving the knowledge and skill base** of public and private sector health providers

Continued

Need for Cascade Training

- Some efforts are directed at **building community awareness of essential actions** to preserve child health
- And some efforts are directed at **building the capacity for the organizational process** necessary to make community-based approaches succeed

Cascade Training Model in CAPA



State Level Training

- The state level is the primary focus for quality control, advocacy, providing services, and resources to support CAPA, and receiving referrals
- The state should provide master trainers to initiate and coordinate the training at the LGA and catchment area (community) levels
- As such, it is essential that state-level participants be well informed about child survival interventions, be thoroughly grounded in the CAPA approach, and be fully committed to community/health sector partnerships

Content: Three Categories of Training

- There are **three general categories of training** for SMOH personnel in which project staff (with the help of consultants) train groups of master trainers
  - 1. Training Of Trainers (TOT) to **improve technical team skills and knowledge** about key child survival issues and interventions (immunization, nutrition, malaria)
  - 2. TOT to **prepare state facilitators as coordinators of the CAPA** processes
  - 3. TOT at local government level for **facilitating the training and performance of CAPA committees** in advocacy and mobilization

Second Round for the CHPs

- The three phase training process with state teams takes place again when it is time to train Community Health Promoters (CHPs) in mobilization, home visiting, and group education techniques around the priority technical intervention areas

Training Modules

Area	Modules	Content
Routine Immunization	5	Target diseases, cold chain, service delivery, communication, monitoring
Essential Nutrition Actions	2	Breastfeeding, vitamin A, weaning
Malaria	1	Case management, treatment, bednets
CAPA Committees	3	Technical content, planning, and advocacy processes
Community Health Promoters	1	Using counseling cards for technical content

State Facilitators Trained to Lead TOTs at LGA Level

- Provide training on technical issues and on training communities for CAPA
- Provide training on the use of the integrated CAPA modules
- Provide training on the implementation steps
- Conduct orientation on facilitation and teaching skills
- Define roles and responsibilities of partners (community, public sector, and private sector)

State Level Participants

- State immunization officer
- State nutrition officer
- State malaria officer
- State monitoring and evaluation officer
- Three to four representatives of multi-sectoral group

State Trains Local Government Facilitators

TASKS

- Master trainers train participants to improve communication skills
- Promote understanding of the roles and responsibilities of CHPs
- Develop and adopt a timetable for LGA trainings
- Assign trainers to LGAs

LGA Team Participants

- Community health officer
- Immunization manager
- Health educators
- Nutrition officer
- Monitoring and evaluation officer
- Environmental health officer
- Other LGA sectors
  - Community development
  - Education
  - Information
  - Women's affairs
  - Agriculture
  - Finance

CAPA Committee Training

PROCESS

- Conducted by LGA team
- 30 Volunteers selected after pre-CAPA visits
- Three day workshop on three essential technical areas
- Concurrently develop a workplan
- CAPAC members organize election of own officers

Photo: USAID, BASICS

Sample CAPA Committee Training Participants

- Ward political leaders
- Local institutions (educ., agric., etc.)
- Private health facilities
- CBO leaders by type and location
- Patent medicine vendors assoc.
- Parent Teacher Associations
- Road transport employers and employees
- Ethnic groups, traditional leaders
- Farmers' clubs
- Local NGOs
- Savings cooperatives

