A system of influence: Identifying and addressing factors which determine the transfer of training on sexual and reproductive health in humanitarian settings

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Certificate of original authorship

I certify that the work in this thesis has not been previously submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text. I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Student:

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ADPC	Asian Disaster Preparedness Centre
AIDS	Acquired Immune Deficiency Syndrome
ALNAP	Active Learning Network for Accountability and Performance in Humanitarian Action
ANC	Antenatal Care
AusAID	Australian Agency for International Development
CARE	Cooperative for Assistance and Relief Everywhere
CASP	Critical Appraisal Skills Programme
CERF	Central Emergency Response Fund (UN)
CHW	Community Health Worker
UNDP	United Nations Development Programme
DPRK	Democratic People's Republic of North Korea
DRR	Disaster Risk Reduction
FAO	Food and Agriculture Organisation
FHW	Frontline Health Worker
FSM	Federated States of Micronesia
GBV	Gender Based Violence
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
IAFM	Inter-agency Field Manual on reproductive health in humanitarian settings
IASC	Inter-agency Standing Committee
IAWG	Inter-agency Working Group on reproductive health in crisis situations
ICPD	International Conference on Population and Development
ICRC	International Committee of the Red Cross
IDMC	Internal Displacement Monitoring Centre
IFRC	International Federation of Red Cross and Red Crescent Societies
INGO	International Non-Governmental Organisation
IPPF	International Planned Parenthood Federation
IRC	International Rescue Committee

JHPIEGO	Johns Hopkins Program for International Education in Gynaecology and Obstetrics
JSI	John Snow, Inc
KL	Kuala Lumpur
LMIC	Lower Middle Income Country
LTSI	Learning Transfer System Inventory
M&E	Monitoring and Evaluation
MHW	Maternal Health Worker
MISP	Minimum Initial Service Package for Reproductive Health
MNH	Maternal and Newborn Health
MoH	Ministry of Health
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organisation
NIEW	NAM Institute for the Empowerment of Women
OECD	Organisation for Economic Cooperation and Development
PICOS	Population, Interventions, Comparators, Outcomes, Study
PPH	Postpartum Haemorrhage
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
RAISE	Reproductive Health Access Information and Services in Emergencies
RH	Reproductive Health
RHA	Reproductive Health Assessment
RHRC	Reproductive Health Response in Conflict
SGBV	Sexual and Gender Based Violence
SPRINT	Sexual and Reproductive Health programme in Crisis and post-Crisis Situations
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SV	Sexual Violence
TBA	Traditional Birth Attendant
ToT	Training of Trainers
TPB	Theory of Planned Behaviour
UN	United Nations
UNDP	United Nations Development Programme

UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees (office of)
UNICEF	United Nations Children's Emergency Fund
UNISDR	United Nations International Strategy for Disaster Reduction
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
WCF	Women and Children First
WFP	World Food Programme
WHO	World Health Organisation
WRC	Women's Refugee Commission

Abstract

By the end of 2013, almost 80 million people were forcibly displaced worldwide due to persecution, conflict, generalized violence, human rights violations or natural disasters. The sexual and reproductive health (SRH) needs of populations surviving these hazards continue and often increase in their aftermath. In order to meet these needs, competent and engaged human resources are required to deliver lifesaving interventions. However, the development of workforce capacity remains a key challenge in these settings, and is further complicated when training programmes do not facilitate the transfer of knowledge and skills into policy and practice. Effective training is essential to ensure the competence of this workforce and maximise the application of training to benefit vulnerable populations.

The gap between training and use of training is referred to as 'the transfer problem' and studies have found this to be associated with a range of factors which influence the use of newly developed knowledge and skills in work contexts. Little is known about the transfer problem in training for humanitarian settings. In response to this paucity of knowledge I conducted research to explore the passage of participants in the *Sexual and Reproductive Health programme in Crisis and post-Crisis Situations* (SPRINT) training course from the training room to their work setting. I sought to identify and understand the factors which enabled and impeded the ability of trainees to transfer their training.

I conducted a multi-phase qualitative study in which I interviewed SPRINT trainees, administered questionnaires, carried out observation at regional and national level training events, and reviewed numerous documents including country level and regional monitoring and evaluation reports. Through these data, I discovered a system of factors which operate to determine whether a training participant can and/or will transfer their learning on return to work. These factors operate on and between four distinct layers that include individual level moderators; training design factors; organisational structures; and wider environmental issues. These factors were also found to have an association with a trainee's *intention*, and eventual *application* of knowledge and skills developed during the training course.

Identifying and understanding these factors is important, as they can be planned for and addressed to increase the application of new knowledge and skills. This research provides recommendations which will enable training efforts to be optimised and, in so doing, ensure that aid is more effectively applied, and the SRH needs of those living in humanitarian settings are better met.

Chapter 1

Background and key concepts

Introduction

Training is beneficial. Decades of research have provided clear evidence that training interventions can have a positive impact on individual trainees, the teams in which they work, their organisations and society more generally (Aguinis and Kraiger, 2009). It is not, however, the panacea it is often assumed to be. Behind the vast numbers of aid dollars spent in development and humanitarian work on 'capacity building'- a term often used as little more than a surrogate for 'training'- are the persistent questions: how much of the knowledge and how many of the skills that are developed through training interventions are actually utilised when those participating in training return to their places of work? Training transfer research has long tried to provide insight into this gap between training and its use. Studies in the field suggest that there is a system of factors operating on and between individual, training and organisation levels to determine the likelihood that trainees will be willing and able to apply what they have learned to their daily work tasks.

Such studies on the transfer of training provide a conceptual platform from which it is possible to look more closely at the specific system of factors which accompany a trainee as they enter, interact with and return to work from a course of study on sexual and reproductive health in humanitarian settings. However, the composition and functioning of this system of training transfer factors was little understood for SRH training for humanitarian contexts. The few existing studies located only tangentially consider transfer (Teela et al., 2009; Homan et al., 2010; Nelson et al., 2012; Sullivan et al., 2004; Smith et al., 2013). Even so, they suggest an expansion of the system of training transfer factors and the addition of a broader environmental level of influence.

The lack of attention to the transfer of training in this sphere is concerning for a number of reasons. First, people, particularly women and girls, surviving in humanitarian settings are vulnerable to a range of SRH related disease, disability and death. Second, global evaluations of SRH services in humanitarian settings (IAWG, 2004; Chynoweth, 2015) have identified capacity-related gaps as impediments to the implementation of SRH services which could

mitigate these vulnerabilities. Some of these capacity related gaps could be closed through appropriate training and training-supportive interventions. Little is known, however, about what constitutes 'appropriate' training related interventions in this field. Third, inappropriate training interventions, or more specifically, training which is not utilised by those who have been trained, represent a waste of too scarce aid resources. Fourth, and most importantly, if training efforts in this field are not transferred to action, the opportunity to close gaps in capacity and, in so doing, provide essential lifesaving sexual and reproductive health services may be lost.

Accordingly, this research has sought to uncover the system of training transfer factors which impact on the willingness and ability of participants in the SPRINT Training programme to use any knowledge and skills developed during the course when they return to work. The identification of these factors and an understanding of how they influence transfer is important, as such moderators can be planned for and addressed through targeted interventions before, during and after the training programme. If this is done, training efforts will be optimised by the increased transfer of learning, aid will be more effectively applied, and the SRH needs of those living in humanitarian settings will be better met.

The motivating threads which have guided this work are:

- The belief that sexual and reproductive health is a right for all, including those in humanitarian settings;
- That for full sexual and reproductive health to be realised, competent and engaged human resources are necessary;
- That training can be an effective tool to increase the competence of involved actors, but that training alone is insufficient for knowledge and skills to be transferred from training to work; and finally
- That training which is not practically applied represents a waste of scarce aid resources, and most importantly, signifies a missed opportunity to prevent sexual and reproductive health related disease, disability and death in humanitarian settings.

This chapter will provide a background to the above reflections by defining key concepts underpinning the research.

Sexual and reproductive health

Full sexual and reproductive health (SRH) encompasses "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (ICPD, 1994). Implicit in this definition are the rights of all individuals to a satisfying and safe sex life, the agency of women and men to decide if and when to reproduce and how to regulate their fertility safely, and an understanding of the importance of access to appropriate sexual and reproductive health care services for all populations.

Despite the resolution of this definition at the International Conference on Population and Development (ICPD) in 1994 and a growing emphasis on SRH as both a human right and a matter of choice for individuals, sexual and reproductive health problems remain the leading cause of death and disability of women globally:

- Worldwide, around 800 women die from preventable causes related to pregnancy and childbirth every day. Ninety nine per cent of these deaths occur in low and middle-income countries (WHO, 2014), "making maternal mortality the health statistic with the largest disparity between developed and developing countries" (WCF, 2016). 11 per cent of all births annually occur to young women aged 15-19 years. Young adolescents have a disproportionately high risk of pregnancy related complications and death when compared with older women (WHO, 2014).
- Complications from unsafe abortions lead to an estimated 47 000 maternal deaths annually, and in low and middle-income countries, 5 million women are admitted to hospital every year as a result of unsafe abortion (WHO, 2014).
- One in three women and girls aged between 15 and 49 have experienced physical and/or sexual violence, with consequences including homicide, suicide, injury, unintended pregnancies, gynaecological problems, sexually transmitted infections including HIV, depression, and post-traumatic stress disorder (WHO, 2016).
- In 2014, 36.9 million people were living with HIV worldwide. Women accounted for 17.4 million, or approximately 47 per cent of this number, and 2.6 million children were living with the virus. In the same year, 1.2 million people died of AIDS-related illnesses (AVERT, 2015).

The Programme of Action developed by the ICPD (1994) further states that reproductive health care "also includes sexual health, the purpose of which is the enhancement of life and

personal relations" (ICPD 1994: p10./21 of summary). There remains some contention around the addition of sexual to reproductive health or whether it is implicit in the term reproductive health. In this research, I have chosen to separate sexual from reproductive health and allow it equal representation for a number reasons. The first of these is for consistency, as the title of the project being studied is *Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations in East South-East Asia and the Pacific.* More fundamentally than this, however, this research prefers the term Sexual and Reproductive Health (SRH) to Reproductive Health (RH) in acknowledgement that subsuming *sexual* under *reproductive* can promote a concentration on particular aspects of RH such as maternal and newborn health at the expense of politically controversial components. Though more difficult, elements such as sexual and gender based violence must be addressed if "a state of complete physical, mental and social well-being… in all matters relating to the reproductive system and to its functions and processes" (ICPD, 1994: para 7.2) is truly and comprehensively sought. The designation of sexual health as a separate public health issue is also in keeping with more recent movements in the field. This emphasis "arose later as a result of, *inter alia*, the HIV pandemic, increasing global rates of sexually transmitted infections, and the growing recognition of the public health importance of issues such as violence against women and girls" (Glasier et al., 2006:1). While acknowledging the interconnectedness of the terms, SRH will be used throughout this research to both emphasise the equal importance of sexual and reproductive health, and to best reflect the contents of the training programme it investigates.

Humanitarian settings and response

Humanitarian settings are found where "an event or series of events has resulted in a critical threat to the health, safety, security or well-being of a community or other large group of people" (IAWG, 2010:5). Accompanying this disruption to the normal functioning of society is the overwhelming of an affected community's capacity to cope using their own resources (IAWG, 2010: 5; UNISDR, 2009: D9). The event or series of events mentioned in the above definition may be natural, technological, the result of political repression or armed conflict, an epidemic, famine, or complex, involving a combination of events (see appendix 1 for full definitions of these hazards; IAWG, 2010: 5-6).

These events in and of themselves may not result in a humanitarian crisis or disaster. As emphasised in the definition of humanitarian settings above, an important factor in

determining the impact of a hazard is an affected society's capacity to cope with or resist the threat at hand, be it natural, human induced or a combination of the two. This capacity is determined by the physical, material and human resources available to affected populations (IFRC, 2015b). Following this logic, the United Nations International Strategy for Disaster Reduction (UNISDR) has declared that

> [T]here is no such thing as a 'natural' disaster. Many *hazards* are natural and usually inevitable, like cyclones, floods, droughts and earthquakes. They are 'hazards' in that they can *potentially* harm people, economies and the environment *if* they are not adequately prepared. A 'disaster' occurs when a hazard results in devastation that leaves communities or even whole nations unable to cope unaided…But disasters are neither inevitable nor 'natural' (2010: 8).

The above understanding of humanitarian crises or disasters and their resultant settings represents a changing conceptualisation of humanitarian response and is a critical concept for this study. Until quite recently, disasters were viewed as exceptional events, unrelated to social and developmental processes (Yodmani, 2001:1). What has developed in recent thinking on disaster management and response is a far more active approach, less confounded by inevitability, and more focused on increasing the capacity of individuals, organisations and systems to resist and respond should a hazard event occur. A useful equation, often used to explain the impact of a hazard and to clearly show where points of intervention lie is the following, taken here from the International Federation of Red Cross and Red Crescent (IFRC, 2015b) Societies:

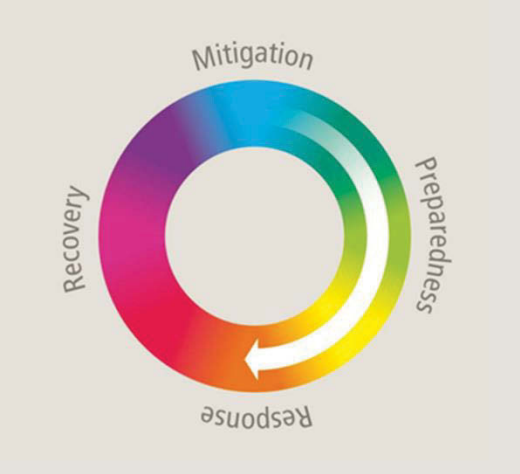
$$\frac{\text{Vulnerability + Hazard}}{\text{Capacity}} = \text{Disaster}$$

Within this framework, vulnerability and capacity are viewed as opposing sides of a common coin, with vulnerability referring to a diminished individual, group or systemic capacity to anticipate, resist, cope with and recover from the impact of a hazard (IFRC, 2015b); and capacity describing individual, group or systemic resources available to anticipate, resist, cope with and recover from the impact of a hazard (IFRC, 2015b). When understood in this manner, interventions which can reduce vulnerability and increase capacity will mediate the impact of a

hazard and therefore the scale and nature of a disaster. In line with this, my study focuses on the potential of training to increase capacity so that the impact of hazards on the sexual and reproductive health of affected populations may be mitigated.

A further function of this equation is to blur the line between the traditionally separate domains of development assistance and humanitarian response. The recognition that the negative impacts of hazards may, to some degree, be avoided through prior and post-disaster action has seen the recent development and adoption of a more holistic approach, often referred to as Disaster Risk Reduction (DRR), where interventions are planned throughout the emergency management cycle (represented in Figure 1, below). While development organisations may have focused on recovery and mitigation and humanitarian agencies targeted preparedness and response, this new paradigm calls for coordinated efforts across sectors in the understanding that each phase is influenced by the efficacy of actions during the previous stage, and in turn impacts successes in the stage to follow.

Figure 1: The Emergency Management Cycle



Adapted from: SPRINT, 2011

This understanding of the linkages between development and humanitarian response also, by default, expands the population with whom humanitarian agencies may work. In addition to this, 'humanitarian space' has broadened in focus from the camp-based settings which predominated during the last decades of the cold war (Spiegel et al., 2010) to now include any situation in which refugees, internally-displaced persons or internally 'stuck' populations can be found. This shift has accompanied the changing nature of conflict, the increasing prevalence

and severity of natural hazards and the consequent increasing numbers of internally displaced people. People who are internally-displaced are far less likely to seek refuge in camps, and instead, urban and peri-urban sites have absorbed increasing numbers of those displaced (Spiegel et al., 2010). Even for populations who seek refuge in other countries, the United Nations Population Fund (UNFPA) estimate that more than half of all refugee women and girls now live in cities, not camps (UNFPA, 2016a). In addition, populations targeted as beneficiaries of humanitarian response may also be found in their own and neighbouring communities (such as those affected by natural disasters with no capacity or opportunity to flee), in transit, in the homes of family or friends, or in temporary evacuation centres.

Current statistics estimate that:

- Globally, more than 125 million people are currently in need of humanitarian assistance due to conflict, natural disasters or other hazards (UNFPA, 2016a).
- In 2014, 59.5 million people around the world had been forced to leave their homes, and around 42 500 people were forcibly displaced by conflict or persecution every day (UNHCR, 2016). In addition, the Internal Displacement Monitoring Centre (IDMC) estimate that an average of 27 million individuals were forced from their homes by natural disasters each year between 2008 and 2013 (IDMC, 2014).
- More than 75 per cent of people currently affected by humanitarian crises are women and children (UNFPA, 2016b).
- The average period of displacement for the world's refugee population is now 20 years (UNFPA, 2016b).

How organisations respond to the needs of these diverse populations has also changed. Humanitarian action has a long history, marked by both advancements and disastrous inadequacies. The establishment of the International Committee of the Red Cross in 1863 marked the initiation of organisational provision of humanitarian aid, and the devastation of the Wold Wars resulted in significant development of international human rights, humanitarian and refugee law (Chynoweth, 2014). However, humanitarian response did not expand significantly until the entrance of non-government organisations in the 1970s and 1980s. Within this growing field, attention to standards of response was scant. The early 1990s saw humanitarian agencies entering more complicated settings and being subject to deeper scrutiny and analysis (Buchanan-Smith, 2003). There was growing concern at this time "about the range of standards and performance to which different agencies operated" (Buchanan-Smith, 2003: vi). A number of Codes of Conduct, including that of the International

Red Cross and Red Crescent were established at this time, but it was the Rwandan genocide, the devastation of the humanitarian crisis which followed, the unprecedented international response- and its accompanying failings and scrutiny- which created momentum to address inconsistencies and gaps within the humanitarian sector (Buchanan-Smith, 2003).

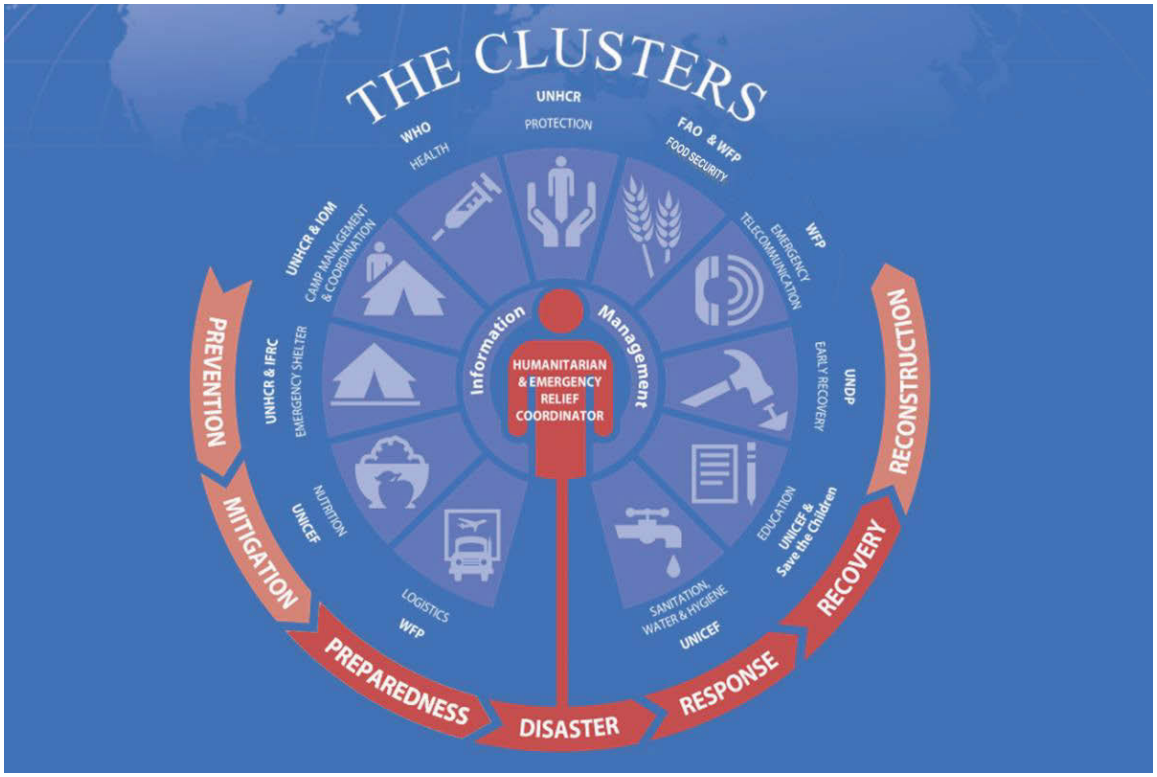
What resulted from these push factors was the Sphere Project, an initiative designed to bring the wide range of organisations involved in humanitarian response together "to improve the quality of humanitarian assistance and the accountability of humanitarian actors to their constituents, donors and affected populations" (Sphere, 2015). In the year 2000, the Project published a 'Humanitarian Charter and Minimum Standards for Disaster Response, which provides a set of common principles and universal standards in life-saving areas of humanitarian response (Sphere, 2015). Sexual and reproductive health is represented within this framework by the Minimum Initial Service Package for Reproductive Health (the MISP), a key concept for this research which is outlined in more detail below.

Overlapping this changing approach to humanitarian response, and originating from similar motivating factors (namely inadequacies in coordination, lack of accountability and inconsistent intervention), the United Nations Inter-Agency Standing Committee (IASC) began a Humanitarian Reform Process in 2005 with the aim of improving "the effectiveness of humanitarian response through greater predictability, accountability, responsibility and partnership" (IASC, 2015). Part of this process has been an agreed division of labour and responsibility, known as the Cluster Approach, which brings groups of humanitarian organisations (both UN and non-UN) together to address the main sectors of humanitarian need. The Cluster system was instigated to improve partnership and coordination, and to provide a structure to formalise leadership, responsibility and accountability (UNOCHA, 2015). Nine technical Clusters, including areas such as education and health, two service Clusters for emergency telecommunications and logistics, and four cross-cutting issues (age, gender, environment and HIV/AIDS) have been established. Further, each of these Clusters is led by an organisation charged with ensuring a cohesive and effective sectoral response (Chynoweth, 2014; see Figure 2, below). Sexual and reproductive health is subsumed under the Health Cluster, though the breadth of activities involved in implementing the Minimum Initial Service Package for Reproductive Health necessarily involves coordination with multiple Clusters. WHO's Health Cluster Guide states that the incorporation of SRH under the health cluster is to "avoid the establishment of standalone groups in sub-areas of health cluster work such as

reproductive health or mental health" (WHO, 2009: 26). The integration of SRH under the general Health Cluster has, however, been contentious, with some reproductive health experts concerned about the historically limited attention paid to the MISP by health actors in humanitarian settings, particularly in comparison to the traditional focus on infectious diseases (personal communication). The WHO Health Cluster Guide itself recognises that the SRH response has been inadequate in the past, stating that:

> The reproductive health (RH) area (including the three subsectors of STI and HIV, maternal & newborn health and sexual violence) requires increased attention in humanitarian settings. To ensure adequate coverage of these essential services, an organization that is a partner in the health cluster and has specific expertise and capacity in country must be assigned the responsibility to support, promote, advocate for and lead actions in the reproductive health area (WHO, 2009:50).

Figure 2: The Cluster System (Source: UNOCHA, 2015).



These efforts at improving predictability, accountability, responsibility and partnership have not been without criticism, and continuing gaps and weaknesses have been reported, particularly in the wake of recent large scale emergencies such those seen in Haiti after the earthquake and in Pakistan as a result of the 2010 floods. In response, a second round of reforms, titled the Transformative Agenda was launched in 2011 to address challenges found in "deploying adequate leadership; putting in place appropriate coordination mechanisms at various levels and ensuring clear mutual accountabilities" (IASC, 2015).

While the importance of a strong, effective and coordinated international response to humanitarian crises is clear, it is also important to understand that not every disaster will provoke an international response, and not every national government will allow the provision of international assistance. In a majority of crisis situations, response will be managed and led by national, provincial and/or more local government agencies. It is only when the impact of the hazard exceeds the capacity of a national government to cope using its own resources that international assistance may be requested or accepted. An understanding of the role national actors have to play in disaster response is becoming increasingly important for a number of reasons. First, governments are increasingly asserting their sovereignty when it comes to disaster relief due to both improved economic capacity in some developing counties and the concomitant ability to respond to the needs of their citizens without external assistance, and, despite commitments to the contrary, a continuing failure of the international system to cooperate effectively with national authorities (ALNAP, 2010). As explained by The Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP),

> International aid interventions depend on the consent of the government of the affected country. Whether a government is strong or weak, abusive or concerned for its citizens' welfare, it essentially determines whether humanitarian actors can be present in crises. As the case of Myanmar's response to Cyclone Nargis shows, it is almost impossible to provide relief assistance without government consent (2010:1).