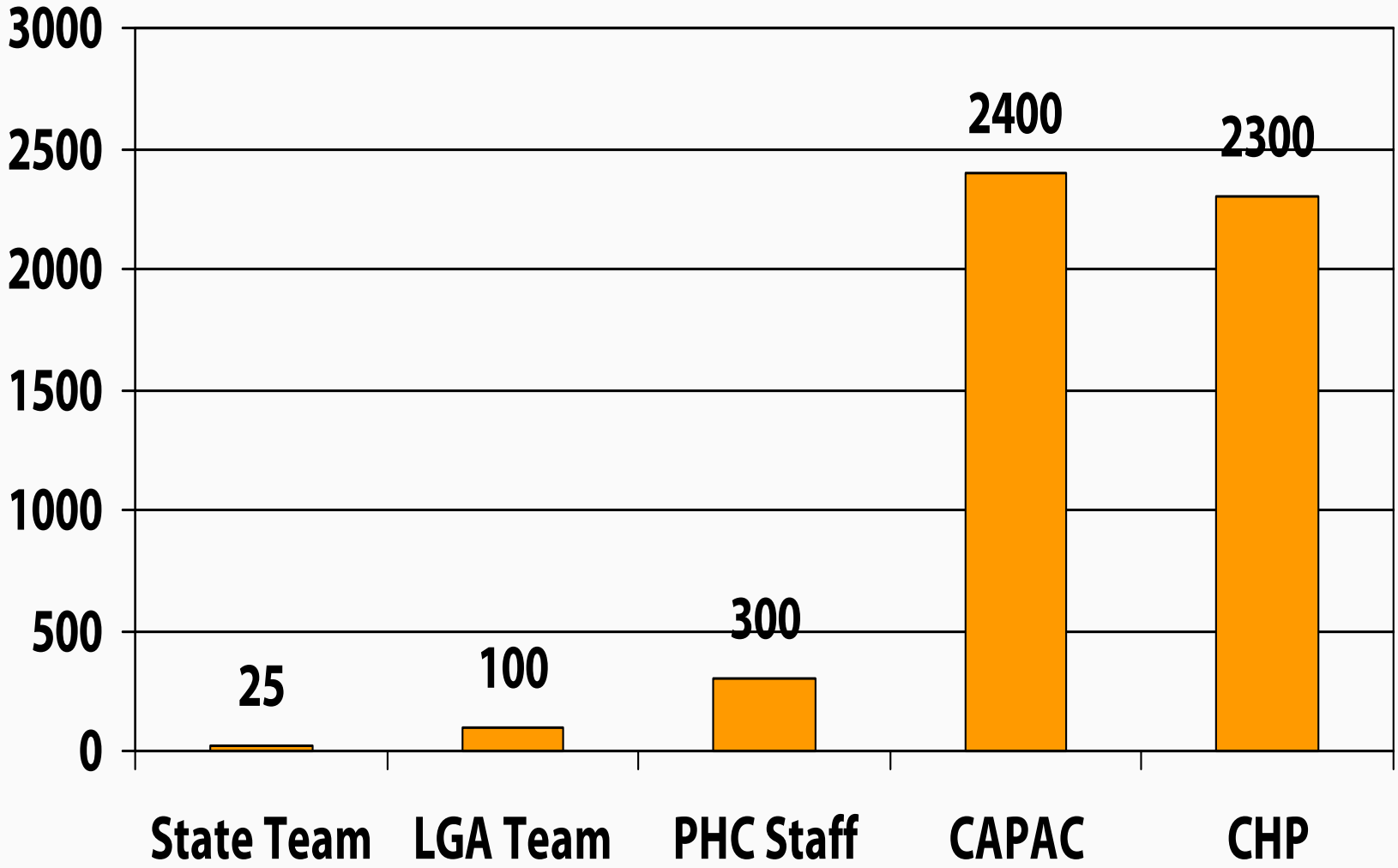
Community Health Promoters

- Who is a CHP?
  - A literate volunteer with a natural interest in promoting child health and who is ready to offer assistance to the community as a counselor, adviser, and motivator
- What is the objective of CHP training?
  - To create a cadre of volunteers to convey key household messages about protecting the health of children, seeking care in a timely way, and making wise choices when seeking assistance for their children
- This results in 20-30 unpaid volunteers per catchment area