Second, a refocussing of attention onto the role of national governments, encouraging alignment and harmonisation between national and international agendas, and an increased emphasis on national ownership of development processes can be seen in international movements for Aid Effectiveness and Disaster Risk Reduction (ALNAP, 2010). As such, when considering how to tilt the vulnerability/capacity equation (outlined previously) in favour of

resilience and away from disaster, capacity not only within global response systems, but within national and sub-national response systems becomes a vital consideration.

Sexual and reproductive health in humanitarian settings

The need to address SRH in humanitarian settings

SRH is an important public health concern, and during crises the SRH needs of surviving and host populations continue and often increase. The risk of sexual violence may intensify during periods of instability caused by conflict or natural disaster (UNFPA, 2016a). Legal, social and community support systems which would normally serve as protective mechanisms may be weakened, destroyed or not yet established in situations of forced displacement. This absence of protection, together with a loss of men's power, the use of rape as a weapon of war, and the lack of access to resources and income generation for women can lead to an increase in transactional sex, sexual abuse and rape. Up to 40 per cent of women were raped during Liberia's 14 year civil war (Refugees International, 2004), while in the Democratic Republic of Congo, doctors now classify vaginal destruction as a war crime due to the systematic use of exceptionally violent gang rape as a method of warfare in the nation's ongoing conflict (Amnesty International, 2004). Increased violence against women has also been reported in the aftermath of natural disasters including in the Philippines after the Mount Pinatubo Eruption, in Central and North America after Hurricane Mitch, in Sri Lanka after the 2004 tsunami and in Australia after flooding (Felten-Biermann, 2006) .

The relationship between incidence levels of STIs/HIV and humanitarian settings is complex, but the displacement which accompanies both conflict and disaster situations is recognised as an important risk factor for transmission. Concomitant social instability, the trauma of conflict and displacement, the presence of military or peace keeping forces, increased economic vulnerability of women and minors and resultant sexual exploitation, lack of work and educational opportunities and ensuing boredom and frustration may contribute to risky sexual behaviour and place young people at particular risk. Interaction between populations with different STI prevalence may lead to the spread of infections, including HIV, and conflict and natural disasters may also disrupt access to STI/HIV treatment and prevention services and where services are available, lack of staff and resources may hinder safe work practices including adherence to standard precautions and safe blood transfusion (Spiegel, 2004).

It is estimated that 4 per cent of any population displaced by disaster or conflict will be pregnant at a given time (IAWG, 2009). Of these women, 15 per cent are estimated to experience life-threatening complications as a result of their pregnancy. During the acute phase of an emergency and where populations are displaced, childbirth will often take place without trained assistance or even the most basic of resources, making women vulnerable to death or disability from otherwise preventable causes (WRC, 2006). Adding to these fundamental risks, malnutrition and epidemics often accompany crises and can increase the probability of pregnancy complications. UNFPA estimate that in 2015, 61 per cent of maternal deaths worldwide occurred in 35 countries experiencing humanitarian crises (UNFPA, 2016a). Lack of access to immediate newborn care caused by displacement and the breakdown of health systems also jeopardises infant survival and health.

Current statistics show that the global level of displacement is the highest on record since the collection of comprehensive statistics began (UNHCR, 2016), and that this figure is expected to rise in the coming decades (IDMC, 2014). When it is understood that the SRH needs of populations surviving in humanitarian settings at least continue, and most likely increase, the scope of SRH as a humanitarian health concern becomes clear. So too does the need to ensure competent assistance to prevent "death, disease and disability related to unwanted pregnancy, obstetric complications, sexual and other forms of gender-based violence, HIV infection and a range of reproductive disorders"(IAWG, 2010).

The developing field of SRH in humanitarian settings

SRH was first brought to light as an important, and often overlooked, aspect of humanitarian response in the 1990s. In 1991, UNHCR published Guidelines on the Protection of Refugee Women, a document which called for recognition of the particular needs of refugee women, including "protection against manipulation, sexual and physical abuse and exploitation, and protection against sexual discrimination in the delivery of goods and services" (p1). In 1993, an editorial in the Lancet highlighted the rights of refugees to reproductive health and the lack of services available to uphold these rights (p929), and in the same year, the American Public Health Association released a position paper titled The Health of Refugees and Displaced Persons: A Public Health Priority. The following year was formative in the positioning of SRH as an issue of concern for humanitarian practice and witnessed both the publishing of the

Women's Commission for Refugee Women and Children's report Refugee Women and Reproductive Health Care: Reassessing Priorities, and the International Conference on Population and Development (ICPD) at which delegates identified reproductive health as a human right for all, including those in humanitarian settings (Austin et al., 2008). The Fourth World Conference on Women in Beijing and the targeted violence against women seen in the Balkan and Rwandan conflicts further highlighted the specific SRH needs of women and girls in humanitarian emergencies (Schreck, 2000).

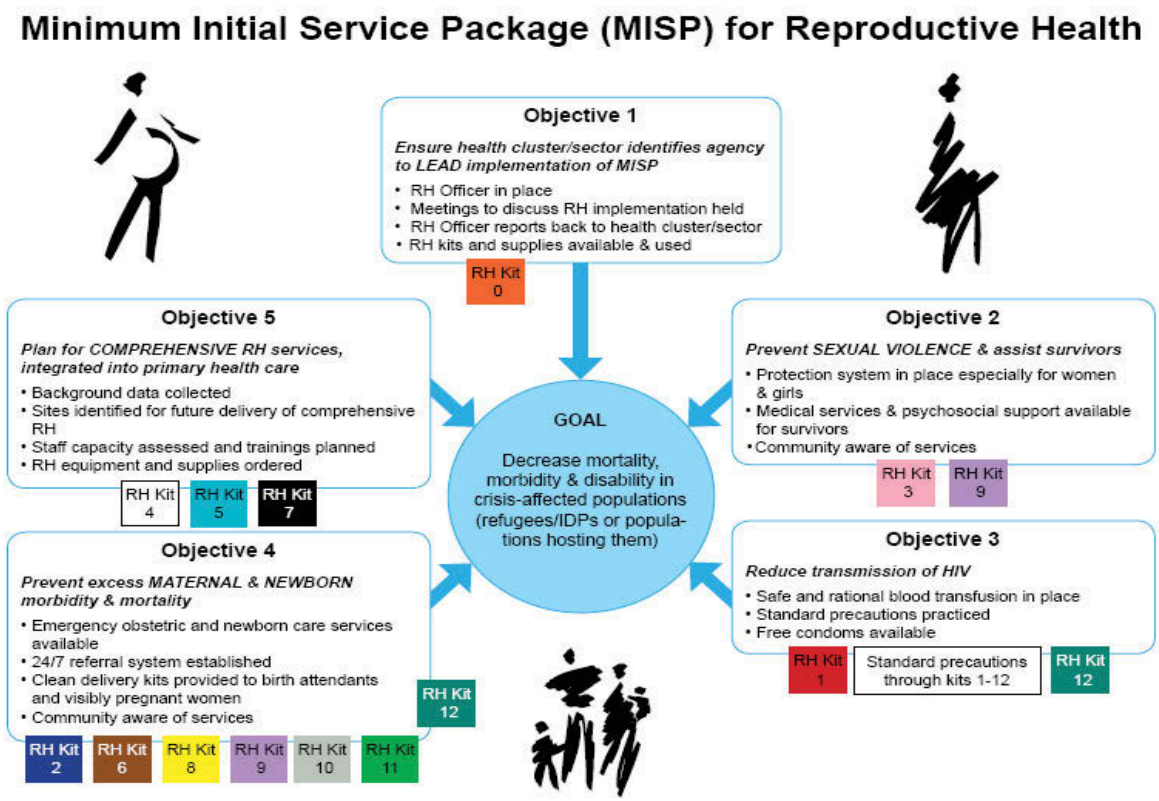
The momentum to address SRH in crises was driven by growing recognition that access to SRH care is a human right, that people need SRH services for their bio-psycho and social health- and, as discussed above, often more so in times of crisis- and that provision of timely and appropriate services can prevent disease, prevent disability and prevent death. This impetus for action culminated in the founding of the Inter-agency Working Group (IAWG) on Reproductive Health in Refugee Situations, a group of approximately 40 United Nations, academic research, governmental and nongovernmental organizations. The IAWG published the first field manual for humanitarian workers on how to implement SRH services in emergencies. Recognizing that comprehensive SRH services are not feasible at the onset of a crisis, the IAWG developed minimum standards in SRH response, known as the Minimum Initial Service Package (MISP) for SRH.

First articulated in the IAWG field manual, the MISP is a set of priority activities to be implemented during the onset of an emergency and forms the starting point for all SRH programming (see Figure 3, below). The MISP was integrated into the 2004 revision of the Sphere Humanitarian Charter and Minimum Standards in Disaster Response for humanitarian assistance providers (Sphere Project, 2004), and meets the life-saving criteria for the United Nations Central Emergency Response Fund (CERF). The Inter-agency Standing Committee (IASC) Global Health Cluster endorses the MISP as a minimum standard in health service provision in emergencies (IASC, 2015). A number of guidelines have been developed to further support both MISP implementation and the transition from emergency response to more comprehensive programming. Important amongst these are the IASC's Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action (2015) and Guidelines for Addressing HIV in Humanitarian Settings (2010), and UNFPA/Save the Children's Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings (2009). The five-fold objectives of the MISP are further supported by a range of Reproductive Health Kits comprising

essential drugs, supplies and equipment. These kits are not required to implement the MISP, but are designed to supplement depleted or overwhelmed in-country supplies.

Most importantly, the services and resources included in the MISP were established to minimise death, disease, and disability from SRH causes among crisis affected populations, and developed in the understanding that SRH must form a critical component of any humanitarian response. The ICPD Program of Action (1994) enshrined access to these sexual and reproductive health care services and established such access as a basic human right. These rights extend to all, including those in humanitarian contexts, and efforts to ensure their fulfilment must consider the specific needs and settings of those affected by humanitarian crises (Girard and Waldman, 2000).

Figure 3: The Minimum Initial Service Package (IAWG)



More recent additions to the MISP have seen the five objectives expanded to include making contraceptives available to meet demand, the syndromic treatment of STIs, and safeguarding antiretrovirals for continuing users. Although progress has been made in advancing the MISP in policies, significant gaps in implementation remain. In 2004 a global evaluation on SRH in

emergencies (IAWG, 2004) conducted by IAWG showed that the MISP continued to be neglected by humanitarian health actors. Key challenges explaining this neglect were found to be:

- a lack of awareness of the MISP, and perceptions of SRH services as inappropriate or not a priority during the early phase of a crisis,
- a lack of preparedness for SRH in emergencies, and a lack of resources and capacity to implement the MISP in emergencies, and
- poor coordination of SRH in emergencies.

More recent assessments conducted for IAWG have confirmed that although improvements are being made, the MISP has still not been fully implemented in any humanitarian emergency to date (Chynoweth, 2015). The development of individual and collaborative capacity remains a key challenge to delivering the life-saving services and activities provided for in the MISP to populations surviving crisis and living in post-crisis situations.

Filling the capacity gaps: Training for SRH in humanitarian settings

The benefits of training

There is a reported shortfall of health and emergency management workers with the skills and engagement to coordinate and implement the lifesaving components of the MISP. This requires a strategic approach to developing relevant human resource capacity (IAWG, 2004). Anecdotally, the most often requested, cited and implemented strategy to address this capacity gap is 'to train'. Training itself "refers to a systematic approach to learning and development to improve individual, team and organisational effectiveness" (Aguinis and Kraiger, 2009:452), and may be differentiated from 'learning' in its emphasis on performance improvement, not solely the acquisition of knowledge and skills. In this sense, "learning is a means, not a primary organisational outcome" (Yamnill and McLean, 2001: 196).

Training is beneficial. A profusion of studies and decades of research provide clear, documented evidence that training activities can have a positive impact on individual trainees, the teams in which they work, their organisations, and the host society (Aguinis and Kraiger, 2009). Key to the above sentence, however, is the word *can*. Training *can* provide benefits, but misdiagnosis of capacity problems; and misuse, over-reliance, and 'silo-ing' of training

programmes can undermine their effectiveness (Stetar, 2005). Maximising the potential benefits of training becomes an important consideration when it is understood that training continues to be widely sought after and used as a capacity development strategy in and by development and humanitarian organisations, despite limited evidence of its use and effectiveness, and the ALNAP finding that "much of the training provision in the Sector appears to be weakly linked to the action practice of humanitarian agencies" (2004, in Clarke and Ramalingam, 2008: 32). While no specific figures could be found to provide insights into the dollar amounts reserved by funding organisations for 'training', a 2013 snapshot review of development assistant projects which incorporated the wider concept of capacity development or capacity building- which is often "merely a euphemism referring to little more than training" (Potter and Brough, 2004:336)- found that:

> Of more than 19,000 current development projects listed on the development business website DevEx.com in April 2013…almost half (8757) made reference to 'capacity'. They included an Asian Development Bank 'Governance and Capacity Building Project' in Bangladesh, an EU 'Capacity Development Project for Non-State Actors' in Zambia, a 'Capacity-Building Project for Private Sector Development' in Angola, and a Finnish government project on 'Strengthening the Capacity of the Nepal Scouts' (www.devex.com, 7 April 2014). The terms of reference for advisers and consultants working on projects such as these invariably include a requirement that the adviser will build the capacity of local counterparts and institutions (Venner, 2014:3).

Training for SRH in humanitarian settings

In line with the call for increased capacity for SRH in humanitarian settings and the perceived utility of training as a measure to meet this need, a diverse range of training manuals, curricula and workshops have been developed to address the standard components of an SRH response for humanitarian settings. In order to better understand the range and availability of these resources, I conducted a mapping exercise in 2015 with a two-fold search strategy. First, a general scoping search using Google and various combinations of the search terms *sexual and reproductive health training course* returned 324, 000 results. I reviewed the first five pages of these results due to the diminishing relevance of suggested sites. After this initial search, I targeted and reviewed the websites of 25 organisations active in the field of sexual and reproductive health and/or humanitarian preparedness and response. I focused this mapping

exercise on in-service training courses and curricula which have been or are currently available for participants from diverse organisations as this is the form of training investigated in my research. I excluded guides, guidelines, toolkits, handbooks, field manuals, field tools, training restricted to employees of the organisation providing the training (for example, courses provided by MSF for MSF staff only), and pre-service clinical or academic courses.

Thirty training resources, including manuals, curricula and courses were identified and mapped against the 5 objectives of the MISP. A table summarising this mapping is included in appendix 2. It shows that there is a large number of resources available and that these resources tend to concentrate on specific areas of the MISP, particularly sexual violence. It also indicates a recognition both that SRH is an important consideration for emergency preparedness and response, and that human resource capacity is wanting.

The SPRINT Initiative (SPRINT)

Amongst the available training curricula and programmes found in the mapping exercise is that provided by the *Sexual and Reproductive Health programme in Crisis and post-Crisis Situations*, (or SPRINT) Initiative, the pilot programme of which will form the basis and content of this research. SPRINT is an Australian government funded initiative managed by the International Planned Parenthood Federation (IPPF) in collaboration with the United Nations Population Fund and key national and international partners. Begun in 2007 as a pilot programme in East and Southeast Asia and the Pacific, the SPRINT Initiative was established around the goal of increasing access to SRH information and services for persons surviving crises or living in post-crisis situations in this region. To achieve this goal, the Initiative established the following set of objectives:

- Increasing national and regional capacity to implement the Minimum Initial Service Package for SRH in crises,
- Strengthening coordination of SRH stakeholders and activities,
- Responding in a timely fashion to SRH needs in crises, and
- Enhancing access to comprehensive SRH information and services for affected populations.

A cornerstone activity employed by SPRINT to meet these objectives was training in-country actors on coordination of the MISP. A five day training of trainers course was developed and

covered the content areas set out in appendix 3. Instructional methods included lecture, discussion, group work, action planning and pre- and post-testing.

The basis of the training was to strengthen coordination capacity in country, and for this reason, inter-agency collaboration and partnership was an underpinning strategy of the SPRINT Initiative. Participants in the training were a mixed group and included both clinical and non-clinical trainees, members of national non-government organisations, international non-government organisations, United Nations agencies, ministries of health and national emergency management departments, academic institutions and other relevant organisations. Pre-requisites for participation included experience in SRH and/or humanitarian work and a stated willingness and ability to integrate SRH in crisis related activities into day to day work. These diverse actors representing a broad range of organisations were brought together at Regional Training of Trainers workshops to form national level inter-agency coordination teams (labelled *SPRINT coordination teams* throughout this thesis) in recognition that multiple sectors and agencies are required for MISP implementation (Beek et al., 2013:6).

SPRINT's expectations of trainees on return to their setting were three fold. First, the coordination team, or designated members, were expected to undertake advocacy to governments, organisational superiors or other stakeholders, to ensure the integration of SRH into national, regional or organisational emergency preparedness and response plans. Second was a focus on increasing national capacity for MISP implementation through the organisation of in-country trainings which were to 'echo' the regional training they had received (to a cascade training model). Finally, it was expected that coordination team members would coordinate action for preparedness and response, including applying core concepts and techniques provided in the MISP in line with tasks laid out in the action planning component of the regional training.

The role of the SPRINT Initiative's Secretariat, housed in IPPF's Kuala Lumpur office, was to support all three of these objectives by providing technical assistance, supporting advocacy, training resources, and funding where necessary. Since the three pilot Regional Training of Trainers workshops, the Initiative has been rolled out to further regions, amended its training curriculum and strategies to support trainees, and changed in scope from its initial focus. This research, however, is limited to the training component of SPRINT and to participants from the three original training of trainers courses conducted in Kuala Lumpur, Sydney and Suva.

Summary of Chapter 1

Populations, and in particular women and girls, need access to appropriate SRH services in humanitarian contexts, where vulnerabilities to related death, disease and disability are often exacerbated. International commitment to building the capacity of health workers to provide these services is evident and a number of training courses, curricula and capacity building programmes have been developed. Despite the availability of these training resources, inadequacies in MISP implementation due to a lack of capacity are still reported. It is evident, therefore, that important gaps remain in our understanding of how and why participants apply knowledge and skills gained through these training programs to best provide SRH services in humanitarian settings. In the following chapter, I provide an overview of literature which will provide important insights into the processes which determine whether training is applied to practical use.

Chapter 2

A review of the literature: Maximising the potential benefits of training

Introduction

As established in Chapter 1, training can be beneficial, and with the plethora of courses, curricula and training guides available in the field of sexual and reproductive health for humanitarian emergencies, it would be hoped that some of these benefits have been experienced by girls, women, boys and men living in humanitarian situations. While improvements in meeting the SRH needs of people in crises are noted, the findings of global MISP evaluations (IAWG, 2004; Chynoweth, 2015) suggest that the full potential of training is not being realised for these populations. In this chapter, I provide an overview of the literature which works to explain the dissonance between training and application of training and discuss the theoretical frameworks which have informed my research.

The importance of using knowledge and skills developed during training

Two underlying concepts may help to explain the misalignment between training provision and on-the-ground improvements. First, the availability of training does not always lead to learning (or the right kind of learning); and second, where (the right kind of) learning does occur, it is not always translated into the action it was designed to provoke. As explained by Aguinis and Kraiger (2009), "training works, in the sense that it has an impact on individuals and teams and on the organisations and the societies in which they function. However, training efforts will not yield the anticipated effects if knowledge, attitudes and skills acquired in training are not fully and appropriately transferred to job-related activities" (p465).

This gap between training and use of training is often referred to as 'the transfer problem' after Baldwin and Ford's influential 1988 examination of training literature. Estimates as to the extent of this 'transfer problem' vary, but range from Georgenson's (1982) assessment that only 10 per cent of training results in any behaviour change, to Saks' (2002) suggestion that 40

per cent of trainees do not transfer immediately after the training, 70 per cent "falter in transfer one year after the program, and ultimately, only 50% of training investments result in organisational or individual improvements" (Burke and Hutchins, 2007:263).

To appreciate whether the transfer problem exists for a particular programme, it is necessary to have a clear definition of what is being measured. Generally, training transfer is regarded as "the degree to which trainees apply to their jobs the knowledge, skills, behaviours and attitudes they gained in training" (Holton et al., 1997:96). More recently, and as a result of meta-analytic research into training transfer, Blume et al., (2010) have differentiated between transfer measurements of *training use* and *training effectiveness*. For the purposes of this study, and in keeping with the focus of my research questions, I have defined transfer in terms of *use*, recognising transfer initiation as a first crucial step toward training effectiveness.

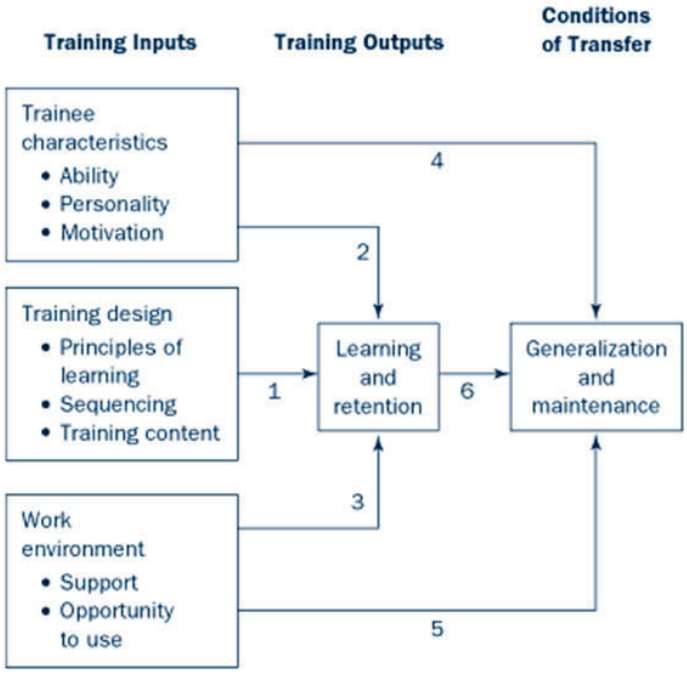
There is consensus in the training, human resource development, performance improvement and management fields that what is learnt in training must be transferred to the workplace. If it is not, resources dedicated to training will have been wasted (Chiaburu et al., 2010) and, in the instance of SRH for humanitarian settings, the opportunity to develop capacity required to coordinate and deliver the life-saving services prescribed by the MISP will be missed. In accordance with the critical function transfer plays in ensuring that training programmes can deliver their potential benefits, an abundance of research has been generated since the identification of the 'transfer problem' to try to explain why it exists and how it may be overcome. A substantial part of this work has been in the identification of factors which may intercede to support or hinder the transfer to work settings of knowledge, attitudes or skills newly acquired through training.

A system of influences on the transfer of training

In their pivotal work reviewing the extant literature on training transfer, Baldwin and Ford (1988) suggested a conceptual mode (included as Figure 4, below), dividing the literature into three levels of transfer moderating factors which may influence the transfer of training to on the job activities. The first of these was labelled *trainee characteristics* and included the ability, personality and motivation of an individual training participant. The second level of factors was found in the *training design* and accounted for principles of learning, sequencing and training content. The final level proposed was the *work environment*, comprised of support and the

opportunity to use new knowledge and skills. These three layers of factors were hypothesised to influence the generalisation and maintenance of transfer directly, or through the mediating variables of learning and retention (as training outputs) (Baldwin and Ford, 1988:65).

Figure 4: Baldwin and Ford's Model of the Transfer Process (1988)



This influential model paved the way for a proliferation of research into training transfer, which both expanded on the scope and range of potential transfer moderating factors suggested by Baldwin and Ford, and generally maintained the three-level explanatory approach offered by these authors. Factors added by subsequent research to the trainee level of analysis include, but are not limited to, self-efficacy; pre-training motivation; motivation to learn; motivation to transfer; extrinsic/intrinsic motivation; anxiety/negative affectivity; conscientiousness; openness to experience; extroversion; perceived utility; career planning; organisational commitment; and locus of control (Burke and Hutchins, 2007). Similarly, the list of proposed factors which may influence the transfer of training at the training design level was expanded by later research to include needs analysis; learning goals; content relevance; practice and feedback; particular instructional strategies such as over-learning, cognitive overload, active learning, behavioural modelling, and error-based examples; self-management strategies; and technological support (Burke and Hutchins, 2007). The final level suggested by the conceptual work of Baldwin and Ford (1988), the work environment, has also been

extended by ensuing work to cover strategic linkages; transfer climate; a division between supervisor and peer support; and accountability (Burke and Hutchins, 2007).