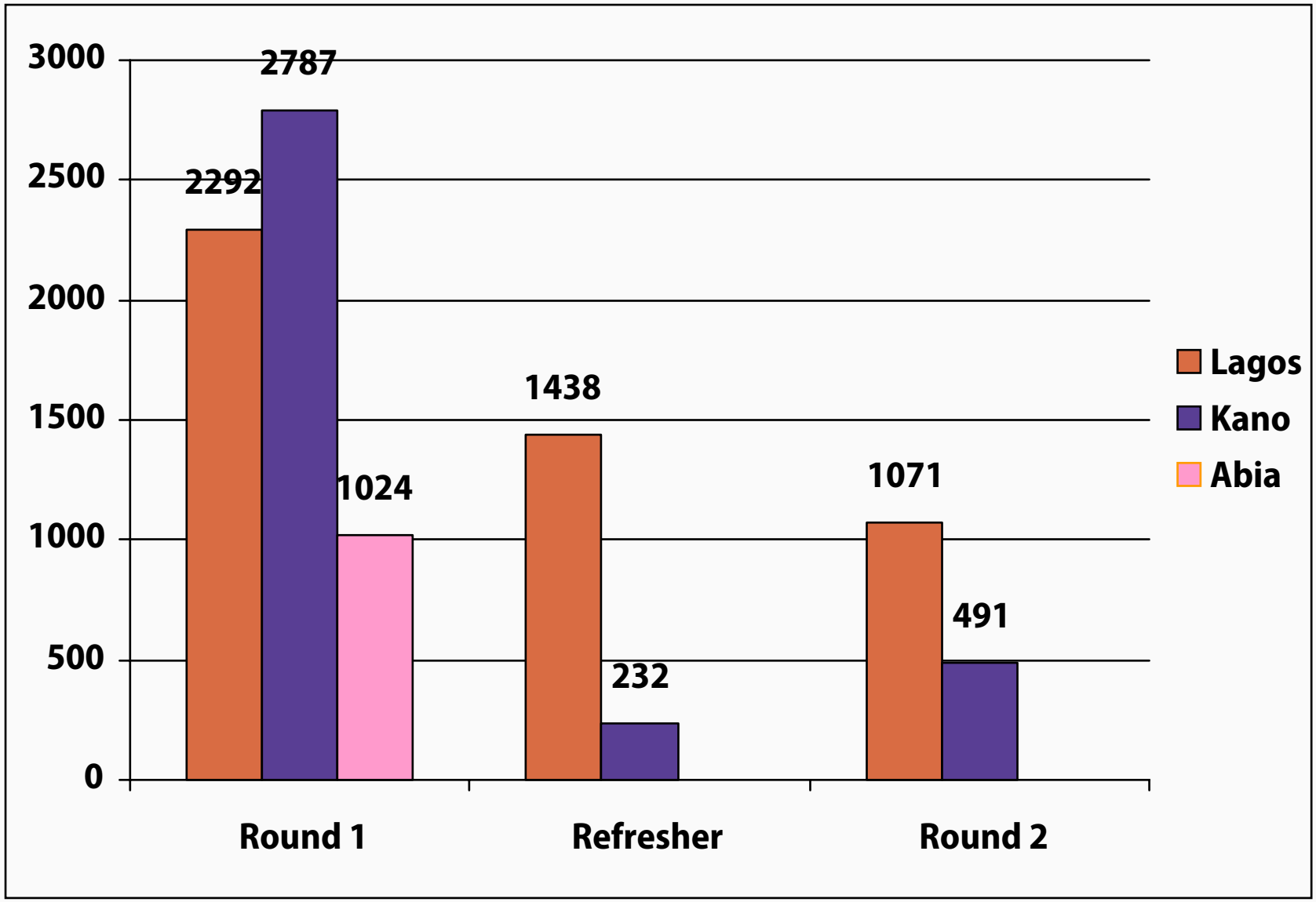
Community Health Promoter Training Agenda

- The need for community health promoters in CAPA
- Importance of immunization and immunization schedule
- Key practices for successful breast and complementary feeding
- Importance of vitamin A
- Home management of malaria illness
- How to counsel mothers/caregivers using counselling cards and home health booklet
- Field practice/discussion on field practice
- Conducting group education