This subsequent research has included laboratory simulations, field studies, and field experiments in different settings and across differing time intervals (Blume et al., 2010). An important outcome of such work is the understanding that "transfer can only be completely understood and predicted by examining the entire system of influences" (Holton, et al., 2000:336). Important to this understanding is the work of Holton et al. (2000) and their development of a Learning Transfer System Inventory (LTSI), which was designed to measure factors in the system which influence the transfer of training. This inventory included sixteen constructs such as learner readiness, supervisor support, and sanctions, perceived content validity and opportunity to use, and represented an important advance in broadening focus and recognising systemic influences on the use of trained knowledge and skills.

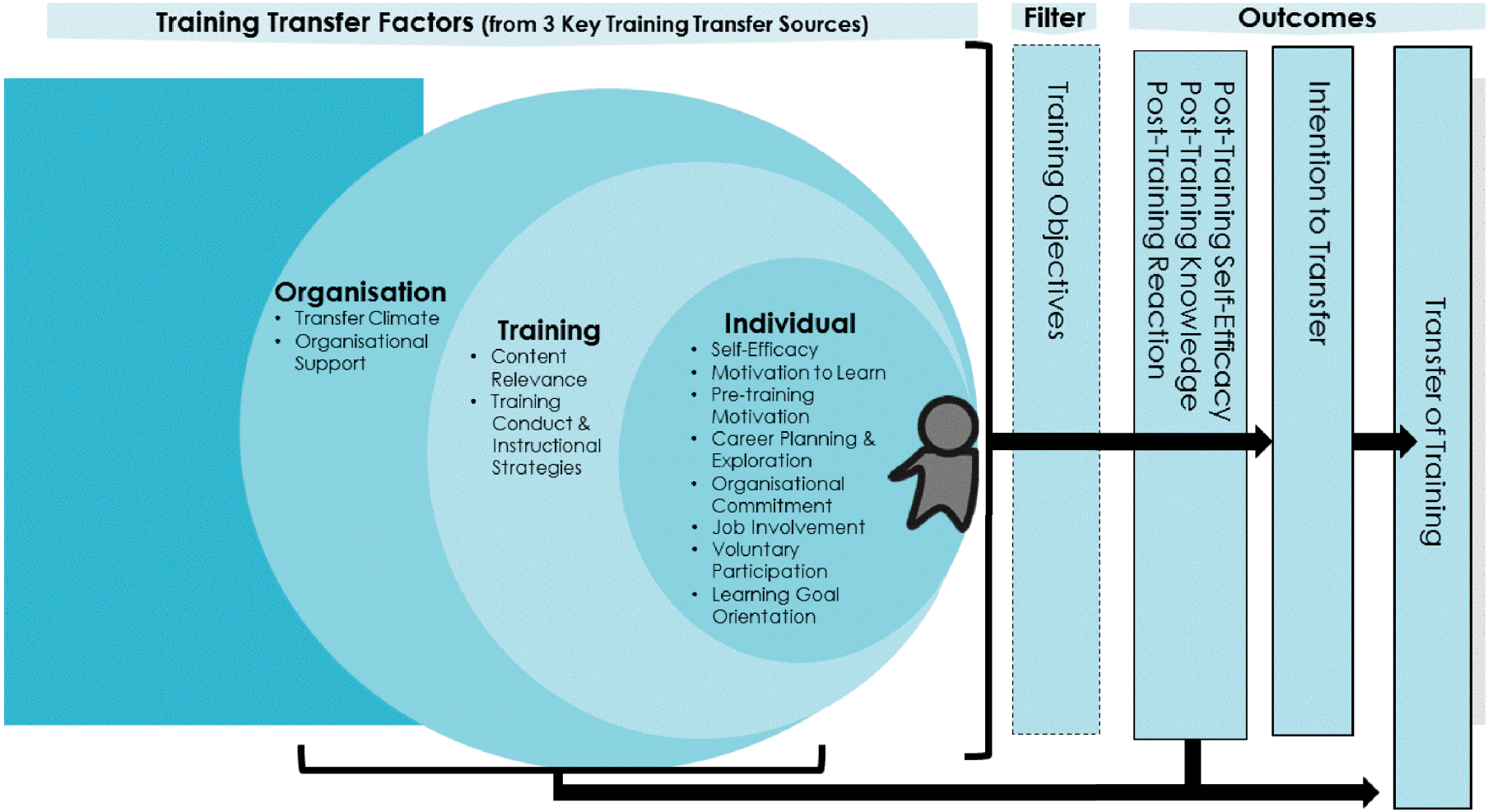
The burgeoning literature which supports this system of transfer moderating factors has not, however, been without inconsistencies, contradictory and counter-intuitive findings and methodological issues (Blume et al., 2010). Mixed support and weak associations have been found for some often-quoted transfer moderating factors. For example, Cheng and Ho (2001) report that ten studies under their review found positive associations between *organisational support* and the transfer of training, two studies documented negative relationships, and five indicated that the link between this long-held moderating factor and transfer was insignificant.

In response, and recognising the importance of transfer for training effectiveness, a number of qualitative reviews have been undertaken to synthesise what is known about transfer from this expanding literature base. Often cited amongst these due to its scope, methodology and comprehensiveness is Burke and Hutchin's (2007) integrative literature review of training transfer research from the disciplines of management, human resource development, training, adult learning, performance improvement and psychology. A further important contribution to our understanding of factors which have proven relationships with training transfer is the meta-analytic review provided by Blume et al. (2010). These two important pieces of work, together with a review by Grossman and Salas (2011) which identifies those factors which have exhibited the strongest and most consistent relationship to transfer, have integrated evidence and confirmed relationships between elements within individual, training and organisation levels which can impact on the transfer of training to different contexts and tasks. I have

synthesised the findings of these studies in a conceptual model outlined in the diagram at Figure 5. This model includes moderators specified by Blume et al. (2010), Burke and Hutchins (2007) and Grossman and Salas (2011), and throughout this study I will refer to these factors, as well as other moderating factors uncovered in my research, as *training transfer factors*.

This conceptual model (Figure 5) is a new illustration of contemporary understanding of the reasons behind the 'transfer problem'. It includes only those factors found to have a relationship to transfer in the important reviews listed above, excluding findings of mixed support or where only minimal empirical research exists. A further important exclusion are dispositional factors and stable psychological states such as extroversion, conscientiousness, locus of control and openness, as these are both beyond the scope of the research undertaken for this study, and least amenable to transfer intervention. Taken as a whole, the following conceptual model I developed through this literature review represents an elaboration of previous frameworks and is based on the most rigorous research currently available in the training transfer field. It provides the theoretical basis for the research presented in this study and is further explained below.

Figure 5: Integrated model of factors which influence the transfer of training (Blume et al., 2010; Burke and Hutchins, 2007; Grossman and Salas, 2011)



Training transfer factors: Why training is or is not transferred to work settings

As with previous training transfer conceptual models, and based on the findings of Blume's (et al., 2010) meta-analysis, Burke and Hutchin's (2007) integrative literature review and Grossman and Salas's (2011) synthesis, the above model maintains a three level approach to identifying and explaining factors which may moderate the transfer of training. These are included on the left of the model under the heading *training transfer factors*, and have been depicted in overlapping circles to represent the inter-relationships and inter-influences which exist between factors both on and between varying levels. As mentioned above, the factors depicted in Figure 5, above, are taken from the literature and have been found to influence the transfer of training. This influence may be positive or negative, depending on the particular circumstance and character of the factor's representation. For example, *organisational support* may be strong, thus acting as a factor which enables transfer. Alternatively, an individual trainee may have little positive involvement in their job, and as such, this factor would work to undermine the transfer of learnt skills to the workplace. Each included factor will be defined and discussed in further detail below.

Individual level factors

A search for the "transfer-ready trainee" (Blume et al., 2010:1090) has preoccupied much training transfer literature, particularly that emanating from the field of psychology. While many individual level factors have been suggested as potentially important supports or hindrances to the use of training in work contexts, Blume (et al., 2010), Burke and Hutchins (2007) and Grossman and Salas (2011) found surprisingly few factors at this level with consistently strong relationships to transfer. After extracting innate characteristics such as cognitive ability from consideration, the following factors remain as confirmed predictors of training transfer.

Self-efficacy

Self-efficacy is a concept founded in social learning theory which generally refers to beliefs or judgements people, in this case trainees, make about their "capabilities to organise and perform the courses of action needed to achieve given goals" (Bandura, 1997, in Bhatti and Kaur, 2010: 662). Shown to have a powerful influence over an individual's behaviour, self-efficacy "is one of the main determinants of whether an individual will benefit from training

and transfer their training to the workplace" (Machin, 2002:10).This concept has been used in the training transfer literature to refer to pre-training self-efficacy, performance self-efficacy and post-training self-efficacy. Post-training self-efficacy is strongly associated with its pre-training antecedents and will be discussed as a training outcome below. Pre-training and performance self-efficacy are combined into the single factor 'self-efficacy' in the model above, and this combined concept has been shown to have both a direct influence on training transfer and to work through training outcomes to influence training transfer. Pre-training self-efficacy has been linked to individual learning outcomes (Thayer and Teachout, 1995) and eventual training mastery (Harrison et al., 1997; Holladay and Quinones, 2003; Mathieu et al., 1993). For example, Quinones (1995) found that low levels of pre-training self-efficacy undermined learning, which negatively influenced post-training self-efficacy, and in turn compromised transfer to the workplace (in Al-Eisa et al., 2009:1225). Performance self-efficacy, or "an individual's general belief that he/she is able to change his/her performance when he/she wants to" (Holton, 1996 in Bhatti and Kaur, 2010:662) has been significantly associated with training transfer directly and with training transfer through the mediating step of training outcomes.

Importantly, intervention studies designed to increase trainee self-efficacy (Gist, 1989; Morin and Latham, 2000) have found improvements in training performance, indicating that this is a malleable learner characteristic which is amenable to intervention (Burke and Hutchins, 2007). In sum, "[t]o succeed in training, employees with high confidence in their capabilities are more likely to be better prepared and have positive expectations about training, that is, to be more motivated to look for training opportunities and learn the contents of the training programs that they attend" (Al-Eisa et al., 2009:1225).

Motivation to learn and pre-training motivation

The second and third individual level factors listed in the above model are motivation to learn and pre-training motivation. Motivation in regards to training is generally understood as those processes which influence "the intensity and persistence of efforts that trainees apply in learning-oriented improvement activities, before during and after training" (Burke and Hutchins, 2007:267). Motivation to learn, which refers to "the desire of the trainee to learn the content of the training programme" (Klein et al., 2006:668), has been found to be an important contributor to training outcomes, including motivation to transfer and post-training knowledge, and is influenced by both personal and situational characteristics (Tziner et al.,

2007; Chiaburu and Lindsay, 2008; Colquitt et al., 2000; Kontoghioghes, 2002; Klein et al., 2006). In addition, pre-training motivation, or "the learner's level of intensity and desire as measured before the training intervention" (Burke and Hutchins, 2007: 267), has been linked directly to training transfer (Burke and Hutchins, 2007). As such, the two motivation constructs which operate on an individual level both directly and indirectly influence the transfer of training. It is, therefore, important to consider motivation at various stages throughout the training cycle as "trainees must believe that it is possible to learn and increase performance, and that such improvements will benefit them" (Grossman and Salas, 2011:110) for transfer to occur.

Training transfer and associated literature also discuss the separate concept of motivation to transfer. For the purposes of this research and in keeping with recent developments in the field, this factor is addressed as part of the training outcome *intention to transfer* and will be discussed in detail below.

Career planning and exploration, organisational commitment, and job involvement

Taken together as career or job variables, the next three factors have been found to affect training transfer as those "who rated high on these variables tended to perceive more potential benefits from a training intervention to enhance their current or future job performance" (Burke and Hutchins, 2007:270). Career planning and exploration refer to the extent to which trainees develop and maintain plans for achieving career goals and the self-assessment of skills (Burke and Hutchins, 2007). Learners exhibiting a high degree of organisational commitment were found to be more likely to want to acquire and utilise new knowledge and skills at work (Colquitt et al., 2000; Kontoghiorghes, 2004), and Mathieu (et al., 1992) and Noe and Schmidt (1986) found that transfer was associated with the degree to which a trainee positively identifies with, attains self-worth from, and actively participates in their job, that is, their 'job involvement'.

Voluntary participation

Through their meta-analysis of the training transfer literature, Blume et al. (2010) found a moderately strong relationship between the voluntary participation of trainees and transfer. This finding has been linked with processes of motivation as Facteau et al. (1995) determined that internal motives influenced motivation, while "when training was obligatory, there was a negative impact on the motivation of the person to learn as well as to the motivation and

actual transfer to the workplace" (in Nikandrou et al., 2009: 258). As such, and as indicated in the model above, voluntary participation supports or hinders the transfer of training through the interceding variable of motivation.

Learning goal orientation

Training participants who are interested in developing competence through training are said to have a learning or mastery goal orientation. This is significantly related to transfer in that such trainees "are more likely to take on challenging tasks that will further support learning acquisition" (Chiaburu et al., 2010:189). In this way, learning goal orientation influences the transfer of training indirectly through the filter of training outcomes (post-training knowledge). This factor has also been shown to be linked with pre-training motivation (Chiaburu and Marinova, 2005) and other cognitive processes. Unlike cognitive ability which is an innate characteristic, however, learning goal orientation finds its precursors in situational cues such as organisational support, and is therefore a factor which may be responsive to intervention (Chiaburu et al., 2010).

Training level factors

The work of Blume et al., (2010), Burke and Hutchins (2007) and Grossman and Salas (2011) synthesise strong evidence from the field on the importance of design and delivery factors for the transfer of training. These can be broadly divided into the categories of training content and instructional strategies, and significantly influence training outcomes, and through those, the transfer of training. As explained by Nikandrou et al., (2009), "the planning of the training programme is very important for its total success and therefore for transfer at work. The goals and extent of training, the training methods and means, as well as the training place and equipment, are important factors related to training programme planning" (pp256-257).

Content relevance

The correspondence between a training programme's contents and objectives and trainee perceptions of applicability to job requirements has been empirically shown to correlate with transfer (Axtell et al., 1997; Yamnill and McLean, 2005). Much of the research on content relevance, also called perceived content validity and instrumentality in the literature, has been based on an understanding of two important premises - identical elements theory and

principles theory. The first of these presupposes that transfer may be improved by increasing the degree of similarity "among the training setting stimuli, responses, and conditions and those related factors operative in the performance setting" (Yamnill and McLean, 2001:201). This type of content relevance has been positively associated with a form of transfer called 'near or direct transfer', that is, the application of knowledge and skills developed through training to situations similar to those of the training. Near transfer "would seem to be most desired when pursuing technical training, because technical training usually teaches specific behaviours and procedures applicable to the current job" (Yamnill and McLean, 2001:202).

The second guiding premise related to content relevance is that of principles theory, which suggests that training content should focus on the underlying principles, theories and concepts needed to learn a task (Lim and Johnson, 2002; Yamnill and McLean, 2001). In contrast to the above, principles theory lends little consideration to the similarity of training artefacts and workplace settings, and is instead related to the application of learned knowledge and skills to dissimilar situations in order to solve problems in diverse transfer contexts (Bhatti and Kaur, 2010). This form of transfer, called 'far transfer' is related to more abstract and less technical skills, such as management training or creative problem solving (Yamnill and McLean, 2001).

A link is thus made between training design and the kind of objectives or learning goals of the training. The importance of training objectives and their type as mediators between training transfer factors and transfer is discussed in more detail below. Content relevance has also been shown to relate to motivation to transfer (Chiaburu and Lindsay, 2008) and performance self-efficacy (Bhatti and Kaur, 2010). In addition, it is generally not sufficient for training content to be relevant, but the training participant must also recognise and understand the relationship between training contents and work practice for transfer to occur (Nikandrou et al., 2009).

The concept of instrumentality, which I have included under content relevance in my conceptual model, extends and personalises the link between a training programme's contents and objectives, and a trainee's perceptions of new skills and training objectives. In essence, instrumentality "represents an individual's belief that performing a specific behaviour will lead to a desired outcome" (Chiaburu and Lindsay, 2008: 200). Such a desired outcome may be related to a trainee's job or career progression, their perception of the need for newly acquired skills to assist in the execution of usual work, or the belief that transferring new

knowledge and skills will benefit the individual's organisation or potential clients or beneficiaries. This shows a further important link between training transfer factors and training outcomes- in this case between perceptions of content relevance and post-training reaction. These linkages are depicted through relationship markers between factors and outcomes in the above model.

Training conduct and instructional strategies

In their review of the training transfer literature, Baldwin and Ford (1988) reported a lack of investigation into instructional interventions which could positively influence transfer. Since that time, a growing body of research has examined the link between specific training strategies and training transfer. Despite this, Blume et al., (2010) report finding only small to moderate meta-analytic effect sizes of existing transfer interventions on transfer. The following are those training design strategies shown by this and the two other key reviews (Burke and Hutchins, 2007; Grossman and Salas, 2011) to positively influence the use of trained knowledge and skills.

Behaviour modelling incorporates a number of learning principles and is based on social learning theory (Bandura, 1977). It "includes clearly defined explanations of behaviours to be learned, models displaying the effective use of the behaviours, opportunities for trainees to practice learned skills and the provision of feedback and social reinforcement following practice" (Grossman and Salas, 2011:111).

Error management is a twofold training design strategy related to behaviour modelling. The first approach involves allowing trainees to make mistakes and providing instructions on managing these errors. The second error-based strategy is showing trainees examples of what can go wrong if target knowledge and skills are not used in the workplace (Grossman and Salas, 2011).

Practice and feedback, when integrated into training design, have been shown to improve the long-term use and maintenance of trained skills (Burke and Hutchins, 2007).

Optimistic preview is noted by Blume et al., (2010) as a significant programme framing strategy. Although based on a small number of studies, this pre-training intervention "in which positive statements about the upcoming training are communicated to trainees, had a moderate, positive relationship with transfer" (p1096). In addition, Baldwin and Magjuka (1991) suggest that signals of the training's importance from within the organisation had a positive impact on subsequent transfer intentions.

Goal setting is a contested instructional strategy, understood differently by two of the main inputs into the above model and theoretical framework of this research. Optimistically, Burke and Hutchins (2007) attest that "using goals (both assigned and participative goal setting) to increase training transfer has received much support in the extant literature" (p273). The link between goal setting and transfer is believed to work by enabling trainees to direct action and focus, mobilise energy and effort, and motivate individuals to strategise for goal attainment (Burke and Hutchins, 2007). In contrast to this, Blume et al., (2010) found that goal setting had a relatively small effect on transfer. These authors do, however, suggest that this small effect may be due to the relatively small amount of time provided for such interventions during most training courses.

The included instructional strategies influence transfer in a number of ways. Behaviour modelling, for example, has been shown to be associated with self-efficacy (Burke and Hutchins, 2007), while error management is related to post-training reactions. Integrated practice and feedback are pre-cursors to post-training knowledge, and goal setting has been shown to be related to intention/motivation to transfer.

Organisational level factors

As the crucial test of training effectiveness is whether trainees use their newly developed knowledge and skills on the job, organisational factors- both perceived and experienced- have been shown to have a significant impact on transfer. Organisational level factors "define the stimuli that individuals regularly confront, place constraints on behaviour, and reward or punish behaviour" (Colquitt et al., 2000:680). In fact, Blume et al., (2010) found that "[w]ork environment factors were just as strongly related to transfer as trainee characteristics" (in Saks et al., 2014:82). The inclusion of organisational factors is an opportunity to view training within its context (Burke and Hutchins, 2007; Burke and Hutchins, 2008) and to account for situational variables which may support or impede the transfer of training. These may include the transfer climate, variance of support, levels of follow-up at the completion of training, and opportunities to practice or perform new skills and to apply new knowledge.

Transfer climate

Transfer climate, which encompasses "individual perceptions or group-level-shared interpretations of factors in the organisational environment that can affect successful application of learned skills on the job" (Hutchins et al., 2013:251) has been established as an

important composite consideration for effective training programmes. Based on social learning theory, Rouiller and Goldstein (1993) suggested that the *transfer climate* consists of two general categories of workplace cues: *situation cues* which prompt trainees to use new skills and may include set goals, the behaviour or influence of supervisors, peers or subordinates, resourcing and relevant equipment, and permissions to act; and *consequence cues*, or feedback trainees receive after applying new skills, knowledge and attitudes at work (Yamnill and McLean, 2001). This feedback may be categorised as positive, negative, non-existent or punitive (Grossman and Salas, 2011), and should be viewed by supervisors as an opportunity to enhance learning and maintenance (Salas and Stagl, 2009).

An important component of workplace cues has been described by Grossman and Salas as post-training follow-up, whereby organisational structures ensure that the "completion of formal training does not mark the end of the learning experience" (p114). This follow-up may take the form of after-action reviews, trainee reflective practices, and the implementation, design or provision of job aids or tools including informational aids, procedural aids, and decision making aids designed to "assist with job performance and further facilitate the transfer of training" (Grossman and Salas, 2011:114).

Training transfer literature commonly includes any opportunity or encouragement to use newly developed knowledge and skills on return to work as a part of the transfer climate. Through their integrative literature review, Burke and Hutchins (2007) found a consistent pattern of research to show that "positive transfer is limited when trainees are not provided with opportunities to use new learning in their work setting" (p282). As one example, Clarke (2002) found limited chance to perform trained skills to be the strongest impediment to transfer. These opportunities must be explicit and should occur soon after formal training has ended to maximise transfer (Salas et al., 2006 in Grossman and Salas, 2011). In addition, studies have shown that the provision of opportunities to perform are perceived by trainees as a mark of support in themselves (Grossman and Salas, 2011). In sum, trainees need to be afforded the time, as well as the resources and encouragement to apply their newly developed knowledge and skills within the work context if transfer is to be optimised.

A number of studies have supported the conceptual framework of Roullier and Goldstein (1993) (for example, Lim and Morris, 2006; Kontoghiorghes, 2001; Tracey et al., 1995; Holton et al., 2000), finding that these transfer climate factors directly influence the transfer of

training, or more indirectly "as a moderator between individual or organisational factors and transfer (Burke and Baldwin, 1999), and as a correlate to transfer implementation intentions (Machin and Fogarty, 2004)" (Burke and Hutchins, 2007: 280) and motivation to transfer learning to work contexts (Holton et al., 2000). In fact, Blume et al. (2010) found that transfer climate had the highest relationship with transfer amongst a broader set of work environment factors which included support and organisational constraints.

Taken together, these cues form ""a sense of imperative"..that arises from a person's perception of his or her work environment" (Schneider and Rentsch in Yamnill and McLean, 2001:203). Noteworthy in this understanding of the transfer climate is the significance of a positive work environment for transfer, the role of individual perceptions of the elements which make up the organisational environment, and the consequences of these perceptions for motivation, intention and eventual transfer.

Organisational support

Since Rouiller and Goldstein (1993), the concept of transfer climate has been further developed to encompass organisational support. In fact, training transfer research has consistently found that support from both supervisors and peers is one aspect of the organisational environment most consistently related to transfer. This factor is clearly linked to transfer climate, particularly the consequence cues outlined by Rouiller and Goldstein (1993). It is included separately here, however, given that it has been found to exert a unique influence on transfer in a number of studies (Burke and Hutchins, 2007).

Supervisor support may be provided at multiple stages throughout the training process- before, during and after- and has been shown to relate to training transfer in both empirical and qualitative studies (Grossman and Salas, 2011; Burke and Hutchins, 2007). Positive trainee perceptions of managerial support have been correlated with increased transfer of knowledge and skills (Burke and Hutchins, 2007), while trainees cited a lack of supervisor support "as a significant barrier to the transfer of training" (Grossman and Salas, 2011:113). Supportive behaviours by supervisors may include collaborative goal setting both pre and post-training, managerial involvement in training, positive feedback, information sharing and encouragement to apply new skills (Lim and Johnson, 2002; Burke and Hutchins, 2007;

Grossman and Salas, 2011). Together with transfer climate, supervisor support was found by Blume et al.'s (2010) meta-analysis to be one of the strongest work level predictors of transfer.

Peer support is also recognised as a reliable influence on the transfer of training. Such supportive relationships may be characterised by networking, coaching, sharing ideas from the training course and/or observing colleagues use newly trained skills (Grossman and Salas, 2011).

Both forms of support have been found to directly influence the use of training at work and to also work through motivation and intention constructs to affect the transfer of training. Blume et al. (2010) reported a stronger relationship between supervisor support and transfer than peer support and transfer (p1092), and while warning that this particular correlation is based on small sample sizes, the breadth of literature on support factors mean that "[o]rganisations should have little doubt that support, both from supervisors and peers, does matter" (Grossman and Salas, 2011:114).

Importantly, together with training design, organisational level factors provide a crucial point for the implementation of interventions to maximise transfer. Blume et al. (2010) explain that politics and logistics often influence the selection of participants and therefore the ability to account for individual level transfer factors, but "situational variables…can potentially be actively managed…Therefore, the finding in support of positive transfer climates is encouraging in that it supports a proactive approach to leveraging transfer" (p1092).

Training objectives: A filter between training transfer factors and training transfer

Moving to the right of the conceptual model adapted from training transfer literature (Figure 5), I have included training objectives as a 'filter'. This is intended to denote a point at which the influence of the preceding training transfer factors may be refracted as the trainee moves to transfer or to not transfer their training. This filter stands alone as an additional moderator of the proven transfer factors to its left, and is in addition to the multiple interactions noted between and within the individual, training design and organisational levels. This filter has been shown by the literature to alter the influence of the training transfer factors on transfer, and will be further explained below.

Training objectives or learning goals have a number of moderating affects in the training transfer factor- to- transfer relationship. The type of training objective- whether the goal of training is to acquire 'closed' or 'open' skills- is an understudied but vital consideration in the transfer process (Blume, et al., 2010). Training objectives linked to "learning specific skills that are to be produced identically in the transfer environment as in the learning context are labelled closed skills, whereas training objectives tied to learning principles are labelled open skills" (Blume et al., 2010:1072). This difference has important consequences for the transfer of training. A training objective linked to an open skill, for example, may demand a more supportive transfer climate and higher levels of motivation and intention for transfer to occur than is necessary for the application of closed skills. Open skills are also more difficult to train, require higher cognitive abilities, depend fundamentally on trainee perceptions of opportunities to apply and decisions to apply, and may decay more rapidly than closed skills. In this way, the influence of certain training transfer factors (such as transfer climate and supervisor support) may be heightened and, if these are negatively perceived, result in refraction away from desired transfer outcomes due to the type of skill being trained. The impact of these same situational variables on the use of closed skills may be far less, given their prescribed nature (Blume et al., 2010). A link between content relevance, the type of skills being trained, appropriate instructional strategies and eventual near or far transfer is outlined above under the training level transfer factor of content relevance.

The particulars of training course objectives may also mediate the relationship between the training transfer moderating factors outlined in the model and the eventual transfer of training. For example, the three training objectives outlined for the SPRINT Initiative- advocacy, in-country trainings and coordination of action for MISP preparedness and response- are diverse and require different workplace cues, support on a number of different fronts, and opportunities to perform diverse tasks once back at work. Perceptions of how relevant all content areas of a training course which covers these three dissimilar objectives are to job requirements or role descriptions, and the instructional strategies required to support each training objective may differ. Finally, each objective may interact with individual level characteristics in unique ways. As an example, a trainee bringing experience in adult education practice may have high self-efficacy in reference to the in-country training objective, but this same participant may have little or no experience in coordinating SRH services within humanitarian settings and as such, feel less confident about their ability to perform skills associated with MISP preparedness and implementation.

It is reasonable to assume then, that training objectives act as an important filter which can intensify or diminish the effect of training transfer moderating factors and refract the direction of trainee action either toward or away from eventual transfer.

Proximal training outcomes: Post-training self-efficacy, knowledge and reaction

Much training transfer research has been dedicated to examining the link between training outcomes and the eventual transfer of trained knowledge, skills and attitudes. The following three concepts are supported by the literature as important training outcome variables. I have labelled these *proximal training outcomes* as they are evident and identifiable immediately post-training. These proximal training outcomes are influenced by the preceding training transfer factors and by relationship with each other, and in turn determine action towards the transfer of training.

Post-training self-efficacy

As detailed previously, self-efficacy is a judgement made by individuals about their ability to perform particular roles (Bandura, 1982). In relation to the transfer of training, the "higher the trainees' self-efficacy, the more confidence they will have in their ability to successfully acquire targeted skills and perform trained tasks" (Grossman and Salas, 2011:109). The first aspect of this construct- a trainee's confidence in acquiring new skills- is included as an individual level training transfer moderating factor under the label self-efficacy (see above). The second component- a trainee's confidence in their ability to perform "as prescribed by the training programme" (Zhao and Namasivayam, 2009: 141)- is included here as a result of undertaking training, and as such, as one proximal training outcome which may intercede between training transfer factors and transfer. Zhao and Namasivayam (2009) explain that attending a training programme can increase or reduce a participant's self-efficacy, noting that "this is important …because the nature of the training programme (content and learning difficulty) influences the individual's level of self-efficacy, with consequences for training transfer" (p141). Blume et al. (2010) found that post-training self-efficacy had small to moderate mean corrected correlations with transfer, and in their meta-analysis of training motivation literature, Colquitt et al. (2000) found that evidence "continues to underscore the importance of self-efficacy…in models of motivation and performance" (p699). These authors went on to suggest that

trainers incorporate strategies to persuade participants that they are capable of succeeding in order to optimise post-training self-efficacy. This construct has also been related to individual characteristics, including pre-training self-efficacy (Machin and Fogarty, 2003), and the transfer climate, supporting the position of post-training self-efficacy as a mediator which, though malleable, can redirect the impact of training transfer factors on intention to transfer and transfer (Al-Eisa et al., 2009). As explained by Grossman and Salas (2011), taking into account the individual characteristics and organisational factors included in the conceptual model above, and incorporating self-efficacy building strategies into the training content and design, "trainees must believe in their ability to perform certain skills before they can be transferred to the workplace" (p109).

Post-training knowledge

Learning and retention are included in Baldwin and Ford's influential model (included as Figure 4, above) in the understanding that in order for transfer of trained knowledge and skills to occur, participants must learn and must retain this new capacity. Training has been shown to be beneficial in increasing declarative knowledge (knowledge about 'what'), procedural knowledge (knowledge about 'how'), and strategic knowledge (knowledge about 'when' to apply specific learning or skills), as well as having performance consistency and behavioural outcomes (Aguinis and Kraiger, 2009). Declarative knowledge and skill acquisition are reported by Colquitt et al. (2000) as the two most commonly examined outcomes in training research, a statement supported by the general preponderance of and reliance on pre- and post-testing for the evaluation of training courses.

As discussed earlier, however, increases in knowledge and skills that result from undertaking training are not guarantees of use, and in their meta-analysis, Blume et al. (2010) found that post-training knowledge had a small to moderate relationship with transfer. This correlation was significant enough, however, for these authors to state that "[l]earning outcomes are also related to transfer, suggesting that to the extent that the training program can increase posttraining knowledge and self-efficacy, the more likely trainees will be to transfer training" (p1096).

As outlined in the preceding sections on individual, training design and organisational level factors, the extent of learning is directly predicted by many training transfer factors (Machin

and Fogarty, 2003), including motivation to learn, pre-training self-efficacy, learning goal orientation, and instructional strategies. In turn, the degree of post-training knowledge acquisition contributes to intention to transfer and eventual transfer (Colquitt et al., 2000).

Post-training reaction

Reaction to the training has been included as a proximal outcome of the training programme as it is a long established variable that has been found to intercede between training transfer factors and training transfer (Cheng and Hampson, 2008). Reactions to training content and delivery are usually categorised as either utility or affective reactions. The first of these is closely aligned with content relevance and can be defined as "the extent trainees felt like training was useful to helping them perform on the job" (Burke and Hutchins, 2007:270); while the second encompasses a trainee's emotional reaction to the training course.

The inclusion of these reaction measures in training transfer research and conceptual work is based on Kirkpatrick's (1976) influential model of training evaluation, which proposed that reaction (what participants think and feel about a training, such as satisfaction), learning (changes in knowledge, skills or attitudes), behaviour (the use of new knowledge, skills and/or attitudes at work), and results (for the organisation, based on individual performance) are linked in a causal manner (Colquitt et al., 2000). Many authors have since criticised this model (Ruona et al., 2002), particularly in relation to its assumptions regarding the linkages between the four included factors, but despite this, the reaction measures suggested by Kirkpatrick "remain one of the most over-used methods of evaluation in the field of human resource development" (Bhatti and Kaur, 2010:664).

While it is valid to remark on the over-dependence of many training course evaluators on 'smile sheets' or satisfaction surveys given the array of proven training transfer moderating factors included in the above model (Figure 5), Blume et al. (2010) found that "[p]osttraining utility reactions had a small to moderate correlation with transfer [and] both affective reactions and overall reactions (which included both affective and utility dimensions) had small correlations" (p1092).

Utility reactions are generally held to be influenced by perceptions of content relevance and situational constructs, as when training participants perceive that "the content of the training

is similar to the actual job, the reaction of the trainee (utility reaction) would be positive" (Bhatti and Kaur, 2010:664). A positive affective reaction to training has been shown to enhance learning, and through this, training transfer (Bhatti and Kaur, 2010). This intermediary position of trainee reaction between training transfer factors and training transfer warrants its inclusion as a proximal training outcome, as reaction to a training programme may cause action toward training transfer to intensify, dissipate or redirect. As explained by, Gegenfurtner et al. (2009), "[a]fter training, trainees' affective, content and utility reactions toward the program play a role in determining if and how participants are motivated to transfer learning to the workplace" (p412).

This review of current literature on training transfer also revealed the suggestion of a third trainee reaction factor, labelled by Cheng and Hampson (2008) as attitude toward the transfer behaviour. These authors cite a number of studies which show that attitude is related to behaviour and that this relationship is more powerfully predictive when the two variables are measured at corresponding specificity. As such, and as our interest here is in the behaviour of training transfer, "attitude towards the transfer behaviour will be more relevant to explaining that transfer behaviour" (Cheng and Hampson, 2008:336) than other attitudinal constructs. The value of including this third reaction factor will become evident in the section to follow, which details the role of intention to transfer training and further explores the powerful influence of attitudes on behaviour.

Training outcome: motivation and intention

Intention to transfer has been described as a "trainee's end-of-course motivation to use aspects of training in their work setting. A participant's intention essentially represents the proximal determinant that influences a trainee's decision to initiate transfer of what he or she has learned in training on the job" (Foxon, 1993 in Al-Eisa et al., 2009: 1224). As explained by Machin and Fogarty (2003) in their important work on transfer implementation intentions, a trainee will develop an intention to transfer as a precursor to initiating transfer actions. Training transfer intention thus has a clear link with transfer and has been reported as the most crucial stage in the transfer process (Al-Eisa et al., 2009).

As with the three proximal training outcomes of post-training self-efficacy, post-training knowledge and post-training reaction represented in the conceptual model above (Figure 5), it

is important to appreciate how the antecedents of intention function, in order to understand how a positive intention outcome can be achieved.

A variable which is often closely related to intention is described throughout the literature as motivation to transfer. This training outcome is often regarded as a unique variable, separate and distinct from training transfer intentions. In fact, training transfer intention is a relatively recent concept to the field, not as widely considered in the literature as motivation to transfer and the two terms therefore warrant some explanation and differentiation. Motivation to transfer may be understood as the *desire* of a training participant to use the knowledge and skills developed in training on return to work. Intention to transfer, on the other hand, can be regarded as an umbrella term with captures both the motivational processes associated with training transfer and an endpoint indication of how much effort a trainee is willing to exert (Al-Eisa et al., 2009), or "an individual's willingness and purposeful aim to perform a desired behaviour" (Hutchins, et al., 2013:253). The difference between transfer motivation and transfer intention is summarised by Al-Eisa et al. (2009) in their statement that "transfer intention relates more to a trainee's tendency to initiate transfer than to the motivation or desire to apply newly acquired knowledge or skills. Whereas motivation to transfer refers to a desire to initiate transfer, transfer intention refers to a commitment to initiate transfer" (p1224-1225). Hutchins et al. (2013) further explain "the relationship between motivation to transfer and intent to transfer as a continuum, whereby motivation to transfer is a starting point of the motivational process that *may* develop into a commitment to transfer the knowledge and skills acquired in training" (p254).

This understanding of the role intention plays in predicting behaviour is derived from the Theory of Planned Behaviour (TPB), a robust social psychological theory which works to uncover the links between the antecedents of intention, intention, and behaviour (Cheng and Hampson, 2008). Posited by Ajzen (1991), TPB hypothesizes three precursors to intention:

1. Attitudes, which are defined as "an individual's positive or negative evaluation of a relevant behaviour and are expressed in terms of the perceived outcomes of performing the behaviour" (Al-Eisa et al., 2009:1228);
2. Subjective norms, which refer to "an individual's perception of whether significant others support or discourage his or her performing a given behaviour" (Al-Eisa et al., 2009:1228-1229); and

3. Perceived behavioural control which describes “an individual’s evaluation of the difficulty or ease associated with performing the target behaviour” (Al-Eisa et al., 2009:1229).

In relation to the transfer of training then, attitudes include those toward the transfer behaviour (as discussed in relation to Cheng and Hampson’s 2008 work, above), subjective norms refer to influential others within the work environment (such as supervisors, peers and managers), and behavioural control relates to a trainee’s confidence in their ability to transfer, and is, as such, considered identical to self-efficacy (Al-Eisa et al., 2009). The correspondence between this theory and training transfer literature is clear and because of this, there are increasing calls to integrate TPB into training transfer research (see, for example, Hutchins et al., 2013; Cheng and Hampson, 2008; Al-Eisa et al., 2009; Gegenfurtner, 2013). The relevance of TPB to understanding training transfer and evidence from many empirical studies based on Ajzen’s theory (Gollwitzer, 1999) which shows that intentions are reliable predictors of behaviour (Gegenfurtner et al., 2009), has led to the use of the umbrella term ‘intention’ rather than the single factor of ‘motivation to transfer’ in this research.

An associate of intention may be understood as the ‘decision role’ of trainees (Cheng and Hampson, 2008). This refers to considered agency which directs action or inaction, as “when trainees have their right to choose what to transfer…personal intentions become significant” (Cheng and Hampson, 2008:335). In their studies of autonomous professionals, or workers “who decide how they will operate in some or all of their tasks” (Yelon et al., 2013:44), Yelon et al. (2004) found that in the absence of strict supervisory, accountability and reporting structures, “intention to transfer is a vital part of the application process” (p83). Accordingly, in order to optimise transfer, “performance technologists must know what decisions they make that lead them to use an idea voluntarily that they learned in training” (Yelon et al., 2004:83). These authors found that in order for their training participants to form an intention to use knowledge or skills developed in training, they had to perceive an idea as credible or convincing (based on prior workplace experience), practical, and necessary for solving a problem or achieving a goal (Yelon et al., 2004:91).

The bulk of evidence which lies under the intention banner is, however, derived from research into motivation to transfer. The extensive field of empirical and theoretical research into motivation is relevant to this work as, since motivation to transfer is captured by intention to transfer in TPB, it has been induced “that the findings of prior studies related to training

transfer and motivation to transfer can be generalised to transfer intention" (Al-Eisa et al., 2009:1236). Aspects of the motivational process, including pre-training motivation and links between some training transfer factors (including voluntary participation, content relevance, training conduct and instructional strategies, motivation to learn and support) and motivation to transfer are addressed to some degree in the preceding paragraphs on individual, training design and organisational level variables.

Motivation to transfer, or the lack thereof, has been established as a primary factor supporting or inhibiting the transfer of training. Chiaburu and Lindsay (2008) report that "[b]oth conceptual and meta-analytic work position motivation as central in the relationship between training antecedents and outcomes" (p201). In conceptual work, Gegenfurtner et al. (2009) chose to include motivation to transfer as the only factor to mediate the influence of other antecedent factors on training transfer, though they did admit that this "is a provocative hypothesis that clearly needs empirical testing" (p418). In doing so they have, however, highlighted the pivotal position of motivation to transfer, and thus its umbrella concept intention to transfer, through the following hypothetical:

> [T]rainees may find opportunities to use training on the job, but if they are not motivated to transfer, they will not apply the training at work... On the other hand, trainees may find no opportunities in the beginning, but if they are motivated to transfer, their motivation may result in their actively seeking situations or even in changing the work environment, to use their training on the job. Opportunities to perform are a necessary but not a sufficient factor for successfully applying training at work: it is mediated by trainees' transfer motivation (p418).

When intention to transfer is defined as "end-of-course" motivation, and research shows that a decision regarding the extent to which trainees will apply training to their work will have been made by the end of the training programme (Hutchins et al., 2013), a number of important consequences follow. First, it becomes vital for those interested in maximising the transfer of training to identify and understand the role of those training transfer factors which influence the formation of this intention- that is, *training transfer factors* which exert their influence before and during the training. These will include individual level factors and aspects of the training content and design, but will also incorporate each individual's *perceptions* of what may enable or hinder their efforts to transfer the training when they return to work.

Importantly, these perceptions may be based on a trainee's *memories* of their job tasks, and organisational environment (Yelon et al., 2004), as the type of training under consideration for this research removes participants from their work context for the duration of the course. Yelon et al. (2004) explain the importance of these perceptions in their finding that "self-governing workers are influenced by a combination of memories of personal experiences and perceptions of training variables…[A]utonomous workers think through memories of their jobs, tasks, self-evaluations and values during training…[and] actively seek ideas by juxtaposing their memories with what they see, hear, feel and do during training" (pp98-99). As such, perceptions become important for formulating intention and intention becomes important for the initiation of transfer. In support of this, Gegenfurtner et al. (2009) found that work characteristics do not directly influence motivation and intention to transfer training, but rather, a trainee's perception of their work environment is what is critical. Further, Klein et al. (2006) argue that:

> Objective performance constraints (e.g., lack of time…) impact performance directly by preventing the effort that results from motivation from translating into performance. Perceived barriers and enablers affect performance indirectly by impacting motivation itself…Learners are less likely to strive for an outcome when they perceive that their efforts will be impeded and are more likely to do so when they perceive that their efforts will be aided (p671).

In itself, the effect of these perceptions on the formation of intentions is important for optimising transfer as interventions to enhance positive perceptions may be devised and implemented. The second important consequence of understanding the role of intention as a reliable predictor of transfer action (Burke and Hutchins, 2007) is the possibility of employing an assessment of participant intention as part of monitoring and evaluation activities. Hutchins et al. (2013) note the difficulty in collecting evaluation data at intervals post-training, and suggest, given the strong predictive force of intent to transfer, that "[o]ne way to address the proximal challenge of not having a posttraining measure of transfer is to include a proxy outcome score to capture the trainees' *intent* to transfer knowledge and skills learned in training to the workplace" (p253). Al-Eisa et al. (2009) also suggest the utility of assessing intention as part of the transfer process, given its "anticipated capacity to determine the level of transfer that could be achieved" (p1222). This may provide an addition to the traditional, and seemingly inadequate, course satisfaction and knowledge measures conventionally recorded at the close of the training course.

The inclusion of intention to transfer and the associated variable of motivation to transfer as an outcome construct that may lead to training transfer is supported by strong theoretical and empirical underpinnings. The conceptual model presented above (see Figure 5) indicates that not all training transfer factors will operate through this mediator to reach transfer all of the time, an interpretation of the literature supported by authors such as Grohman et al. (2014) in their finding that motivation to transfer was a linking mechanism between the studied training characteristics and transfer, but that in half of their analyses, training characteristics had significant direct effects on transfer outcomes.

Ultimate training outcome: Transfer of training

The ultimate training outcome considered by this research is *training transfer*, or whether a training participant has taken steps to apply any knowledge or skills developed during the training when they return to work. The definition and limits of training transfer I have applied to this research align with research into *transfer initiation* or *training use* (Foxon, 1997; Al-Eisa, 2009). That is, I have understood the realisation of training transfer as a 'point of action'- a step toward meeting the training objectives set forth by the SPRINT Initiative. In defining transfer in terms of *use*, I am recognising that the transfer of training is a process of application, of which transfer initiation is an important step, and not a product of training which can be neatly quantified. In her description of the transfer process, Foxon (1997), for example, proposed a model of five stages of transfer, where each step is presented as a precursor to the next. These five stages: transfer intention, transfer initiation, partial transfer, transfer maintenance, and transfer failure treat the transfer of training as a multidimensional construct. This approach has been confirmed and expanded by subsequent research (see, for example Al-Eisa et al., 2009). My research is concerned with the first two of these stages- transfer intention and transfer initiation. The final three stages have less to do with *training use* and more to do with *training effectiveness,* and while important to understand, an assessment of training effectiveness could include evaluations of transfer maintenance, transfer generalisation, return on investment, and organisational performance improvement (Blume et al., 2010). Training effectiveness is, as such, outside the scope of this research. My research focus on the factors which precede the *use* of training provides insight into the first and most crucial steps in this transfer process. The identification of factors which influence both *intention to transfer* and *transfer initiation* allow training and performance professionals

to account for and plan interventions to support enablers and ameliorate the impact of barriers to transfer. As explained by Holton et al. (2000) in their development of a tool for diagnosing systems-wide training transfer factors:

> Organisations wishing to enhance the return on investment from learning-training investments must understand all the factors that affect transfer of learning, and then intervene to improve factors inhibiting transfer. The first step in improving transfer is an accurate diagnosis of those factors that are inhibiting it (p334).

The remainder of this study will follow this logic and seek to categorise and understand the system of factors which intervene between training and transfer for the field of sexual and reproductive health in humanitarian settings.

Summary of Chapter 2

Transfer is crucial to training programme effectiveness. It is necessary to take a systems-wide view and identify all potential training transfer factors so that they may be addressed during the design, delivery and follow-up phases of training programmes in order to ensure that learning is applied to practice. The following chapter will move from a general understanding of the antecedents of training use to investigate what is known about the training transfer process in the field of SRH in humanitarian settings.

Chapter 3

A review of the literature: Factors known to influence the transfer of training for SRH in humanitarian settings

Introduction

In order to better understand what is known about the specific factors which may be at play for the transfer of training on sexual and reproductive health training for humanitarian settings, I undertook an analysis of peer reviewed literature to synthesise current evidence concerning the transfer of training for SRH in humanitarian settings for in-country health workers working in lower middle income countries (LMIC). Evidence based practice is vital considering the large financial investment and political commitment that has been made to building health workers' capacity in humanitarian settings, the importance of in-country health workers as the first and often best placed responders, and the urgent need to continue to scale up training so that life-saving SRH services are accessible to people in disaster contexts. There remains an important knowledge gap between reports of training activities undertaken in this field and evidence of outcomes, in particular evidence that provides an understanding of why trainees do and do not, or can and cannot make use of training on their return to work. Such insights are critical to the design of training and the development of supportive environments. As the first step to improving transfer involves identifying those factors which work for or against the application of knowledge and skills in practice (Holton et al., 2000), the purpose of this chapter is to review the available evidence in the literature concerning which factors influence the transfer of training on SRH in humanitarian settings. The review contained in this chapter sought to answer the question: What factors support or constrain in-country health workers to apply skills and knowledge gained in training courses to improve sexual and reproductive health in humanitarian settings?

Search protocol

I undertook an initial scoping exercise which first identified databases and websites where literature on SRH in humanitarian settings could be retrieved, and second, assisted with the

selection of potential keywords. I searched four electronic databases (PubMed, Scopus, ProQuest Health and Medical Complete and Medline), websites of 10 relevant organisations (IAWG, Reproductive Health Response in Crisis Consortium, Women's Refugee Commission, RAISE Initiative, Marie Stopes International, JSI Research and Training Institute, Jhpiego, United Nations Population Fund, World Health Organisation, and International Federation of Red Cross and Red Crescent Societies), and reference lists of key documents to retrieve relevant citations. In this search, the following terms were employed: 'training' and 'reproductive' and/or 'sexual' (health) and 'humanitarian'; 'capacity' and 'building' and 'reproductive' and/or 'sexual' (health) and 'humanitarian'; 'capacity' and 'reproductive' and/or 'sexual' (health) and 'humanitarian'; 'training' and 'health' and humanitarian'; and 'capacity' and 'health' and 'humanitarian'. Electronic searches were limited to only those in the English language and those falling within the timeframe of January 2004-December 2014.

Study selection and quality appraisal

A Population, Interventions, Comparators, Outcomes, Study design (PICOS) question was formulated to guide this review. As per guidelines, a PICOS question may be used to identify specific evidence to inform clinical or health service practice (CRD, 2008). The PICOS question for this study was: For health workers from LMIC, what factors support or constrain the application of learning gained from training on SRH in humanitarian settings?