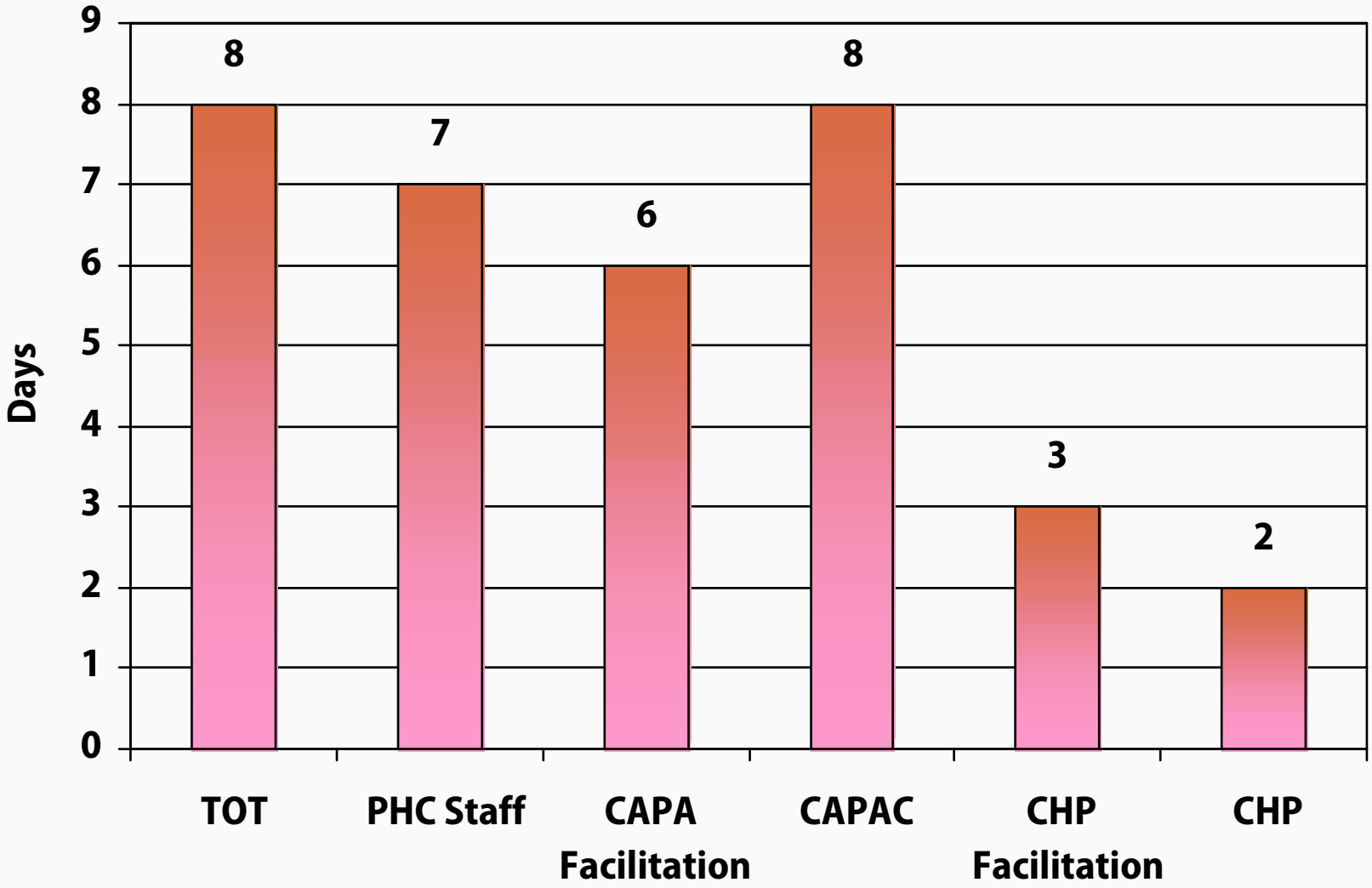
Cascade Training in Lagos State



Community Health Promoter Training



Time Commitment for Cascade Training



CAPAC and CHP for 70 Lagos CAs

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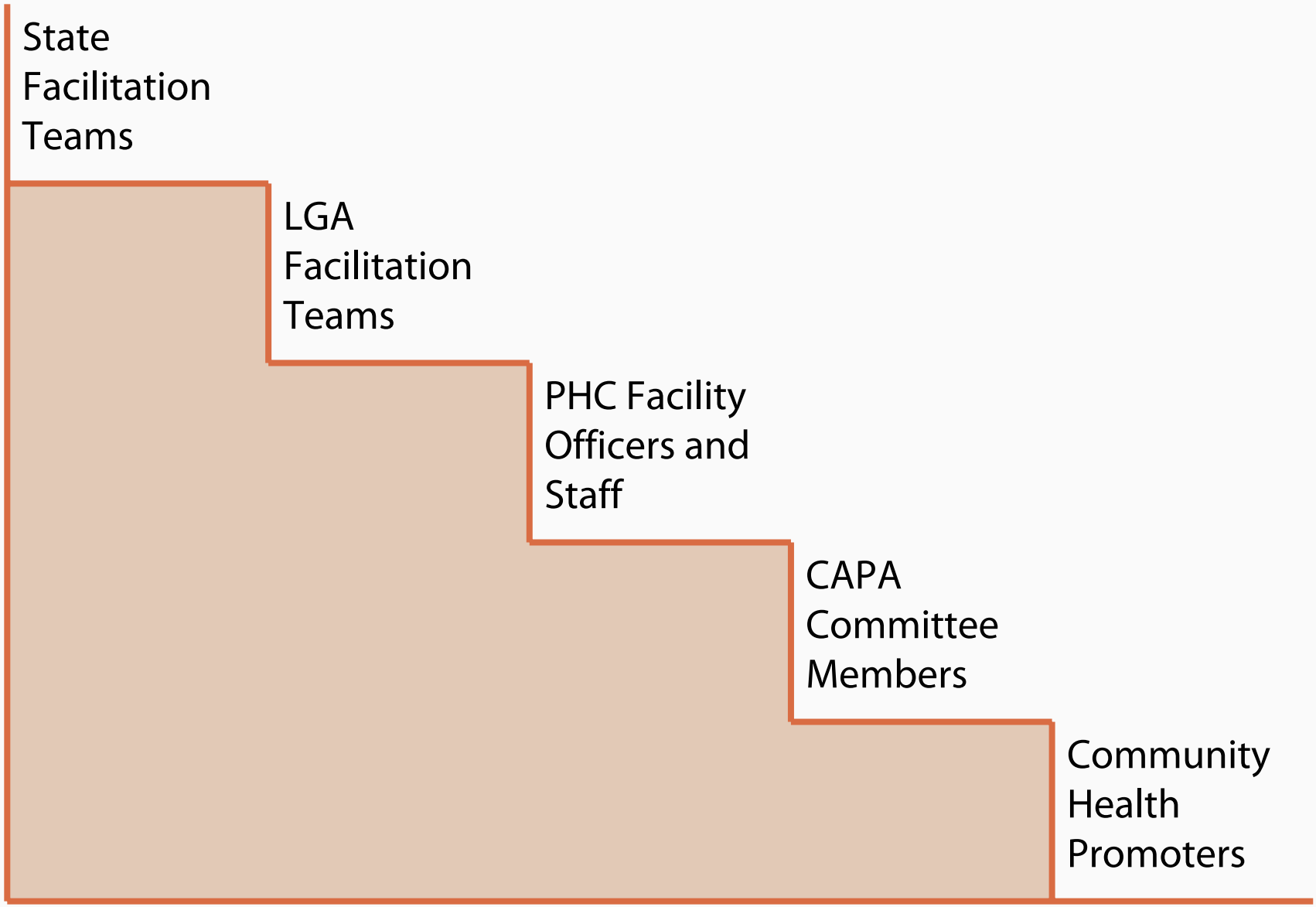
Section C

Ensuring Fidelity of Implementation

A Review of the Cascade



BASICS Staff Efforts with the State-to-LGA Cascade

- Development, printing, and distribution of all the modules for training at all levels
- BASICS staff fully facilitated all the state team training and logistics
  - BASICS transferred all needed skills to the state for training the LGAs
- BASICS staff backstopped some of the LGA team training
  - But supplied standard logistics to all LGA trainings
- BASICS staff ensured QA in process planning, material distribution, training content, and time management at all levels—State-LGA-Community

Observations of State Facilitators

- State teams worked with BASICS in developing the modules
- IEC materials training at the state was easier with them than with the LGA staff
- The state teams are experienced facilitators
  - Worked with other agencies like UNICEF in polio, etc.
  - Easy for them to grasp the procedure, methods, and content

Continued

Observations of State Facilitators

- Although not all of them would go at the same speed, on the whole they mastered the training challenges almost immediately
- The state teams were able to replicate everything in part because BASICS guaranteed a supportive enabling environment

Efforts to Ensure Fidelity from LGA to CA

- BASICS staff made contact through phone/visit to the LGA and wrote to remind the SMOH about each training
- BASICS staff (or consultants) were present at more than 75% of all the LGA technical training—spot checks
- State team had been groomed to respond to both technical and logistic needs at the LGA
- Several state teams were created so the same training could be implemented in different LGAs simultaneously

Continued

Efforts to Ensure Fidelity from LGA to CA

- BASICS staff served as back-up if state facilitators could not observe
- Ensured standard and quality logistical arrangements from handouts to lunch
- State teams had designated monitoring officers for LGAs

Review Sessions with State Facilitators

Photo: USAID, BASICS

- Attendance levels
- Reports of facilitation problems
- Content covered
- Group work/dynamics
- Implementation challenges
- Logistics
- Time management

Examples of Review of LGA TOT Implementation

Photo: USAID, BASICS

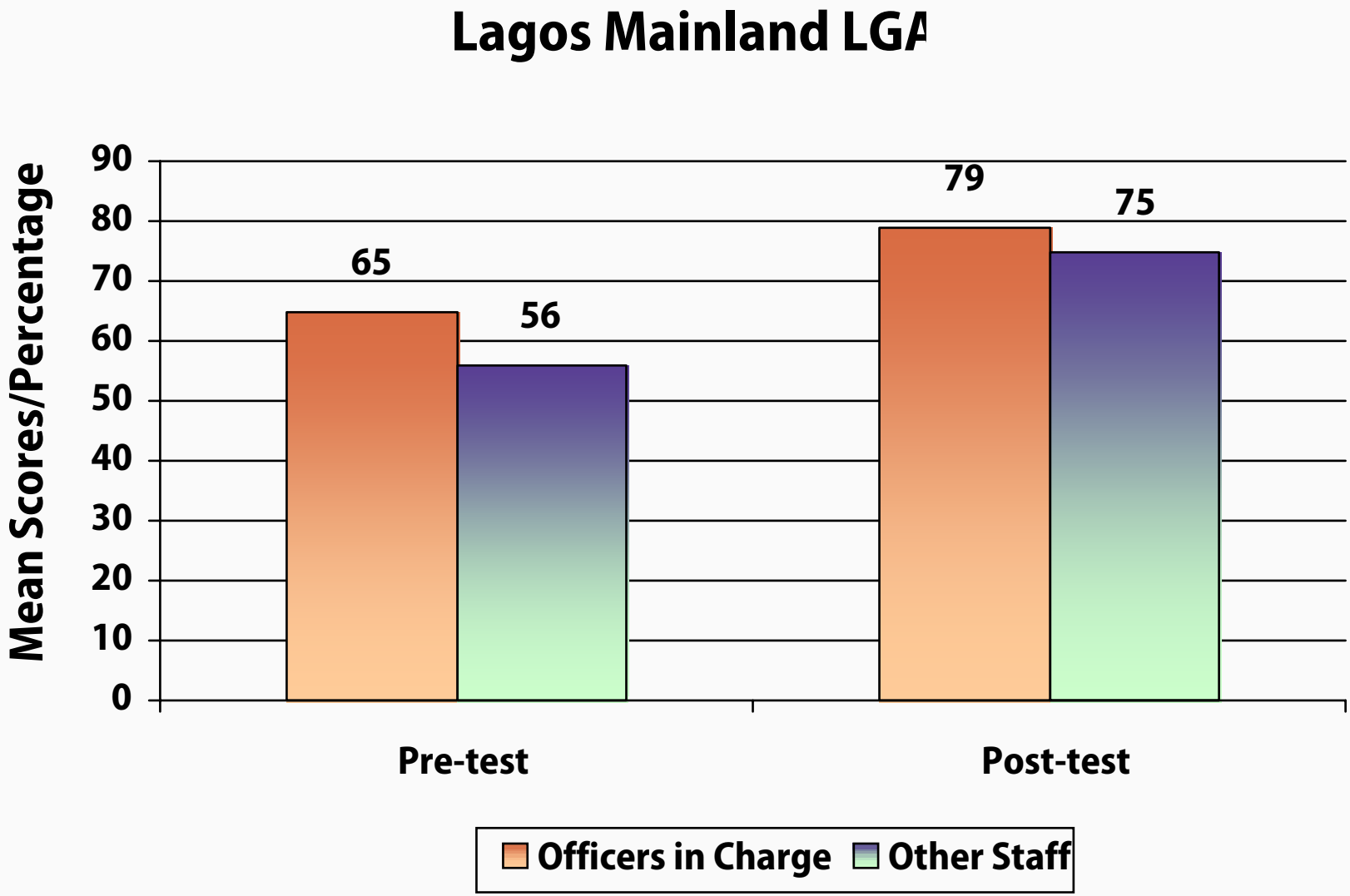
- Participants displayed high degree of seriousness, commitment, and maturity
- Participants showed that they have acquired enough knowledge and skills necessary to train the CHPs in the various catchment areas
- The state facilitators lived up to expectation and were very committed