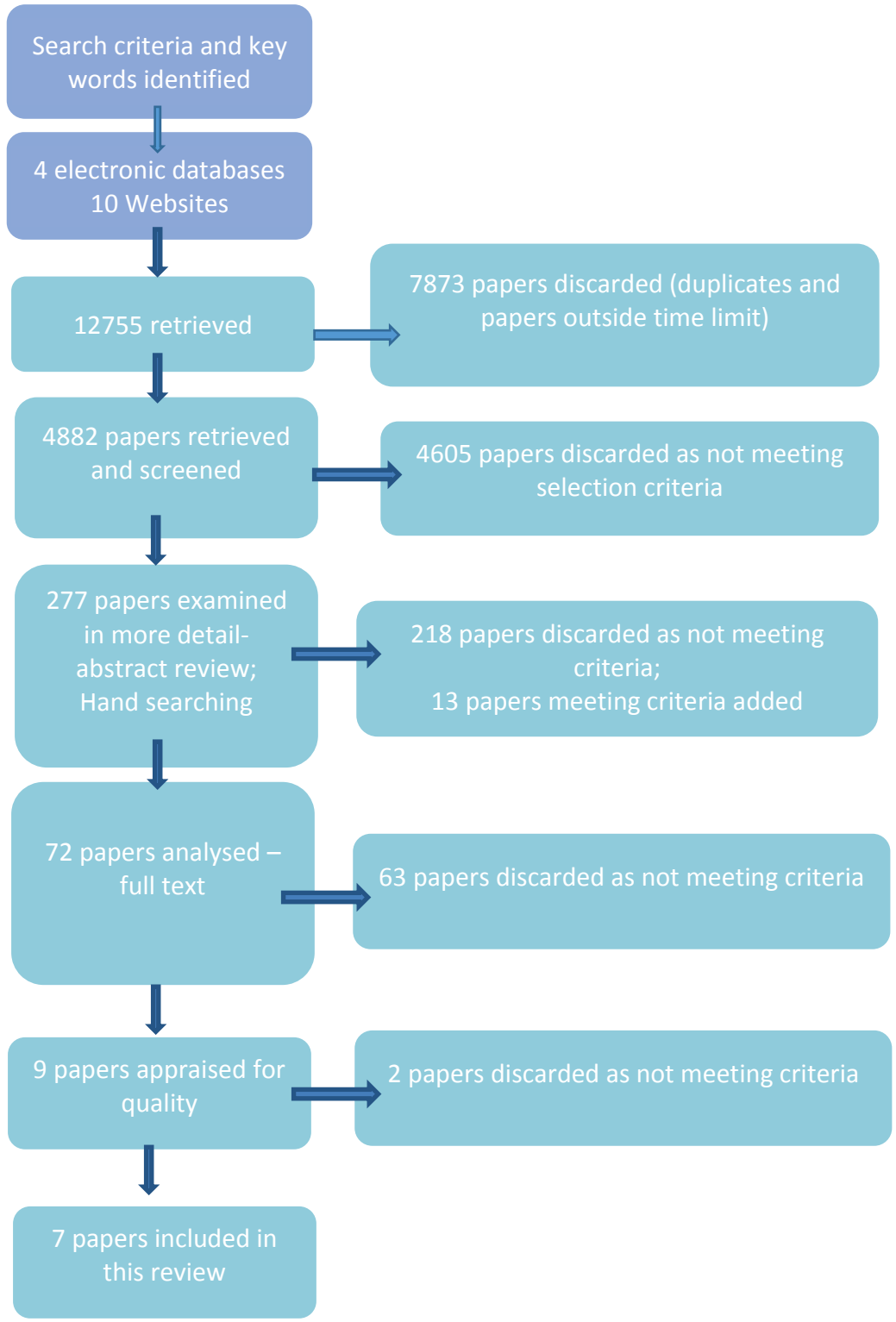
In defining the terms of the PICOS question, this paper limits SRH activities, services and resources to those outlined in the Inter-agency Field Manual on Reproductive Health in Humanitarian Settings (IAWG, 2010). This includes both the MISP and those components of comprehensive SRH which are to be built upon the MISP as the situation allows. The term humanitarian setting is used to pertain to any hazard: natural, armed conflict, complex emergencies, political repression, epidemics, or technological (UNISDR, 2009), and resulting crisis of any type or scale in any LMIC context. A diversity of research evidence was sought for this study and therefore papers using qualitative, quantitative and mixed methodological approaches were deemed suitable for inclusion.
The inclusion/exclusion criteria used to select papers in this review is presented at Table 1.

Table 1. Inclusion/ Exclusion Criteria for Literature Review 2

Included	Excluded
In English	In languages other than English
2004-2015	Pre 2004
Papers pertaining to training on any component of sexual and/or reproductive health outlined in the IAFM (2010), clinical and/or non-clinical	Training on general health
Description of the training program and a discussion of factors which facilitated or impeded the transfer of training into practice	Training and transfer process not described, training recommended not conducted
Papers addressing any point in the continuum of an emergency- from mitigation and preparedness, through response in the acute phase, post-emergency and protracted disaster response, to building more durable solutions	Development settings
LMIC contexts	HIC contexts
In-service or continuing professional development training courses, workshops, exercises/ simulations, continuing medical education, multi-media training	Pre-service training, pre-deployment training for expatriate health personnel, self-directed learning, use of guidelines independent of training
In-country health workers	Expatriate/ internationally deployed health workers
Established in-country health or health management workers (any cadre) with some prior health training (not restricted to SRH or disaster health) and experience	Newly trained health workers (any cadre)

In accordance with the above selection criteria, the literature review process followed the guidelines outlined in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Moher et al., 2009) (see Figure 6, below).

Figure 6: Literature Review Process:



The literature search identified 12755 potentially relevant documents. Of these, 7873 were discarded as duplicates, or outside the 2004-2014 timeframe. The remaining 4882 papers were screened, and 4605 excluded as they did not meet selection criteria. Of the remaining 227 citations, 218 were excluded by abstract review. The reference lists of these 227 papers were reviewed and 13 potentially relevant papers added. An analysis of the full-text of the papers was conducted on 72 citations, of which 63 were excluded as they did not help to answer the PICOS question or failed to meet the inclusion criteria in another way. Nine papers were found to be relevant in understanding factors which affect the ability of in-country workers to apply their SRH training in humanitarian settings. These nine papers were then appraised for quality using the Critical Appraisal Skills Programme (CASP) assessment tool (NHS, 2006) and Pluye et al.'s (2009) scoring system for appraising mixed methods research. After discarding two papers that did not meet quality appraisal criteria, 7 documents remained and are included in this review.

Data abstraction and synthesis

I then applied a content analysis methodology to the remaining papers in order to categorise and count themes in a systematic and replicable manner (Dixon-Woods et al., 2005). This was guided by, but not limited to, a thematic grouping of factors affecting the transfer of training derived from the literature on the topic (as outlined in Chapter 2). Analysis of the findings sections of papers under review involved the identification of factors known to impact the transfer of knowledge, skills and attitudes learned in training courses into practice. However evidence of further moderating factors not discussed in the training transfer literature were also sought.

Findings

Seven papers which met the above selection criteria were included in this review. The characteristics of documents under review are outlined in Table 2 (below).

Table 2: Characteristics of Documents included in Literature Review 2

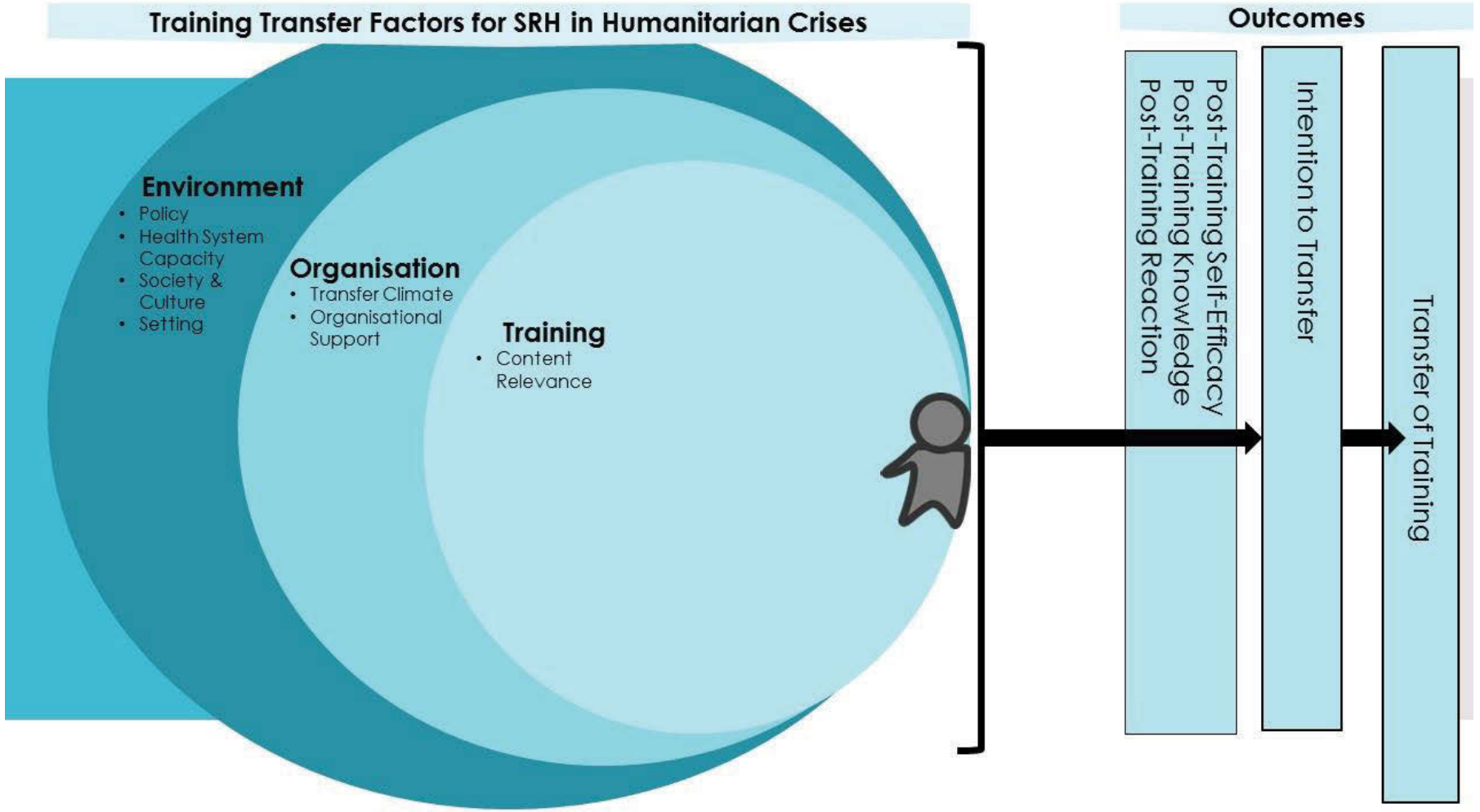
Reference	Method	SRH Area	Training Participants	Disaster Type	Research Aim
Homan FF., et al. (2010).	Quantitative	MNH	Clinicians	Conflict	To present results of a project to establish primary healthcare-based antenatal care in post-conflict Kosovo.
Nelson BD., et al. (2012).	Mixed Methods	Maternal, newborn and child health	Frontline Health Workers (FHWs) (mixed group, partially meeting review inclusion criteria)	Conflict	To develop, implement and evaluate a novel training package on maternal, newborn and child survival for frontline health workers in South Sudan.
Olness, K., et al. (2005).	Mixed Methods	Broad components including MNH & S/GBV	Physicians and health care professionals	All	To review experiences in designing and implementing a training course for international health care professionals in disaster management focussed on the needs of children.
Smith, J. R., et al. (2013).	Mixed Methods	SV	Healthcare Providers (HCPs)	Diverse	To evaluate the effect of clinical care for sexual assault survivors multimedia training on healthcare providers' attitudes, knowledge, confidence and practices in 4 countries.
Sullivan, T. M., et al. (2004).	Mixed Methods	MNH, post-abortion care, infection prevention.	Clinicians	Conflict	To present results and lessons learned on a project to use evidence to improve reproductive health quality along the Thailand-Burma border.
Tanabe, M., et al. (2013).	Qualitative	SV	Community Health Workers (CHWs) (included in this review); Traditional Birth	Conflict	To examine the safety and feasibility of community-based care for sexual assault survivors to contribute to

			Attendants (not included in this review).		building evidence on alternative models of care in humanitarian contexts.
Teela, K. C., et al. (2009). **68**(7): 1332-1340.	Qualitative	MNH	Maternal Health Workers (MHWs)	Conflict	To provide perspectives of maternal health workers on community-based delivery of maternal care in conflict-affected eastern Burma.

Training transfer factors: Why training on SRH in humanitarian settings is or is not transferred to work settings

A range of transfer moderating factors that are well described in the training transfer literature, such as content relevance, transfer climate, and support were identified in the included papers, although no factors pertaining to individual trainees were presented. In addition, factors relating to the broader socio-cultural, health system, and political environment were found. As a result, I have expanded the conceptual model of training transfer factors which was presented in Chapter 2 (Figure 5) by adding a further 'environmental' level. What is presented below (in Figure 7) is an alternative version of my conceptual model of training transfer, inclusive of only those factors which emerged from my analysis of the existing literature on training for SRH in humanitarian settings. The factors included in this model were found, in the limited literature which met my selection criteria, to influence the ability of health workers to transfer knowledge and skills in the unique context of SRH in humanitarian crises. They will be further explored in the section to follow.

Figure 7: Factors Moderating the Transfer of Training on SRH in Humanitarian Settings (from Literature Review 2)



Training level factors

Content relevance

Three studies included in this review discuss the importance of providing training which is relevant and responsive to trainee and community needs (Teela et al., 2009; Nelson et al., 2012; Tanabe et al., 2013). Teela et al. (2009) found that continuous discussion with maternal health workers at follow-up helped to identify important gaps in the initial training and areas which required follow-up training, and allowed project implementers to develop subsequent workshops. As an example, during focus group discussions with project implementers, maternal health workers expressed the need to expand access to a particular drug (misoprostol). This resulted in the development of a specific training module and wider distribution of this important drug.

Work by Nelson et al. (2012) shows the importance of providing training content and materials pitched at the correct level for trainees. In their study into the training of frontline maternal, newborn and child health workers in South Sudan, the authors expressed the importance of providing wholly pictorial materials to their frequently non-literate trainee audience, claiming that this strategy was amongst factors responsible for the success of the programme.

The process evaluation described in the study by Tanabe et al. (2013) reported that the training community health workers received on community-based care for survivors of sexual assault did not directly address intimate partner violence- the most common form of gender-based violence in this setting. This brought into question the completeness of training content to trainees working in this area and community health workers "expressed interest in learning more about domestic violence and stated it as an important issue for community awareness" (p9). Interestingly, Tanabe et al. (2013) believe that this desire for further learning showed a change in mind-set, as prior to the training, some community health workers had not recognised intimate partner violence as a form of gender-based violence or that it could constitute sexual assault. This attitudinal change illustrated the importance of seeking the views of learners in order to ensure that training content focuses on relevant issue facing communities.

Organisation/Project level factors

Transfer climate

The importance of supporting the use of training through situational cues including checklists, forms to prompt and guide practice, and other job aids was highlighted by three papers included in the review (Nelson et al., 2012; Sullivan et al., 2004; Smith et al., 2013). Nelson et al. (2012) credit the success of training on maternal, newborn and child health, in part, to the provision of setting appropriate checklists as part of a comprehensive 'training package'. FHWs reported that these were "useful visual reminders of when to refer patients to higher level care" (p133) and to educate women about the importance of prenatal care. Sullivan et al. (2004) credit the addition of checklists to client record cards to improvements in information provided to clients of a reproductive health clinic on the Thailand-Burma border.

Smith et al. (2013), highlight the need for job aids such as history and exam forms, and written drug treatment protocols to prompt correct practice in response to their findings that less than one-third of health care provider trainees could recall certain procedures three months post-training.

The studies by Smith (et al. 2013), Sullivan et al. (2004), Teela (et al. 2009), and Nelson et al. (2012), highlight the importance of providing follow-up and regular refresher trainings. The first study indicates that the most significant changes to HCPs' attitudes towards care for sexual assault survivors were found when case managers followed up after training. Similarly, improvements in quality of care gained as a result of the project studied by Sullivan et al. (2004) were sustained through weekly follow up quality assurance meetings. Research by Teela (et al. 2009) linked regular refresher training and workshops to an increase in confidence amongst MHWs, while Nelson et al. (2012) found that a decline in skills amongst FHWs at follow-up could be remedied by the implementation of regular refresher trainings.

Resourcing was frequently identified as a potential barrier to the use of trained skills in work contexts. The study by Nelson et al. (2012) recognised that trainees cannot transfer trained skills without the requisite resources which enable them to do so. In response, and due to the limited supply lines in South Sudan, it was found necessary to "directly equip each [FHW] with reusable and setting-appropriate equipment" (p134).

The study by Sullivan et al. (2004) into improving reproductive health quality along the Thailand-Burma border found through facility audit that it was necessary to transform examination spaces for privacy and provide sinks for handwashing in or near consultation areas to support training on universal precautions. Likewise, Homan et al. (2010) report that implementing partners supplied primary health care facilities involved in training staff on antenatal care with an implementation package or "toolkit" of resources necessary for the use of newly trained skills in health centres.

Organisational support

Support from supervisors was found to be a significant factor enabling health workers to put their learning into practice. Smith et al. (2013) found that "[o]rganisational and contextual factors influenced uptake of the training. The most significant improvements to HCPs' [health care providers'] attitudes were demonstrated in Kenya and Ethiopia, where gender-based violence case managers participated in training" (p9). The importance of support also extended to the organisation more generally, as findings showed "[i]nstitutional involvement and commitment has been established as a key element to ensuring facility-wide preparedness to respond to sexual violence" (Smith et al., 2013: 9). Likewise, Sullivan et al. (2004) note the importance of a system of supportive supervision and mentoring in order to enhance and sustain skills.

An additional level of factors: the environment

My analysis of the seven documents included in this review revealed a broader level of factors not generally considered by the transfer of training literature. I have categorised these as 'environment level' as they operate above and around the learner, training intervention and organisational factors outlined above. This level of moderators provided a number of factors which influence the transfer of training on SRH for humanitarian settings. In fact, for the existing literature on SRH training for humanitarian settings, more factors emerged for this additional level than for those most commonly included in training transfer studies (individual, training and organisation). This is, therefore, an important finding, and one which will be built upon through the remainder of my research. Moderating factors which lie on the environment level will be further explained below.

Policy

A health governance issue was reported by Smith et al. (2013) in their finding that policy restrictions on the availability of emergency contraception remained an obstacle to the use of trained skills in an urban refugee setting in Jordan (p9).

Health system capacity

Different aspects of the health system under which newly trained staff would work were found to be significant in five of the papers included in this review. Smith et al. (2013) explained the importance of protocols to the successful use of newly trained skills in practice, stating that for trainees to effectively provide clinical care for survivors of sexual assault "national or international protocols must be easily available in all facilities in the language of the provider and all providers should be made aware of their importance" (p9).

A lack of adequate and appropriate financing, physical infrastructure and resourcing was identified as an important factor in four of the included papers. Homan et al. (2010) count damaged infrastructure, and a lack of resources and funding as among the "innumerable challenges" (p32) faced in establishing antenatal care at a primary health care level in post-conflict Kosovo. Smith et al. (2013) report "health facility level barriers including stock-outs of HIV [post-exposure prophylaxis]" (p9) for clinical care of sexual assault survivors in Democratic Republic of Congo. More specifically, Teela et al. (2009) detail the disruption and deliberate destruction of infrastructure, resources and supply chains in active conflict areas in eastern Burma.

In terms of health workforce, three of the papers included in this review emphasise the importance of collaboration and integrating newly trained staff and/or their skills into health system structures. Olness et al. (2005) predict one of the challenges to allowing trainees to use trained skills will be "in keeping local disaster agencies aware of the local expertise [in the special needs of children in the management of disasters] available to them" (p247). Nelson et al. (2012) explain that one potential explanation for the success of their training programme was that "the initiative was greatly facilitated through close collaboration with federal and state ministries of health and nongovernmental partners" (p134). Collaboration between tiers of health workers was found to be an important contributor to programme success by Teela et al. (2009).

Society and culture

Socio-cultural factors affecting the trust and/or confidence potential clients felt towards the offered services were found to be potential moderators to the application of newly trained knowledge and skills in three of the seven papers included in this review. In describing the post-Soviet health care system of Kosovo as 'specialist-oriented', Homan et al. (2010) remark that "changing the cultural view to have confidence in family medicine and primary care will take time" (pp32-33).

The issue of trust and confidence was found to extend more specifically to health care workers and the services being offered in studies by Teela et al. (2009) and Tanabe et al. (2013). Findings from focus group discussions with maternal health workers in conflict affected Eastern Burma show that "a community or client's trust in a program or its workers influences service-use both negatively and positively" (Teela et al. 2009, p1335). Researchers here found that the development of cooperative and trusting relationships between newly trained service providers and the community through early and inclusive communication facilitated acceptance and implementation, while the failure to do so in one site "led initially to [maternal health workers] receiving delayed notification of some pregnancies, and occasional refusal from mothers to accept in-home services" (Ibid).

Similarly, Tanabe et al. (2013) state that "community members need to feel comfortable in seeking care from [community health workers] or [traditional birth attendants]" (p8) and suggest additional training on elements such as counselling, listening and empathy to enhance trust within the community.

Related to trust and confidence is the belief in a health care worker's technical competence to provide the services offered. This was identified as an important factor by Teela et al. (2009) who found that demonstration of skills by maternal health workers was critical to acceptability and the "provision of timely care- a lack of trust results in delays that cause increased morbidity and mortality" (p1335). Community health workers in the study by Tanabe et al. (2013) also expressed the importance of reminding community members that, along with confidentiality, "we are capable to provide this care and have been trained to do so" (p7).

Traditional beliefs and practices which could impede the transfer of trained skills were also noted. This was seen by Teela et al. (2009) in the position MHWs felt they held in the community relative to that of traditional community providers, who were more likely to be trusted and therefore approached for services. Authors in this study also noted an incident where "the family of a woman who required an urgent blood transfusion insisted on first performing a traditional religious ceremony with a healer" (p1335). In highlighting these cases, Teela et al. (2009) suggest that if newly trained MHWs can build positive relationships with traditional community providers through partnership and respect, communication links between health workers of all types and between health workers and the community may be improved.

In their study of community-based care for sexual assault survivors in eastern Burma, Tanabe et al. (2013) note the cultural responses "shyness; fear of others' opinions, such as the scolding of parents or the fear of being looked down upon by community members; shame; and concerns that they may not receive help" (p8) as important barriers to survivors willingly seeking care. They suggest that these factors could be overcome with increased outreach and awareness raising activities in settings where newly trained community health workers are placed. In an similar way, Teela et al. (2009) state that "a more refined framework for achieving improved access within a community-based program should consider other factors such as social norms surrounding care-seeking, perceptions of the seriousness of obstetric emergencies, gender and power-relations, household-decision-making, and traditional practices" (p1338).

Setting

Finally, Teela et al. (2009) discuss the important logistical constraints of difficult terrain and climatic factors. Target populations were often accessible only by walking for long periods through difficult conditions, and this proved challenging for MHWs in putting newly acquired skills into practice. In this case, trainees suggested numerous practical solutions at follow-up, and while some were adopted, others, such as the use of donkeys for transport were not possible due to financial and procurement constraints.

Also related to setting, political uncertainty and insecurity were regarded as important factors for the implementation of trained skills in two of the papers (Homan et al., 2010 and Teela et al., 2009). Teela et al. (2009) noted specific threats to MHWs due to their ethnic affiliations

and the deliberate targeting of health workers and their resources. More indirectly, Kosovo's position at a transition point between humanitarian relief and longer-term development, and the political uncertainty inherent in a newly founded nation are listed by Homan et al. (2010) as a challenge to implementation.

Proximal training outcomes: Post-training self-efficacy, post-training knowledge and post-training reaction

Papers included in this study described all three of the proximal post-training outcomes suggested by the training transfer literature. Reports of these outcomes were somewhat indirect in these documents, particularly in regards to self-efficacy. As a result, I have included any mention of 'confidence' which developed through training under post-training self-efficacy in these findings. In relating measures of confidence to self-efficacy, I appreciate that there may be some difference in the definition and boundaries of the concepts. As Bandura (1997) explains, "[i]t should be noted that the construct of self-efficacy differs from the colloquial term "confidence." Confidence is a nondescript term that refers to strength of belief but does not necessarily specify what the certainty is about" (p382). In this definition he continues, however, to highlight the agentive aspects of self-efficacy, and as the studies outlined in this review specifically relate to positive self-perceptions of ability to achieve training objectives, their references to 'confidence' have been equated with self-efficacy. Improvements in knowledge and skills as a result of undertaking training and a training participant's reaction to the training course were more directly considered in the included articles.