Problems Observed

Photo: USAID, BASICS

- Training generally started late, due to the heavy traffic and long distance between office and training venue
- This led to a spillover of the agenda into the second day
- The result was that some of the topics for the second day had to be rushed, while the participants could not be taken through the case scenarios at the end of the module

Sample Results from Malaria Training for PHC Staff



Observer Feedback at CHP Trainings

- Formal feedback opportunities were built into the training and participants commented that . . .
  - The sessions were participatory, with judicious use of brain storming sessions, small group discussions, role-playing, plenary sessions, and demonstrations on net dipping
  - The training went well in most of the PHCs—participation and comprehension was highly commendable
  - Participants were happy to be part of the training
  - They saw it as an eye opener and pointed out that they have acquired the necessary skills needed to give optimal care to the children

CHP Implementation Problems at the Catchment Area

- Training was postponed a day because the officer in charge at Ayagtuga did not mobilize participants due to late notice about the training
- Training was delayed a week because the acting OIC at Coker, Aguda claimed the OIC did not brief her about the upcoming training prior to going on leave
- At Adeniji, Adele, participants complained the training was taking them away from their businesses and work for too long and many slipped away

Continued

CHP Implementation Problems at the Catchment Area

- The hall designated for training at Baruwa was not available the first day of training so the health officer had to rent canopies while participants waited
- Several LGAs experienced transfer of trained health staff prior to CHP training

Addressing Special Skill Gaps

- BASICS staff monitoring in the field discovered some challenges to LGA facilitators
  - Training approaches to illiterate CAPA committee members and volunteer CHPs

Continued

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Continued

Addressing Special Skill Gaps

- BASICS staff monitoring in the field discovered some challenges to LGA facilitators
  - Training approaches to illiterate CAPA committee members and volunteer CHPs
  - Sensitive social and cultural issues, such as perceived immunization safety
  - Technical content misconceptions, especially among front line staff with minimal formal training and education

Recommendations from Lagos Field Office

- Review training modules to reduce content
  - Combine nutrition and malaria technical modules
  - Routine immunization module stand alone (intense)
  - Number of training days can then be reduced

Continued

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- Review efficiency of the existing LGA PHC structure
  - Enhance capacity in 70 current CAs to conduct and sustain initial training, refresher training, and replacement training
  - Identify additional CAs and plan training
  - Expand to remaining 11 LGAs

Continued

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  - Enhance capacity in 70 current CAs to conduct and sustain initial training, refresher training, and replacement training
  - Identify additional CAs and plan training
  - Expand to remaining 11 LGAs
- Private sector health facility mobilization needed to supplement government PHC