Post-training self-efficacy

Four papers identified factors related to learner self-efficacy (Olness et al., 2005; Smith et al., 2013; Teela et al., 2009; Tanabe et al., 2013). In their evaluation of a training program which included sessions on emergency obstetrics, newborn resuscitation and sexual and gender based violence, Olness et al. (2005) found positive trainee responses to questions of confidence in fulfilling all learning objectives at the conclusion of the course.

In work by Smith et al. (2013), self-administered questionnaires were used to examine confidence in the use of skills for the clinical care of sexual assault survivors in humanitarian settings. Confidence in the use of these clinical skills was found to differ by sex and trainee profession. It was reported that male health care providers increased their confidence in the use of knowledge and skills while female participants did not. Nurses experienced a marked

increase in confidence while no significant improvement could be found for doctors. All participants, regardless of role, reported an increase in levels of confidence, though this differed, with experienced providers improving from 61% at baseline to 77% at endline (3 months post-training), and those without experience moving from 54% to 67%.

Teela et al. (2009) found differences in levels of confidence to be based on content area covered in the training course, but that "increased ownership over the project…, regular training and capacity-building workshops, and practical experience" (p1337) led to increased confidence among MHWs. In a similar way, Tanabe et al., (2013) report that CHWs were generally confident and comfortable with the subject matter of the training but this confidence declined when asked about implementing new skills such as history-taking and psychosocial care.

Post-training knowledge

Of the seven studies included in this review, four papers give detail on the extent of learning that occurred as a result of undertaking the training (Smith et al., 2013; Olness et al., 2005; Tanabe et al., 2013; Nelson et al., 2012).

Smith (et al. 2013) evaluated change in providers' attitudes, knowledge, confidence and practice as a result of their participation in training on clinical care for sexual assault survivors in four countries. The authors found that the multimedia training tool was effective in improving health care providers' "respect for patient rights, knowledge, confidence, and clinical practice" (p10), but did not change negative attitudes such as blame and disbelief three months after the course had been delivered.

In an evaluation of the impact of training on the special needs of children in the management of disasters by Olness (et al. 2005), pre- and post- tests demonstrated that significant declarative knowledge improvements had been achieved in all countries except one (which had higher pre-test results).

Focus Group Discussions employed by Tanabe et al. (2013) showed that community health workers from pilot sites were knowledgeable about the use of required clinical skills for sexual assault survivors, the need for confidentiality and the use of forms and information management processes (p6).

Nelson et al. (2012) found an increase in knowledge and skills amongst frontline maternal, newborn and child health workers (FHWs) through the use of objective structured clinical examinations conducted pre- and immediately post-training. A significant decline in skills was

found, however, “at follow-up [2-3 months post-training], particularly for skills that were not previously part of the [frontline health workers’] skillsets such as newborn resuscitation” (p134). Nelson et al. (2012) also attributed difficulties trainees demonstrated taking blood pressure measurements to its newness as a technical skill.

Post-training reaction

Two of the seven studies included in this literature review comment on their training participants’ reaction to the training course (Olness et al., 2005); Nelson et al., 2012). In both instances, the reporting of reaction to the training content and delivery is restricted to trainees’ affective reaction or satisfaction with the course. Olness et al. (2005) explain that the training “courses were well-received in every venue” (p244), and Nelson et al. (2012) state that “questionnaires revealed high levels of use, satisfaction, and confidence” (p130). The latter authors report that training participants found the checklists which formed part of the total training package to be useful, but this was the extent of any observation on utility reactions.

Intention to transfer

While no study included in this review directly mentions ‘motivation’ or ‘intention’ in detail, related concepts were presented in three studies (Tanabe et al., 2013; Teela et al., 2009; Olness, et al., 2005). Tanabe et al. (2013) report the ‘enthusiasm’ expressed by training course participants about the opportunity to provide needed care in their communities. Researchers linked this level of enthusiasm to “the utility and promises of this community-based approach in settings where insecurity and other barriers prevent access to facility-based care” (p10). Similarly, Teela et al. (2009) found that the ‘pride’ expressed by MHWs was related to their ability to provide “pragmatic solidarity” or a useful service to their communities in times of crisis. Olness et al. (2005) report that “ a remarkable outcome of this training course has been the development of an international group of highly motivated professionals involved in disseminating information to relief workers at a local level and providing a supportive network among themselves” (p244), but provide no further information to support this statement.

The transfer of training

No study located for this review had training transfer as its central interest and there was variation in the way each understood and explained concepts related to the actual transfer of

training. Two of the included papers (Teela et al., 2009; Homan et al., 2010) discuss the outcomes of the training programme in terms of *use*, acknowledging that effectiveness has yet to be determined. Teela et al. (2009) report interim evidence that the project under their investigation has had some positive results, but state that "a more complete understanding of the impact of the project awaits a quantitative evaluation" (p1339). Homan et al. (2010) assessed trained providers' use of newly developed knowledge and skills in ante-natal care but also report that "it is too early to determine if this programme has positively impacted health indices such as maternal and infant mortality rates" (p7).

Pre- and post-testing, together with objective structured clinical examinations evaluating management and referral of postpartum haemorrhage and management of newborn asphyxia were used by Nelson et al. (2012) at intervals post-training to show that trainees were utilising new skills. In addition to this, the authors comment on the *effectiveness* of the training programme by reporting that:

> although initial health outcome data are limited, they are encouraging; among the 244 deliveries of trained FHWs in the follow-up assessment, participants reported no maternal deaths and 2 newborn deaths. As reference, assuming South Sudan's current mortality ratios and rates, one could expect an average of 5.0 maternal and 16.4 newborn deaths among 244 deliveries (p134).

Two additional papers (Sullivan et al., 2004; Smith et al., 2013) also remark on the effectiveness of the training programme. Sullivan et al. (2004) used a quality improvement framework and found an increase in the quality of reproductive health services based on improvements to facilities and enhanced staff skills. Similarly, Smith et al. (2013) report that "provider practice improved following training as demonstrated by a documented increase in eligible survivors receiving emergency contraception…, HIV post-exposure prophylaxis…,and STI prophylaxis and treatment" (p1/10).

The two remaining studies (Olness et al., 2005; Tanabe et al., 2013) were either unable to report on transfer due to a lack of opportunity to implement newly acquired knowledge and skills (Tanabe et al., 2013), or did not mention post-training outcomes beyond satisfaction with the course and increased scores in post-training testing (Olness et al., 2005).

Implications of literature review findings

The aim of this review was to synthesise the literature to gain insights into factors which influence the ability of health and health management workers in LMIC to transfer SRH training into practice in humanitarian settings. To my knowledge, this is the first review to extract meaningful lessons from the published literature on why these workers do or do not use newly trained skills and knowledge to improve SRH outcomes for people in emergency situations.

The limited number of research papers identified for this review highlights significant gaps in knowledge. No citations were found which detailed training interventions specifically for mitigation and preparedness. Training for response predominated and three of the seven papers had protracted crises as their setting. Conflict was the hazard most commonly discussed, and while the training interventions detailed in two of the references could be applied to diverse or all disaster types, no citations could be found on disasters resulting from natural, political, complex, epidemic, or technological hazards. Further gaps in the literature concern components of SRH services for humanitarian settings as outlined by the Inter-agency Field Manual on reproductive health in humanitarian settings (IAWG, 2010). No documents were found in relation to HIV and other STIs, adolescent sexual and reproductive health, family planning, comprehensive abortion care or planning for comprehensive SRH services as the situation allows. Most pertinent to an understanding of the SPRINT Training programme, no literature was available on the transfer of training for coordination of an SRH response in humanitarian settings or the implementation of the MISP specifically. This is despite findings from global MISP evaluations (IAWG, 2004; Chynoweth, 2015) which indicate that gaps in capacity for coordination are a central impediment to addressing SRH needs in crises.

The findings of this review indicate the influence of a number of important training transfer moderating factors that concur with the training transfer literature, such as the importance of a supportive transfer climate and trainee perceptions of self-efficacy. Significantly, the individual level commonly cited in training transfer literature is missing from these studies. In addition, included studies only tangentially consider transfer, and no study specifically sought to understand the full system of potential *training transfer factors* and the influence of *proximal outcomes* and *intention to transfer* that may be unique to SRH in humanitarian

settings. This could point to a lack of attention to transfer in the development and evaluation of training programmes in this field.

Another important outcome of this literature analysis is the addition of a further layer of influence, which I have labelled 'environment level' factors. This has implications for the training transfer literature as it relates to training for SRH in humanitarian settings, and more importantly to the capacity building of humanitarian staff more generally. Socio-cultural factors, health system capacity issues, the political environment and the physical setting of transfer were found to have important relationships with transfer in a majority of the studies included in this review. This points to the need for further research to understand how these factors influence transfer, and to identify the presence of any further moderators on this or other levels within the transfer system.

Both training transfer theories and the findings of this review show that, although training can be an effective strategy to improve knowledge and confidence, it alone is not sufficient to ensure that new knowledge and skills will be transferred to the workplace. Successes documented in the studies included in this review invariably relied on buttressing strategies to facilitate transfer. For example, post-training improvements in knowledge were maintained and gaps in understanding addressed through regular follow-up and refresher trainings (Smith et al., 2013; Sullivan et al., 2004; Teela et al., 2009). Supportive transfer climates were ensured through adequate resourcing, encouraging support and providing cues to prompt the use of new skills (Nelson et al., 2012; Sullivan et al., 2004; Smith et al., 2013). Sociocultural issues of trust and confidence were addressed through strategies of building respectful cooperative relationships between the programme, community members and tiers of health workers (Teela et al., 2009; Homan et al., 2010; Tanabe et al., 2013).

The findings of this review highlight the importance of identifying potential *training transfer factors* on multiple levels during the design or pilot phase, and integrating strategies to either harness or ameliorate their influence before, during and in follow-up to the training programme. Each potential moderating factor identified may be seen as a point where it is possible to implement interventions to maximise transfer. A key lesson from this review is that training should not be implemented as a stand-alone strategy without consideration of the system of moderating factors which operate to influence its effectiveness. As Homan et al. (2010) explain, "[i]t is all too common for international aid initiatives to focus too narrowly on

training or resource distribution, without adequate attention to improving the systems that are required for ongoing success" (p32).

Some domains of moderating factors may be more amenable to intervention than others and implementing interventions to address factors at the environmental level may prove difficult and require the addition of strategies which lie outside those of a traditional training programme. Advocacy, community awareness raising, health systems strengthening and rights-based approaches are mentioned in the studies analysed for this review as useful for producing an environment which supports the use of newly trained skills. While this work may not be so straightforward, these papers suggest that ignoring the influence of environmental level factors could compromise the use of training and therefore the effectiveness of training programmes. In the field of humanitarian response, where the call for training to build capacity is very often repeated, this may require hard decisions. Training may be seen as a direct way to develop the competencies of workers to respond to health needs in humanitarian crises, but without an environment supportive of the use of this training, scarce aid resources may be wasted.

Summary of Chapter 3

A review of the literature identified that transfer is critical to training programme effectiveness, and it is necessary to identify potential transfer moderating factors so that they may be addressed during the design, delivery and follow-up phases of training programmes in order to leverage transfer. The area of training transfer is a long-established field of research and this review of the literature has provided insight into elements which affect the use of training in humanitarian health contexts. An important finding has been the identification of a further level of factors which influence the transfer of training on SRH for humanitarian settings, here labelled the 'environment level'. This concept lies beyond the scope of the training transfer literature that generally informs our understanding of why and how participants in training programmes apply their newly acquired knowledge and skills, and is of significance given that "the first step to improving transfer is an accurate diagnosis of those factors that are inhibiting it" (Holton et al., 2000:334). A corollary of this finding is that additional theories may be required to explain the wider system of influence on training transfer, a call also made by some within the training transfer field itself (Kim, 2004).

The conceptual model developed in the first literature review chapter (Chapter 2: Figure 5) and built upon through literature from the SRH in humanitarian settings field (Chapter 3: Figure 7) should be understood as a foundation instrument which will be modified and expanded as the findings of my research are presented in the ensuing chapters. The remainder of this study will work to identify and understand the system of factors which influence the transfer of training on SRH for humanitarian settings. The methods I employed to explore this system will be explained in the chapter to follow.

Chapter 4

Methods

Introduction

Addressing the SRH needs of people surviving humanitarian crises can prevent disease, disability and death, but we know from global evaluations (IAWG, 2004; Chynoweth, 2015) that there are important gaps affecting the provision of these services, including in coordination. It is also clear that training is a strategy that has the potential to help close these gaps, but that there is generally a 'transfer problem' between attending a training course and applying the learning gained in the workplace. The later – which is known as the "transfer problem" may be influenced by a range of factors pertinent to individual trainees and their contexts. Given all of the above, I set out to investigate training transfer factors and the extent of training transfer in the context of the SPRINT training program. Three research questions guided this research:

1. Which *training transfer factors* determine the *intention* of training participants to transfer learning gained through SPRINT Training?
2. Which *training transfer factors* determine the *transfer* of learning gained through the SPRINT Training?
3. How can *training transfer factors* be addressed so that the transfer of learning gained through the SPRINT Training is *optimised*?

This qualitative study was undertaken in two phases to answer these questions.

Research methodology: A multiphase qualitative study

The questions which formed the basis of my study demanded a rich understanding of the contextual realities in which each informant trainee sits. I was interested in learning from the first-hand perceptions and experience of SPRINT trainees at the time of the training and as they returned to their work places, and I sought to do this in relation to their complex histories and surroundings. For these reasons, I deemed it appropriate to adopt a qualitative approach in line with Carter et al.'s (2009) description of this form of research and its researchers:

> Qualitative researchers attempt to understand what happens in participants' everyday lives, how things work and what things mean to participants…Qualitative researchers rarely presume which variables are important, but rather seek to discover what is relevant by speaking with participants, reading texts or observing behaviours…Qualitative researchers seek to study the social world in its ordinary, complicated, changing state (p 106).

Qualitative methods have been used to explore and describe the kind of complex, real world phenomena of interest to this study (Ritchie et al., 2003). The aims of my research align with the broader aims of qualitative inquiry- to provide "an in-depth and interpreted understanding of the social world of research participants by learning about their social and material circumstances, their experiences, perspectives and histories" (Ritchie et al., 2003: 3). Like Nikandrou et al. (2009) I employed a qualitative study design to explore "whether and to what degree the participants in [a] training programme transferred to their work the knowledge and skills acquired at [a] seminar" (p259), and "the factors that support or hinder the participants' transfer of training to the workplace" (p259). Nikandrou et al. (2009) reported that "[t]he qualitative methodology….provides rich information regarding the training transfer process" (p255).

The functions of qualitative research in relation to this research

Looking broadly at research approaches, Ritchie et al. (2003) describe four distinct functions of qualitative methods. The first of these is contextual research, which is concerned with "*what* exists in the social world and the way it manifests itself" (p27). The authors emphasise the utility of a qualitative approach for this purpose in that it allows researchers to describe and report the phenomena of interest in the research participant's own voice. The second function of qualitative research as categorised by Ritchie et al. (2003) is explanatory, in that it is "concerned with *why* phenomena occur and the forces and influences that drive their occurrence" (p28). Qualitative research, they argue, "provides a unique tool for studying what lies behind, or underpins, a decision, attitude, behaviour or other phenomena…This makes it possible to identify: the factors or influences that underlie a particular attitude, belief or perception…[and] the motivations that lead to decisions, actions or non-actions" (p28). The third use of qualitative research is for evaluative purposes, and the fourth is its generative

utility, or ability to aid in the development of theories, actions or strategies (Ritchie et al., 2003). The first two functions of qualitative approaches outlined by Ritchie et al. (2003) are most pertinent to my first two research questions. I am interested in the *what*, or how participants perceive, experience and report the factors which exist for them as they enter the training room, interact with the training programme and exit to return to work. I am also fundamentally concerned with the *why*- what lies behind these perceptions, experiences and reports, and how these are associated with particular post-training attitudes, actions and non-actions. My research also engages the generative function of qualitative research, in that it seeks to "determine actions that are needed to make programmes, policies or services more effective" (Ritchie et al., 2003: 31), or in the case of this study, how to optimise the transfer of training on SRH in humanitarian settings.

Theoretical perspective

This research is informed by the theory of Constructivism which allows and gives equal attention to simultaneous and co-existing perceptions and interpretations (Charmaz, 2006). In constructivism, "[r]ealities are apprehendable in the form of multiple, intangible mental constructions, socially and experientially based, local and specific in nature…, and dependent for their form and content on the individual persons or groups holding the constructions" (Guba and Lincoln, 1994: 110-111). My research places the trainee at the centre of my understanding of the training transfer system and is focused on uncovering the varied 'realities' of individual trainees.

As an actor in the research process, it is important to situate myself within the context of the research and acknowledge how my social interaction with participants and reflections play a role in the generation of new meaning. I came to the topic of training for SRH in emergencies from a background in applied anthropology, development studies, international public health and adult education. These four aspects of my work and educational history corresponded perfectly with the topic of this study. They also shaped the values and beliefs I brought with me when approaching my research. As stated at the start of this thesis, I believe that full sexual and reproductive health is a right for all people. I am motivated by my conviction that human resource capacity can be built through training to ensure that people in humanitarian settings have this right upheld. I am also mindful and concerned that the effectiveness of aid resources can be compromised when money dedicated to training does not result in the use of

new knowledge and skills. These values and my social, political and cultural history which informed them have influenced the research questions I have chosen, the direction of my study and its priorities, and the way in which I have interacted with participants and the data they provided.

I acknowledge these personal predispositions at the outset and have sought to work in constant conversation with myself, through reflexive memoing and journaling, and with my research informants (in ways described below) to understand how my "own values, perceptions and behaviours…can indeed affect data collection and analysis" (Lambert et al., 2010: 322). It is also important to situate myself within the broader programme, of which SPRINT Training forms a part. I first became involved with SPRINT and the Initiative's programme coordinators when the training course was being designed. It was recognised at this time that I was a student interested in looking at the programme but that I was not a part of the programme itself. When I attended the three Regional Training of Trainers workshops, I sought to maintain this more distant position so that I could speak freely with participants and so that they felt they could speak freely with me.

The nature of my relationship with the SPRINT Initiative and its coordinators changed throughout the years after the original Regional Training of Trainers as analysis of my findings suggested useful strategies which could enhance the training course and its buttressing strategies. Again, my belief in the potential of the training to address the gap in coordination capacity for SRH services in humanitarian settings influenced the shape of my research experience and I was engaged to provide guidance on updating the SPRINT Training curriculum, and input into the design of the Initiative as it moved into its second phase.

Throughout the passage of my research alongside the SPRINT Initiative as it moved and developed, I was accompanied by three other researchers, each of whom were interested in complementary aspects of the SPRINT programme. As a group, we discussed our findings, reflected on our experience with the training programme and broader elements of the Initiative and our PhD journeys, and acted as foils for each other's ideas, insights and theorising. This affiliation and camaraderie allowed a way to externalise the concerns brought about by critical personal reflexivity and through challenging one another's assumptions and sharing our insights, provide some assurance about the conclusions we reached.

Qualitative research and the use of a conceptual framework

My approach to uncovering and making sense of participants' realities was inductive. Working with my research participants, I allowed the data to reveal the concepts, patterns and associations which contributed to my conclusions (Ritchie et al., 2003). My review of the training transfer literature and what is known for the transfer of training for SRH in humanitarian settings (Chapters 2 and 3) was important as it enabled me to place my study within its theoretical context, and contributed to my understanding of the concepts, patterns and associations which emerged through my research. From these reviews I was able to construct conceptual models of the current state of theory of training transfer (Figure 5) and training transfer for SRH in humanitarian settings (Figure 7). The development of these conceptual models and their use as a guide in my subsequent research did not, however, compromise the guiding principle of induction. Throughout, my approach remained exploratory and the analysis was not purposively directed by the concepts contained within the literature-derived conceptual models. My work is in line with the following description by Morse (2003) due to my understanding that:

> Theoretical frameworks should not be used to the extent that they influence the research design deductively. For instance, they must not provide a coding scheme that will presort data or overly constrict observations. If the [researcher] has enough knowledge to develop a detailed theoretical framework, then he or she should not be using qualitative methods but, rather, should be testing the framework using quantitative inquiry (p840).

Research methods

By employing in-depth interviewing as my primary data gathering technique, I sought to elicit, explore, refine and confirm the perceptions, interpretation of experiences, and histories of each individual respondent *with* my interviewees in line with the constructivist epistemology of this research. My data were generated through an interaction between myself, the interviewer and my research participants. The flow of these encounters, though guided by topic lists, questions and probes, was, in all cases, determined by my interviewee's answers (Ritchie et al., 2003). A fitting metaphor of the approach I took to interviewing is that provided by Kvale of the researcher as 'traveller', or one who moves with the interviewee and works

through dialectical interchange (Guba and Lincoln, 1994) to develop meaning and insights through interpretation:

> The traveller ... asks questions that lead the subjects to tell their own stories of their lived world, and converses with them in the original Latin meaning of *conversation* as 'wandering together with'. (Kvale, 1996: 4, in Ritchie et al., 2003: 139)

In addition to in-depth interviewing, I relied on observation to provide further insights into: my key informants' perceptions and experiences; the nature of the training course and its participants as a whole; the character of the training providers and facilitators; and expressions of confidence, learning, satisfaction and utility amongst training participants generally. I was also able to consult a range of documents which provided information on: general levels of learning (in terms of declarative knowledge) of all training participants; the plans and expectations of all SPRINT coordination teams; feedback on the training course and its objectives; the professional histories of my key informants; contextual information of all participants; and the transfer activities of involved trainees. While in-depth interviewing was my primary method of data generation, enlisting these additional data sources allowed for triangulation by the comparison of data from different qualitative methods (Ritchie et al., 2003). The application of these methods to my research will be explained further in the sections to follow.

Temporal considerations are an important component of my research questions as I was interested in participants' end-of-course *intention* to transfer training, and their eventual *initiation* of training transfer when they returned to work. It was, therefore, necessary to design a multiphase research strategy that allowed interviewing the same cohort of trainees on multiple occasions. I employed this form of longitudinal research to describe and understand change over time that could be attributed to the training program. As explained by Ritchie et al. (2003):

> The role of qualitative research [with a longitudinal approach] is not to measure change...Instead it is to describe the different types of changes that take place or the different outcomes that result, to account for them by showing how they arise, and to explain how and why there are differences between sample members. Qualitative research explores the broader context within which change takes place, and so can capture the full set of factors that participants perceive as contributing to change or outcome (p 54).

A multiphase approach to researching the transfer of training is not the norm (Blume et al., 2010), but the value of taking a long view and exploring real world transfer is increasingly being recognised. Nikandrou et al. (2009), for example, report that their use of a longitudinal research framework uncovered important factors which affected the transfer process. These authors go on to state that "[m]ore studies, using a longitudinal methodology, are needed to examine the impact of training transfer" (p268).

Taking this approach, I conducted two phases of data collection. The first phase of research was conducted in the final days, or at the end of the SPRINT Regional Training of Trainers courses in Kuala Lumpur, Sydney and Suva. The study's second phase then followed original research participants at intervals between six months and three years after the training event. These two phases and the methods used for gathering and interacting with the data will be described in detail below.

The research process

Phase 1

Research during phase one was designed to address my first research question,

> Which *training transfer factors* determined the *intention* of training participants to transfer learning gained through SPRINT Training?

As such, my interest centred on the proximal outcomes of self-efficacy, knowledge gains, and reaction to the training content, and background factors and perceptions which may influence a participant's intention to transfer the training.

Parameters for participant selection

I conducted in-depth interviews with twelve participants at three SPRINT Regional Training of Trainers courses. These twelve trainees came from seven countries in the Asia Pacific region and were interviewed in the final few days or at the close of the three SPRINT Regional Training of Trainers workshops held in Kuala Lumpur, Sydney and Suva. An exception to this is the key informant Benedict, who was unavailable for interview during the training programme. We did, however, speak often though informally over the course of the training and based on these conversations and information in his application to attend the SPRINT Training, I

determined that he suited my selection criteria well and would provide valuable insights. As such, I interviewed Benedict in his home country after the regional training concluded. His answers during our interview reflected the observations he conveyed to me during the training workshop, in addition to explanations of his post-training action. I have, therefore, included his insights in both phases of my research findings.

I employed criterion sampling in order to ensure that all key constituencies relevant to my research questions were included, and to confirm that chosen participants represented diversity within each of my key criteria (Ritchie et al., 2003). From my broad study population (participants at the three SPRINT Regional Training of Trainers courses held in Kuala Lumpur, Sydney and Suva), I first sought to ensure that I had representatives from all major organisational groups in attendance at the training. These groups included NGOs, INGOs, UN Agencies (particularly UNFPA), departments or ministries of health and/or emergency management, and other (such as academic institutions and hospitals). Second, my informants from these organisations included participants with many years of experience working in SRH for humanitarian settings, those with little experience in this field, and those with none. Some participants were currently working in the field of SRH for humanitarian crises and others had previously conducted this kind of work. Data were also provided by respondents who had experience in related fields such as SRH (for stable settings), general emergency response, general health, or government work. Informants interviewed for this phase of research were both clinical and non-clinical, and either involved in training activities or not involved in training activities. I adhered to these criteria when selecting my key informants by appraising training application forms and curriculum vitae, speaking with SPRINT Training facilitators and coordinators, and through informal interaction with trainees during the early days of the training courses.

In sum, my twelve key informants were selected for their diversity, so that I could optimise the scope of data exposed during interviewing (Denzin and Lincoln, 2005; Carter et al., 2009: 107). This heterogeneous sampling approach (Ritchie et al., 2003) is in line with the exploratory nature of my research and its aim to uncover the broad range of training transfer factors which were at play for the full diversity of SPRINT Training participants.

Phase 1 methods

I conducted in-depth semi-structured interviews with twelve research participants as this method provides "an opportunity for detailed investigation of people's personal perspectives, for in-depth understanding of the personal context within which the research phenomena are located, and for very detailed subject coverage" (Ritchie et al., 2003). Interviews were designed to learn more about the background, experience, qualifications, current work, and organisational structures of participants attending the SPRINT training. I also sought to develop an understanding of how the characteristics and contexts of participants intersected with the content, conduct and objectives of the training course to influence post-training outcomes. In doing this, my focus was on trainees' perceptions of what they anticipated would support or impede their use of the training on return to work. Finally, I was interested to know what, if anything, participants thought they might do with any newly developed knowledge or skills when they returned to their place of work. Interviews generally lasted between one and two hours and were conducted in English. Permission was given to record interviews on all occasions, allowing uninterrupted dialogue and the capturing of verbatim quotations. I employed a broad interview guide for this phase of research based on a review of the pertinent literature and my observation of the training programme in the days leading up to conducting interviews. As explained above, areas covered during the interviews were not restricted to those in the interview guide.

In addition to interviewing key informants, I analysed pre- and post-test results, conducted observation during the training sessions, recorded vignettes and analysed open-ended questions from feedback and application forms, country action plans, presentations and discussions with facilitators and training stakeholders. This was undertaken to support the exploratory nature of my research. These additional methods provided a broader overview of the experience of all trainees (not only those selected as research participants), substantiated how interviewees stated they reacted to and learnt from the training, helped establish the parameters of my interview questions and prompts, and allowed a rich description of each informant's context. A summary of my phase one data collection process is included in Table 3, below.

Table 3: Summary of Phase 1 Data Collection

Phase 1 Data Collection					
Data Sources	**Interviews**	**Observation**	**Feedback & Other Forms**	**Country Plans**	**Discussion**
	South Eastern Asia: 10 North Asia: 1 Pacific: 1	Planning meeting for ToT curriculum development; Kuala Lumpur ToT; Sydney ToT; Suva ToT.	Kuala Lumpur ToT; Sydney ToT; Suva ToT; Applications to attend ToT (all attendees)	Australia, Cambodia, China, Cook Islands, DPRK, Fiji, FSM, Indonesia, Japan, Kiribati, Lao RC, Malaysia, Mongolia, Myanmar, Niue, Philippines, PNG, Samoa, Solomon Islands, Thailand, Timor Leste, Tokelau, Tonga, Tuvalu, Vanuatu, Vietnam.	Kuala Lumpur- daily debrief, discussion with international organisations & regional actors; Sydney- overall debrief; Suva- daily training debrief.
Quest-ions	**What factors did participants anticipate would have an effect upon their ability to transfer their learning when they return to work?**		**How did participants feel about the training, their learning, and their ability to use what they had learnt?**		**Did participants intend to transfer their learning into practice?**
	↓		↓		↓
Findings	19 training transfer factors identified		Post-Training Self-Efficacy, Knowledge & Reaction		Intention to Transfer No Intention to Transfer

Phase 2

The second phase of my research involved following up and re-interviewing my original respondents. This was done in order to address my second research question,

> Which *training transfer factors* determined the *transfer* of learning gained through the SPRINT Training?

I was, therefore, interested in what training participants had done with any knowledge or skills they developed during the SPRINT Training, the reasons behind this action or inaction, and any connection with their post-training transfer intentions.

Phase 2 methods

In the second phase of my research, and at intervals between six months and three years after the regional training events, I collected data through follow-up in-depth interviews with eight of my original twelve research participants. I approached all previous informants but was not able to re-interview four because they were unavailable for reasons which included that they were ill, or were no longer contactable. I also conducted corroborating interviews with members of key informants' SPRINT coordination teams or colleagues from within their organisations.

Along with data from these in-depth interviews, I analysed conference presentations by SPRINT trainees, open-ended responses to a survey I administered to all training participants, observation and vignettes from sub-regional echo-training events, country and sub-national reports and discussions with SPRINT programme managers, donors and fellow SPRINT researchers. These additional sources added context, corroborated, and gave depth to answers given by my eight key informants. After compiling data from these multiple sources, I discovered that I had a richness of information that would allow a deep understanding of the experience of each of these eight original informants.

During analysis it became clear that common themes on the experience of transfer were emerging for these trainees, and that these themes were based very much on their workplace origin. As a result of reaching this data saturation, I selected three cases which were illustrative of the broader experience of their colleagues. For this reason, and to answer my second

research question on which moderating factors supported or impeded the *use* of the SPRINT training after return to work I selected as cases one participant each from:

1. The United Nations Population Fund
2. A local NGO, and
3. A representative from a ministry of health

As mentioned above, I found that patterns of response were largely determined by the participant's place of work. On this discovery, it became clear that a deeper examination of three representative cases, and a comparison between these three representative cases would allow me to maximise what could be learnt about the process of training transfer for SPRINT trainees (Tellis, 1997). I therefore applied a cross-case analytical approach to the data I gathered during phase two of my study (Yin, 1984). This approach is useful:

> "1. To explain complex causal links in real-life interventions
> 2. To describe the real life context in which the intervention has occurred
> 3. To describe the intervention itself
> 4. To explore those situations in which the intervention being evaluated has no clear set of outcomes" (Tellis, 1997: 3).

Each of these applications of case study research is applicable to the aims and questions of my research.

Case study research is known as a 'triangulated' strategy as the researcher works to access all available sources of data for each case (Richards, 2005). I was able to employ multiple data sources for each of my cases. For two of these, I utilised data from corroborating in-depth interviews with in-country SPRINT coordination team members from different organisations. This was not possible for my third case study as no other members of the original SPRINT coordination team for that country were still involved or contactable. In this instance, I interviewed this participant on three separate occasions and spoke with SPRINT Initiative managers about any transfer achievements and feedback. I also attended conference presentations by two of my three cases and observed training courses facilitated in part by these same two participants. Documentary sources of data for my three cases included open-ended responses to a survey I administered generally to all SPRINT participants and numerous reports (country level, SPRINT Initiative monitoring and evaluation documents, and end of programme reports, for example). The data sources which informed this phase of research are outlined in Table 4, below.

Table 4: Summary of Phase 2 Data Collection

Phase 2 Data Collection							
Data Sources 6-18 months post-training	**Inter-views**	**Conference Present-ations by Trainees**	**Country/ Sub - national Reports**	**Survey**	**Observat-ion (national level trainings)**	**Feedback Forms**	**Discussion**
	South Eastern Asia: 9 Pacific: 1 South Asia: 1 Aust.: 1	South Eastern Asia: 4 Pacific: 1 South Asia: 1	South Eastern Asia: 3 Pacific: 2 Australia: 1 SPRINT M&E Reports	38 respond-ents (from ToTs in Kuala Lumpur, Sydney and Suva)	South Eastern Asia: 3 Pacific: 2 Australia: 1	South Eastern Asia: 3 Pacific: 2 Australia: 1	Regional and internatio-nal actors; In-country SPRINT actors; AusAID (consultant and contact); SPRINT managers and facilitators PhD research team

Data Sources 3+ years post-training	**Interviews**	**Country Reports**	**Discussions**
	South Eastern Asia: 11 Pacific: 1 SPRINT Initiative Coordinator: 1	Progress reports (all countries trained). SPRINT monitoring and evaluation reports. End of programme reports (SPRINT & AusAID)	Planning sessions for SPRINT Phase 2 (Kuala Lumpur) with SPRINT programme managers and AusAID. Discussions with PhD research team

Quest-ions	**What factors facilitated or constrained the ability of participants to transfer training?**	**Did participants apply their learning in practice?**
	↓	↓
Find-ings	19 training transfer factors influenced transfer	Initiation of transfer No initiation of transfer

Data analysis and interpretation

For data gathered in both phases of my research, I deemed it appropriate to conduct a thematic analysis across all data sources. As Lofland (1971: 13, in Ritchie et al., 2003) explained, using this method of analysis helps, in the "task of delineating forms, kinds and types of social phenomena; of documenting in loving detail the range of things that exist" (p214). The method I followed to conduct this thematic analysis had a number of progressive steps. I initially prepared the data by transcribing interviews and locating additional documentary sources. I entered all text-based documents, including interview transcripts, observation notes, open-ended survey answers, and reports into NVivo, a qualitative data analysis tool (QSR International Pty Ltd., Version 9, 2010) for data handling. I then undertook a process of reading and re-reading all texts and making annotations and memos of issues, topics, personal reflections and insights as they emerged across the whole data set. Using the NVivo software package, I sorted decontextualized pieces of data into proto-themes. As discussed previously, my coding of these themes was data-driven (Braun and Clarke, 2006) but informed by literature on training transfer and training on SRH for humanitarian settings. I then looked again at all documents and transcripts to locate any further incidents relevant to each emerging category and to refine my understanding of each theme. The categorisation, arrangement and re-arrangement of related pieces of data and the processes of moving from descriptive labels to cross-cutting themes was aided by the use of tree nodes and models in NVivo. I then, finally, worked to resolve, name, define and set the bounds of each thematic unit (Braun and Clarke, 2006).

Ensuring trustworthiness

In place of traditional positivist concepts of validity, reliability and objectivity, I sought to ensure the trustworthiness (Shenton, 2004) of this research by adhering to Guba and Lincoln's (1986) alternative constructs of credibility, transferability, dependability and confirmability (in Denzin and Lincoln, 2005).

The first of these, credibility, poses the question of how closely the research findings reflect reality. Beginning from a constructivist standpoint, the credibility of research findings is based on "the extent to which the investigator's constructions are empirically grounded in those of the participants who are the focus of the study" (Denzin and Lincoln, 2005: 113). I worked to ensure the credibility of my findings and conclusions by conversing (or 'travelling') with

participants; by checking meaning and the accuracy of my interpretations of meaning both during interviews, and back-checking when re-interviewing respondents during the multiphase research process; by employing a range of methodologies and data sources; and by consulting with three other students who were undertaking parallel research on the SPRINT Initiative.

The transferability of qualitative research, or the generalisability of the study's findings must, for qualitative research, always be "modest and mindful of the context of individual lives" (Denzin and Lincoln, 2005: 113). Many methodologists (such as Denzin and Lincoln, 2005; Shenton, 2004), argue that generalisation from qualitative research is, in fact, the task of the reader and not the researcher. It is, however, the responsibility of the researcher to provide enough contextual information to inform a reader's decision to generalise. As explained by Shenton (2004),

> After perusing the description within the research report of the context in which the work was undertaken, readers must determine how far they can be confident in transferring to other situations the results and conclusions presented. It is also important that sufficient thick description of the phenomenon under investigation is provided to allow readers to have a proper understanding of it, thereby enabling them to compare the instances of the phenomenon described in the research report with those that they have seen emerge in their situations (p 70).

I have attempted to provide the 'thick description' requested in the above throughout this study. The background chapter, together with the forthcoming findings chapters were composed with this aim in mind.

The dependability, or replicability of qualitative research is bound up with the contextual peculiarities of each study and its participants. As with transferability, I have attempted to provide rich detail about informants and contexts so that attempts to replicate my findings could be informed by the circumstances from which they emerged. Dependability is closely associated with reliability and can be safeguarded by using and giving a full description of multiple methods (Shenton, 2004), both of which I have done during the course of reporting this research.

The final criteria of trustworthiness is confirmability. This is a qualitative equivalent to objectivity and for constructivists must "ensure as far as possible that the work's findings are the result of the experiences and ideas of the informants, rather than the characteristics and

preferences of the researcher" (Shenton, 2004: 72). As detailed above, I worked to ensure that this was the case by working in conversation with my participants, by engaging multiple data sources and by conducting 'member checks' with informants.

Ethics

This study was approved by the University of New South Wales Human Ethics Committee and ratified by the University of Technology Sydney Human Research Ethics Committee on transfer of my studies in 2011. Informed consent forms and statements regarding the study were provided to all respondents before their participation in the research. In line with the participant information statement, all participants' names have been replaced with pseudonyms in the reporting of my findings in order to ensure confidentiality and anonymity. In instances where I conducted observation of larger groups or training events, I obtained general verbal consent from participants.

This study was funded by the donor, AusAID (the Australian Agency for International Development, now incorporated into the Department of Foreign Affairs and Trade) through a contract with the SPRINT Initiative and its housing organisation. This funding covered costs associated with fieldwork. I was also the recipient of an Australian Postgraduate Award scholarship which provided support for additional costs over my candidature.

Summary of Chapter 4

In this chapter, I have provided an overview of the theoretical frames within which my study sits. These directly informed both the methods I used for collecting data and the ways in which I interacted with and reported the information provided to me by my informants. The following two chapters will detail the results of these methods as I present findings from both phases of my research process.

Chapter 5

Phase 1 Findings: Readiness and intention to transfer

Introduction

Building on the little that is known about factors which may influence the transfer of training for SRH in humanitarian settings, and guided by the training transfer literature, the first phase of my study focused on the research question:

> Which *training transfer factors* determine the *intention* of training participants to transfer learning gained through SPRINT Training?

In order to answer this question, I conducted a series of interviews with key respondents from the three regional SPRINT Training of Trainers workshops in Malaysia, Australia and Fiji. At this stage of research, the focus of my study was broadly two-fold. First, I was interested in learning more of the background, experience, qualifications and current work of participants attending the SPRINT training. Second, I sought to develop an understanding of the interaction between the diverse SPRINT participants and their background, experience, qualifications and work, and the conduct and content of the SPRINT training. I sought to gauge participants' reaction to the training and its relevance for them, whether they believed they had developed knowledge and skills appropriate to SPRINT's objectives, how they thought they may or may not use any knowledge or skills developed during the course of the workshop, and what they perceived may support or constrain any efforts they may take to apply what they had learnt to their work contexts.

To answer these questions, I conducted semi-structured interviews with twelve training participants representing seven countries from the Asia Pacific Region. The following is an analysis of these interviews, informed by, but not limited to the training transfer, motivation and intention literature. In the first section, I identify, define and provide examples of factors discussed by participants. In the second, I provide an analysis of the associations between these factors and the three proximal training outcomes identified through my research. Finally,

I discuss how, for these participants, the three proximal training outcomes were connected with any intention and motivation to transfer SPRINT training.

Factors found to influence intention to transfer SPRINT Training on SRH in humanitarian settings

During the analysis of interview data for this phase of research, I found a broad range of factors which participants identified as potential barriers and enablers to the transfer of SPRINT training on return to work. These included factors that had already been experienced by participants and those which they anticipated would support or impede any transfer efforts. The factors at play for these respondents fell into a strata of influences, including individual factors, specifics of this training, organisational level effects and finally, those factors which operate on a broader environmental level. In this section of Chapter 5, I will outline, define and provide representative examples of these factors. The twelve SPRINT Training participants who contributed to this stage of my research have been de-identified for confidentiality and as such, pseudonyms have been used throughout.

Individual level factors

A number of factors which operate on an individual level to influence participants' decision to use or not use knowledge and skills developed during the training were identified during this phase of research.

Job involvement

Job involvement is defined as the degree to which participants in a training programme positively identify with, are actively engaged in, and attain self-worth from their jobs (Noe and Schmidt, 1986). This factor was identified by the way in which participants spoke about their job or role, how work was related to self during the interview, and mention of positive associations with respective organisations.
In an expression of close involvement with their work, a number of participants identified themselves foremostly as *"humanitarian actors"*, and frequently interchanged personal pronouns such as *"I/we"* with *"my organisation/ our organisation"*.

Several participants reported that they felt a sense of responsibility for carrying out their work through statements such as "*my responsibility is I should coordinate all [of my organisation's]*

response to any emergency situation … so during the emergency I will be the coordinator for all [of my organisation's] response" (Sujana). Similarly, some trainees expressed a personal drive to achieve a high standard in their role, as in Lee's statement that "*I think it's good, [my country] will be, become one of the country to apply the gold standard MISP, we try to do that",* or indicated personal satisfaction from involvement in their work. In speaking of her role in coordinating SRH for emergency situations, Ana explains that:

> *So that's how we think, so it's also enriching in our, in our experience because this is the first time we are doing it plus we are actually implementing coordination…so that's what we are trying to do. We are looking at the experience as a very enriching one.*

It became clear during analysis, however, that the kind of work or role each participant personally identified with was significant. Respondents above show a personal entwining with roles relevant to both the contents and objectives of the SPRINT training. Other forms of *job involvement* were also identified in the analysis, although these were often expressed in opposition to the expectations of SPRINT. This included a divesting of responsibility, and in some cases, showed a rejection of involvement in the roles SPRINT was requesting of training participants. For example, in the excerpt below, Lin shows that she is involved in her work- as a doctor only, and has not assumed responsibility for the SRH problems she sees within the refugee population. In this way, Lin clearly differentiates between involvement in her work (which is for locals), and 'others'' work (which is for refugees, although these others are unidentified):

> *All of [the refugees] came very very badly. I'm not involved in them. [In the general hospital] we have our own reproductive health problem. We have no time for other…we have our priorities for locals which is a big group of people, so the refugees, frankly speaking, I don't care what other people say, I felt that it's not done properly.*

Further to this, I found that some participants were involved with only a portion of the work covered by the SPRINT Training and learning objectives. This was not always seen as problematic, given the team approach of the training, but was a recurrent theme. As an example, Khan frequently identified himself as 'a trainer' (his current position within a teaching hospital), and discussed at length his experience in training clinical staff in general obstetrics and gynaecology. Throughout his interview, this participant focused solely on training design and conduct, and even on prompting, would not discuss the particular subject

matter of the SPRINT training (that is, SRH in humanitarian emergencies), except as it related to how he would undertake future echo trainings. He was deeply involved and engaged with his role as a trainer, but this was the extent of his connection with SPRINT's training contents and objectives.

Personal engagement

Extending the concept of involvement to a point beyond work roles, an important finding of this phase of research was that some participants had a direct personal engagement with the issue of SRH in humanitarian settings which was not mediated by involvement in work. I have, therefore, including personal engagement as an individual level training transfer factor. Participants expressed their personal engagement in a number of ways, and related to a number of different targets. First, some expressed feelings of personal responsibility to apply what they had learned (differentiating their personal commitment from diligence to work roles). Benedict, for example, stated that working toward SPRINT's objectives was now "*part of my personal commitment so I, ah, have to really be an advocate for this".*

Second, a number of participants reported their deep understanding and conviction of the importance of addressing SRH in emergencies. With emphasis on need and 'our people', Lee explains the "*need to review the current existing policy, especially for those to respond to the SRH need for our people in natural disaster. Our current policy has a health component only, and the visibility of the RH need is not that clear. So we need to make it clear, clearer and clearer".*

Finally, some participants highlighted a personal connection between themselves and women, men, girls and boys living in humanitarian settings. This was most commonly found amongst participants, such as Sujana, who had prior experience coordinating or implementing SRH services in crises:

> *If we not provide the services during the emergency, meaning we do not respect the human right. This really really not good for us as humanitarian actors…And the other opportunity [for advocacy] I also invited the woman who was pregnant in emergency situation. This woman told and express her opinion how difficult she to get access to services during emergency situation. And it really, err, useful opinion from the woman, really touching, so the people really understand this is really the need from the community to get the services*.

Importantly, however, a number of participants at the SPRINT Training questioned the need to provide some or all SRH services outlined in the MISP to people in humanitarian settings. Trainees with these beliefs doubted that SRH considerations should be given priority when there were, they stated, more pressing needs in these circumstances. Simone was one such participant, and when explaining that she believed potential beneficiaries would question the provision of SRH services after a natural disaster, acknowledged that she too had misgivings. She also believed that policy makers would share these reservations:

> *Like if I say [to government decision makers], to integrate sexual health into our plan, they feel like it's not a priority, it's not important. [W]e live on the island, we know what it's all about, we know type of crisis, if it happens we know our needs, you know? So if I say this has to go to the plan, everybody will say "oh yeah, it can go to the plan, no problem'. But in reality and in practice, it's not necessary… So even if somebody come with the new training or, you know, we will accept it, but it's not something we are really keen to put into practice.*

Prior experience

A participant's existing capacity was described by interviewees as either a facilitating factor, or a potential barrier to applying what they had learned in the training. Course participants with prior experience in a role related to SPRINT's training content or expected outcomes made a number of comments related to this issue, such as Benedict's statement that "*[the training] was just right, technically I am a doctor, so technically I have some knowledge and know-how. The time is just enough for me, so I think it's just right actually".*

Some trainees felt that they had some, although limited, prior experience and knowledge of work associated with the objectives of the training. Jon, for example, explained that "*this is the first time for me to attend such topic as the MISP, in my life. So training itself is, ah, a little tough. I think technical component [is harder to follow], 'cause even though I graduated from the medical university… the technical side is, you know, a little far from my past experience, so I think it will take some more time to master, if I have to master it".* Even with his medical background, Jon expresses some confusion around the technical aspects of the training course. Understandably then, a number of participants from non-clinical backgrounds (health

managers and coordinators, for example) explained that they found it difficult to understand aspects of the training's subject matter and/or that this made them question why they were attending this particular training course.

For others, including Sujana, past experience and prior knowledge was limited to segments of the broad content addressed during the SPRINT training:

> *I have a knowledge about the RH but I don't had the really in-depth knowledge, for, example, about the GBV, the, I need the expert to make sure I can deliver the right messages, right information, and then, my other colleagues from [my country], like [the NGO], this person maybe knowledge only limited to adolescent reproductive health example, but maternal health, STI, HIV, they had limited. So, from [my SPRINT coordination] team, I have the general knowledge, and then my colleagues have a special knowledge but limited to one topic so, I don't know how to because there are some technical issues there.*

Individual position and influence

The position of a participant within their organisation and/or the wider health system or structure, and their ability to affect change and to access and influence the people required in order to meet SPRINT's objectives was a concern widely discussed by interview participants. The importance of one's position to affect change is described by William in the following:

> *So when you send out [invitations for] who should be coming [to the training], says we're looking for people who already have the following basic knowledge and characteristics, and more importantly, they can influence the implementation of the addition of sexual and reproductive health to the national disaster response fund. So, [in my country] it was very straightforward because we had [a colleague] and other people there who know exactly who had to be approached, how and when.*

Training level factors

Factors directly relating to the training programme were frequently mentioned by training participants as affecting whether they would apply their learning in practice. These include the relevance of training contents to work and context, the appropriateness of training

methodology and instructional strategies, and trainees' perceptions of the support available from the training providers.

Content relevance

Participants commented on the relationship between the content of the training and its applicability first, to their job requirements, and second, to the wider context in which they work. Trainees who were currently involved in work pertaining to the training content or training objectives were likely to perceive the training as relevant to their job requirements. Lee reported that "*this training is very timely and very useful for me because we are in the process to, design this [kind of] activity, so really, really useful".* In a similar way, Ana explained that *"when we started a programme only in 2007, we didn't know what actually are the elements that has to be put in place in a crisis. We were really groping. So, the training for us provide the directions on how we could implement the programme. So, ah, it's a major major help in terms of doing that".*

Part of this type of response was an appreciation that the training had presented them with new, novel or interesting ideas. Some, such as Benedict, spoke of the contents in a 'revelationary' type manner:

> *So then while in Sydney [at the SPRINT Training] I discovered that while I had been responding to health emergencies and disasters, I appreciated that there is really a need for integration of this approach, like MISP because we are more concerned with medicines, drugs, sanitation, but we were not concerned with the needs of women, in, ah, crisis. So it's a realisation on my part… to really, ah, include especially in our planning and implementation during disaster response. So that was my realisation during that ToT.*

Others expressed an interest in the training content as it had provided them with a new lens through which they could perform their existing work. William speaks positively in this way, explaining that:

> *[I was motivated to be involved because] well because it was a bit different, you see? You know cause I've been practising and been in clinical obstetrics and gynaecology for many years. But this was a bit different in the way that it approached the subject. And especially the logistics of it. I really like this exercise, yeah, it's a fantastic exercise.*

But the rest of the stuff, it's a bit ho-hum for me because it's the same old stuff over and over again, you know.

In addition to the relevance of the contents to work roles, participants working in areas susceptible to humanitarian crises and in settings which were directly represented in the training contents were likely to speak positively in terms of the relevance of training contents and objectives. Sujana explained her position in the following way:

I work for [my organisation] as a humanitarian officer, we have the Humanitarian Unit in our office because with finding from the situation in [my country] that we are, ah, vulnerable to the disaster so our office established the unit called the Humanitarian Unit… I think [the MISP] very very useful because it's like a very initial package. And what, and what I learned is that why people are a bit reluctant to provide RH in emergencies because they think that to provide RH in emergencies is very very complicated…but I told them with MISP we really do not need that complicated process, like implement with very limited activities so I think that it is very very useful to ensure that people have access to RH in emergency situations… (Laughing) so that's why I'm so happy when I hear there will be a training for MISP so I really really want to start the training in [my country].

Understandably then, those participants who could not relate the contents and objectives of the training to their context commonly stated that the training was not for them or their country. A number of participants commented that the training was more for larger or less developed countries, or suited better to conflict settings than natural disasters. In comparing the contents of the training to the situation in her country, Simone concluded that:

In terms of crisis, um, it's not so useful in our country. It's just a small island and very small population, if some people were displaced because of a crisis it's, it was not that, it won't be that severe. It's not as much need compared to bigger countries or Africa…It's not, I mean it's more applicable to bigger counties, very big populations and they are displaced by wars and all this. But it's not much in my country… Because we don't have big crisis, nothing, I mean except for just a strong wind, cyclone, but it doesn't get that bad, I mean, to make people homeless, no. I mean even a big major cyclone, people are just normal…No gender based violence. Rape is not a problem. It's not. This may be very useful for Solomon Islands, Papua New Guinea, but not [my country].

Further to this, the particular phase or type of disaster commonly or presently experienced within a country influenced how relevant participants felt the training was to their work. In a number of instances, it was mentioned that the MISP, although devised as a minimum package of services and supplies, provided a higher standard of care than was available in their setting during non-crisis times. This was particularly the case for those from contexts with generally poor SRH outcomes, those who had faced a constant state of crisis in one of the health components contained in the MISP, and for those experiencing a protracted crisis situation. Chan, for instance explained that:

> *In [my country] now, it's like, ah the post disaster because we have problem for a long long time, we suffer from so many years, not just after disaster… So many women in my country really really need reproductive health and many woman face this problem because during the delivery, I can see with my own eyes when we go there, they don't have any health care, they don't know how they can get help with delivery and then they get stuck like this, they have to put the person in the hammock and carry from there to health centre and then at health centre, woman already die.*

Those participants who saw some relevance of the training to their context often asked that the content be further contextualised to their particular country situation. Chan again suggested that facilitators "*get more information how to make it work for each country, and then you can understand what different situation between one country to another county and how we can work on advocacy, maybe you can give us some advice".*

In addition, several participants questioned particular content areas of the training. Sexual and Gender Based Violence were often highlighted as being especially challenging. Recalling her experience in addressing SRH in emergencies, Sujana explained that:

> *Gender is also, like GBV is also a difficult component. Maternal health, STI are a bit easier because maternal health, maternal mortality is really the concern, main concern of our country so if you want to reduce maternal mortality then people will really support, but GBV this also still big challenge for example when we talked about GBV in [a previous crisis] it was difficult because [in that area] was very, very long conflict, still like a sensitive issue.*

Training conduct and instructional strategies

Comments on the instructional strategies employed during this training were generally positive and seen to be easily transferrable to different learning contexts. Jon is representative in his statement that "*mostly I think [the instructional strategies are] appropriate to our context. I think ah, most of them are quite similar to the methodology of the trainings in our context. I will just to repeat or duplicate the methodologies".*

However, the breadth of content was highlighted as being potentially problematic for participants. Respondents noted that the training included a mix of three separate outcomes and a number of content areas. Sujana explained that if she were to conduct echo-training workshops in her country, she would "*really need guidance, yeah, this is not the easy training, beside management side there is also technical side. As a trainer I should really have sufficient knowledge on gender, on STI, on so many technical. I'm worried that I can not cover all (laughing)".*

Related to this too was the match between the training content and training objectives. Training participants reported on how well the training content was able to equip them with the knowledge and skills to meet each of the three stated learning objectives. Advocacy and coordination were found to be generally well supported by the training content and instructional strategies (being related more closely to other factors such as a participant's position and influence). However, participants raised concerns about the training objective of on-training or echo-training. Lee remarked that:

> *[I]n terms of programming, I'm better than before. I see that it's very good for programming when we come back [to my country]. But in terms of building up the training capacity, for trainer, here is not enough. And in the time for practicing, the time for, ah the trainer of future to know about how to training and which contents, which training is required, I mean the time is not sufficient. Because for advocacy is enough. For learning content is enough, for trainers is not enough time for them to, you know, to know about the training agenda, so I think we should, ah, draw some lesson learned and make some adjustment for coming training in other regions.*

Support from SPRINT

A number of participants remarked that they appreciated the level of support available from the SPRINT Secretariat and the enthusiasm of those involved in the programme for this work. In an illustrative comment, William remarked that this was "*the main reason [I wanted to be involved], and I think the fact that the people out of KL were so helpful, always enthusiastic. If they were a bunch of, you know, dumbasses, I wouldn't be involved in this thing. Yeah, so they're keen and they want to spread it out so I'm also keen to do my bit".*

A number of participants said that they would request support from SPRINT on return to their contexts. This support included technical assistance, assistance with advocating to national mechanisms (such as ministries of health and emergency management) and assistance in facilitating echo training. Participants also expressed interest in maintaining networks formed at the Regional Training of Trainers and looked to SPRINT to facilitate this. A SPRINT network was seen as a positive step to share experience and learn from peers and colleagues.

Team member capacity

Participants commented on the different levels of expertise and capacity in their SPRINT coordination teams, and related this to the content and objectives of the training. Team member capacity was usually discussed with a level of concern about the ability of fellow team members to take action towards the training objectives independently or as part of the country team. This is exemplified in Lee's statement that:

> *[T[his exercise is the combination of advocacy, coordination and ToT training, so that's why, like [Khan], he already have some background on the training for health and I myself, I don't have, and ah, [ministry of health colleague], I'm sure he doesn't have, and I don't know about Madame [Mai], but at least most have no background on training, so to some extent that, in terms of selection, choosing participant for next workshop, you need to be very careful…And you can too ask us, I'm sure many of us here, we not be using the training activity because they come from different background.*

Team member position and influence

Some trainees felt that one or more members of their country team was well positioned to access appropriate stakeholders at the correct levels of government or within their

organisation. Such comments were emphasised and stated in reference to the advocacy and coordination objectives of the SPRINT Training. Speaking of her fellow SPRINT coordination team member Benedict, Ana stated that:

> *[Benedict] is high up in the hierarchy… So at the policy level and even at, because they are in charge of implementation, so he's able to bring in all of the coordinators under department of health, the two sexual and reproductive health and the disaster, the [Health and Emergency Management] coordinator…it's important that you make the proper connections in the proper time. The key are the regional directors who are the buddies of, the colleagues of [Benedict].*

Participants also noted that in some circumstances there was no such team member or existing contact with those in a position to meet the training's objectives. Lee explains this clearly in her statement that "*you ask us, I'm sure many of us here, we not be using the training activity because they come from different background, different level of power, many of them are not decision maker, we are lucky to have [a SPRINT team member from the ministry of health] here, but many of them is not decision makers".*

Heng also explained his concern at the composition of his SPRINT coordination team, mentioning that:

> *All our organisations are representative from the civil society, so what we are discussing is it's better to have another one or two person from the government side and from the NGO side that the government respect very much and listen and talk to from both sides. So we may request you to, ah, invite another from the government side and other people from [UN organisation] to attend this kind of training because two people to work big issue…to try to advocate our message to the government, to the other relevant stakeholder… We are thinking about how can we convince my senator (laughing) or my minister, health minister to be involved, think about that is a bit difficult for us, have to say.*

Organisation level factors

Existing perceptions of conditions existing at an organisational level were frequently described by participants. Importantly, as this research was undertaken at the close of or during the final stages of the SPRINT Training of Trainers programme, factors listed here are based on participants' memories and perceptions of job characteristics and their work environment.

Transfer climate

Cues within the transfer climate were found to be important factors for participants, and the most commonly mentioned component of these was the presence of resources within the organisation that would support trainees in pursuing SPRINT's training objectives. These resources were noted, both positively and negatively, to include monetary support and equipment. A number referenced the difficulty they believed they would experience in accessing funding, including Lin who related that "o*f course funding will be a very major problem to us, we definitely not getting it from anyone, and everybody claims they give a lot of money".*

Another important aspect of cues within the transfer climate was related to participants' perceptions of opportunities to perform skills they had learned when they returned to work. A common reason underlying these perceptions of opportunities to apply learning had to do with the granting of time and permission to undertake this work. For some, duties consistent with the training objectives of SPRINT were already integrated into their job descriptions and work plans. Speaking of colleagues involved in health and disaster management, Benedict reported that *"by integration we mean that they include in their usual activity also, of course, to include that in their work and financial plans. Maybe, so that they can implement MISP during disasters".* In a similar way but speaking of her personal situation, Sujana expressed her confidence in moving forward with this work, explaining that *"it's a lot of work actually, but my office is really committed to this, we have allocated the fund…I already know that because I put it through my annual work plan, it already approve by my country, by my office, but I will do my best to make it happen".*

Other respondents were confident about their ability to incorporate these new tasks into their scope of work. Lee, for instance, explained that the UN agency she worked for had already committed funds for this type of work, so that she would only need to "*advocate for the allowance for this and look at our current activities and to integrate or even, you know, submit the work plan".*

Others spoke less confidently about their ability to introduce new tasks into their work plans. It was not uncommon for those interviewed to state that the demands of SPRINT's objectives were additional to their current work. Benedict, for example, explained that his fellow SPRINT

trainees *"belong to the different organisations and we have our own jobs, additional for all jobs is this MISP…[W]hat I think would be my role, is for advocacy especially, in my organisation to do that".* Ana also explained that for some of her original SPRINT coordination team members, "*they have other activities, they are, its, ah, because they have their own [work] and there are also limited number of people".*

Along with the presence of situation cues that prompt action towards SPRINT's expectations, consequence cues, or repercussions for not undertaking this work were mentioned by participants. As SPRINT was an outside agency initiative, the issue of supervisory control was frequently mentioned. This included questions on how to access team members from other organisations, place demands on their time, or require them to take action to fulfil SPRINT's training objectives. This was seen to result from a lack within participants' organisations of over-arching supervisory control, cues to take action, or punitive measures for failure to transfer learning. Lee expressed some concern about calling participants to take action towards the training objectives in her recommendation that:

> *All [SPRINT] team members from one country should know that in the future we work together, so make sure of that, and we need to learn whether in the field we work together in the future or not. Mr [Binh], Madame [Mai], Madame [Zara] [SPRINT team members], work for another organisations, and if we want to mobilize them, we have to assess their future activities, is difficult you see.*

Benedict concurred in his statement that for those he would train within his country, "*I really don't have any supervision control over them. Even though it will be our expectation, but because they have their own regional directors, I hope that [UN Agency] or maybe SPRINT can come up with some activities like monitoring or maybe refreshing, or maybe sending some updates. And maybe, I don't know if that will be still their obligation or their duty".*

Organisational support

Organisational and supervisor support were rated as important factors by participants in enabling or inhibiting their ability to use the knowledge and skills developed during the training. However, some participants were not clear if supervisors were aware of what may be expected of them as a result of attending the SPRINT training course. William, for example, believed that:

Well, it's the selection that is important. Um, and maybe you need to target who the best supervisor is, advocate to make sure that person knows what, ah, the participant is going to be expected to do on return, hey. Well, one of the things is, you see, in [my organisation], when we run a workshop, we put that down in the letters we send out. So, we're running a workshop, this is what we expect of them, we would be grateful if you could ensure there is supervision to ensure that this is carried out.

Many others stated a need to advocate to their supervisors to be granted permission and support to take action in line with SPRINT's objectives. Chan implied that she did not know the level of support she had for the activities required to meet SPRINT's objectives. She explained that part of this was to do with the structure of her organisation and the need for those higher up to "*dedicate me like a focal point of this activity. I can take action because they authorise me to do this".*

Organisational capacity

Training participants commented on the capacity of their own organisation to integrate the expectations of the training into programming. Concerns, such as those expressed by Lin and Sujana, centred on human resources:

Most of our volunteers have their own job or they have retired and come back. Our paid staff is like very minimal. We function with minimal paid staff (Lin).

Because for immediate services we have the supplies but not automatically the providers can do it. It's because [my organisation] only has limited staff so all activities will be implemented by partners or government (Sujana).

Participants also outlined issues concerning the broad programmatic areas covered by the SPRINT Training. The combining of both SRH and emergency response in the training was new to many participants. Some believed their organisation had expertise in SRH, while others stated their organisation's experience lay in disaster response. Ana was an exception in that the organisation she worked for combined both areas. She did, however, note that this was not the norm for many training participants:

It's only now that [the NGO has] been introduced to the disaster. They, they, they don't have any experience in disasters. They have experience in family planning, but not in an emergency. But this is the first time they're coming. While the [INGO],

they're always in emergency but their mandate is you know, for general health, blood transfusion, but not sexual and reproductive health-need to mix them. So [the NGO] gets involved in emergencies and [the INGO] gets involved in sexual and reproductive health.

Organisational position and influence

The position of a participant's organisation within wider health system and political structures was an additional factor operating on an organisational level. Throughout interviews, trainees mentioned the importance of access to ministries of health, either through having a delegate from the government in their coordination team or being seen as working for a valid counterpart to state organisations. Binh explained the importance of involving government actors in the work required by SPRINT's objectives in his assertion that "*we need to understand this initiative need to have very strong involvement of ministry of health as one of ownership, because NGO, donor just both standing alone here".*

The involvement of organisational representatives who were at an appropriate level to access decision makers was also mentioned by several participants, including Lee, "*in terms of the advocacy, we need someone from headquarters [of my organisation] to come and tell [government officials] that. It's like more power for us to raise the issue in the government".*

An organisation's position within particular health and emergency management structures was also seen to be important by participants who wished to undertake work to achieve the SPRINT training objectives. Ana, for example, explained that she was generally happy with the make-up of her SPRINT coordination team, except for the presence of members from a local NGO who "*at this point in time, [are] not in the health cluster [the national health in emergency response coordination mechanism]".*

Organisational mandate

The relationship between an organisation's core mandate and the content and goals of the SPRINT Training was also identified as an important factor in my analysis. The influence of this on trainee perceptions appeared to be dependent on the type or particular organisation a participant worked for. Those originating from UN Agencies, particularly UNFPA, were more

likely to positively link the objectives of the SPRINT training with their organisation's work and mandate. Lee, for instance explained that:

> *I work for UNFPA office and we have responsible for this activity ...I think it depend because Madame [Mai] understand that she come here under the sponsor by [an NGO] and she also work for [an NGO] so I think for her own organisation, she need to advocate for the leader of that to know about this initiative and also to prepare some kind of like proposal for getting a person on side.*

It was predicted by participants that team mates from UN Agencies would most likely be nominated to lead the coordination team and the coordination team's work on return to their context, or to nominate themselves for that role due to an alignment between the mandates of these organisations and the objectives of the training course. Participants also identified UN Agencies, particularly UNFPA, or government organisations as having responsibility for MISP implementation in times of crisis. Both of these situations were explained by Sujana when she stated that in her country, "*MISP is not yet integrated into the whole emergency response, so we try to convince even the ministry of health…Usually during the emergency situation, UNFPA is the only agency always try to advocate about RH in emergency and all the supplies come mainly from UNFPA at the moment".*

Environment level factors

Going beyond the scope of training transfer factors normally discussed within the training transfer literature, my data also pointed to the existence of a wider level of factors. The 'environment level' was found to contain a number of factors which may function as barriers or facilitators to the use of new skills and knowledge in this field. This level was also uncovered in my review of literature on training for SRH in emergencies (Chapter 3), and relates to a broader layer of elements which operate above and around the individual, training and workplace factors discussed above.

Government ownership and support

Throughout my interviews, participants repeatedly referred to the important role of ministries or departments of health in any preparedness or response work. This involvement was regarded as critical, first for approval of proposed activities; second, because in many cases the

ministry oh health would act as the coordinating body for any response; and third that for sustainability and a comprehensive response it would be necessary to integrate SRH into government emergency preparedness and response plans. This was alluded to previously in the discussion of each involved organisation's position, but was spoken of in the following different ways by participants.

It was explained that in many instances, international actors would not be involved in responding to an in-country crisis. This was particularly the case for smaller scale emergencies that did not activate the global cluster system, or where international involvement was disallowed. The importance of integration into government response plans and having support from ministries of health and emergency management was also noted for this reason. Where international actors did respond, the leadership of government was still seen as important. Sujana's experience in responding to natural disasters in her context was illustrative here:

> *[A]t that time the provincial health office collapsed, district health office collapsed, so in the beginning really [my organisation] should, ah, take a lead of all the coordination but later on, the condition is possible then we transfer the leadership from [my organisation] to local authority…But for [a second crisis in my country],… this second kind of emergency situation had a different setting. For [the second crisis it was] the little bit small scale, the victim not that high as in [the first crisis] and also the [second crisis affected] province very strong province… and during the disaster the provincial health office was not affected so there was still functioning so we see coordination mostly by the government.*

In mentioning the ministry of health and the importance of their support, participants spoke in two ways. Some noted positively that they had existing support from the ministry of health (MoH), that they had a representative from the MoH on their coordination team or that it should not be difficult to garner this support from the MoH on return to their context. Lee was confident in the support she perceived from the ministry of health, claiming that "*we are lucky to have Mr [MoH] here, but many of [the other trainees] are not decision makers. Even they know all of the content, they know about the initiative, but application this is the other issue, so, support should be to the maximum".*

Alternatively, trainees explained that they would need government support, that they did not yet have government support or that they were lacking a representative from the ministry of health on their coordination team. Khan stated his concern in the request that "*we have to get someone involve in our future training from ministry of health, we need some permission from ministry of health too, because in [my country] we have committee for natural disaster,…we can get someone involved from the committee, from the ministry of health, and um, department of RH, and, ah, to support it".*

Policy

The importance of having government policies supportive of MISP implementation was also highlighted by many participants. Work towards the integration of SRH into policies, plans, protocols and guidance documents was seen as vital for implementation, the guaranteed involvement of important stakeholders, and the sustainability of this work. Lee, for example, stated that "*the issue of policy is very important"* and a priority of her post-training action would be to review existing policies and frameworks to assess the visibility of SRH within their health components.

In a similar way, Sujana emphasised the need for policies which would support implementation of the MISP. In relation to contingency plans which were being developed at the time of our interview, she stated that:

> *to have the contingency plan at all level, we really need the commitment from the government, the ministry of health do not have the policy yet for the contingency plan so when we go to the district or go to the province, it is still difficult for us to convince them, so we really need to encourage the ministry of health to have the policy-for example, the ministry of health will say everybody should have their contingency plan in place. So, with the policy, that will be easier for us.*

Health system capacity

In addition to governance or leadership from relevant authorities, participants frequently discussed existing capacity within national health systems, commonly recognising the importance of supportive functions across the breadth of the health system and at the many administrative levels which comprise a national hierarchy of health management. The importance of having strong structures in place prior to a humanitarian emergency was

appreciated, as was the important link between capacity and resilience. In discussing the varied strength of sub-national health systems in her country, Sujana explained that "*[the crisis affected provinces are] very strong provinces, that's like, ah, the best, ah number second or number third best provinces related to health so the health is strong, strong health system so also have a very good performance during the disaster".*

In line with Sujana's reference to health systems at a provincial level, trainees frequently remarked on the importance of building or developing human resource capacity at multiple administrative divisions within each country. A lack of capacity on multiple levels was often expressed as an issue of concern. This was reported to be, first, a lack 'above' the focus of the SPRINT training, that is, insufficient knowledge amongst important decision makers and key stakeholders. Benedict noted that:

> *In areas that they have operational disaster coordinating councils [DCC], I think that will be an opportunity- for areas with not-functional DCC that will be a challenge. And of course, a priority for the local government chief executive, ah, if and when the chief executive has the knowledge and importance of this, it will be one of the priorities. But if the chief executive is more inclined to the reason like the economy, that would be maybe less of a priority.*

Second, several participants reported a lack of human resource capacity, 'below' the coordination focus of the SPRINT training, or concerning implementers and service providers. Ana provides the following explanation of this concern:

> *So the gaps are down there and up there. We have the training here, this is for the technical people, for the trainers but implementation-wise we just cannot have the SRH and [health and emergency management people] trained without the service providers having that particular lens and then at the same time the bosses not having an understanding what MISP all about. It needs to be supported up and down, can't just with the middle. So like, right now we are in the middle. So it's not enough to just roll out [SPRINT] echo trainings. It will have to have support as I said, up and down.*

As well as stating the importance of addressing multiple levels within the health system, participants noted that numerous government sectors and external agencies were needed for successful preparedness and response due to the scope of activities included in the MISP.

Again, Ana's explanation of the breadth of organisations required for MISP implementation is representative of others' concerns. She remarked that "*SRH is basically health, and, ah, social welfare but we have to look, because in the process of implementing have to look at what structures you have to deal with at the local level, so, it's important that you make the proper connections in the proper time".* Lee, too, noted the complex environment and the involvement of "*the committee for prevention of natural disaster, such as flood, and ah, landslide. The members of this committee are from many ministries, the ministry of health, ministry of agriculture, and rural development, ministry of finance, and a lot of involved agency".*

As a further component of the health system within countries, participants also indicated their concerns about funding and the provision of commodities and supplies for implementing the MISP. Lee used her experience in responding to natural disasters to emphasise the importance of establishing and maintaining supply lines:

> *First is to review policy, good enough or strengthen the component. And the second is training, and the third is supply, we have some kind of regular supply to maybe move for supply for natural disaster. So, and also the other way the ministry of health support is support from many other different donors and agency like UNDP, WHO, and all of these will work together and focus on different component, to ensure that the government will be quite comprehensive and plan for the natural disaster.*

International standards and protocols

In a number of instances, participants explained a difference between international standards, policies, protocols, practices and expectations, and those required or allowed by national bodies. This divergence was seen to relate to the drugs included in the MISP's reproductive health kits, international drug protocols, and international guidance on the scope of practice for service providers. Sujana explained that:

> *The number of days [of the contraceptive pill provided in the kit] is different, so we distribute the kit and then the midwife is worried to use this pill because we do not usually use this pill we have different one and then before providing the services at the [in-country humanitarian crisis], we call all the…head of the health centre and then we explain one by one the kits because the guideline also in English, all the instruction all is in English so a little bit difficult so we have translated the guideline RH kit guideline into [our language] but still to use the kit we need to explain.*

More directly, Lin expressed her doubts over the suitability of the international standard RH Kits which accompany the MISP by asking *"[w]hat I'm not going to give [midwives] is kits, these are maybe going to the Uganda or other places. There's no way I'm going to give them, no way".* Likewise, Benedict suggested *"in [my country] we do not demonstrate the use of the vacuum, manual vacuum aspirator [as was included in the SPRINT training], it's not really allowed for an ordinary health worker to do manual aspiration and a curettage, so we deleted already".*

Society and culture

Participants explained that aspects of the wider sociocultural environment could affect their ability to transfer the training. This was thought to be of particular importance given that the contents of the training was SRH. For some, such as Sujana, it had proved difficult in the past to gain the trust of local populations:

> *The first time we arrived it was, the people is not easily accept us because after a long long conflict so it was a bigger problem to get a trust from the community to get them to accept us was also, but then the [natural disaster] and the situation changed. I don't know, it's like God tried to solve the problem (laughing). And after that the peace agreement and the conflict ended. Now people can go to [that area] with a secure feeling.*

There was a perception throughout these interviews that certain aspects of SRH may prove more problematic for transfer than others, most notably sexual and gender based violence and condom distribution during crises. Beneficiary characteristics were recognised as being a particularly important aspect of this socio-cultural environment and the character and position of populations with which participants have attempted to, are attempting to, or will attempt to serve was significant. Participants noted a reticence amongst beneficiary populations to discuss or accept SRH services during times of crises. This related to SRH as a whole, or was restricted to particular aspects of the MISP. Several participants, including Simone expressed assumptions (made from a lack of direct experience) that for beneficiaries:

> *The topic itself [SRH], is like a big no to them... Why are they talking about sex? Why these people come and talk about sex?...They feel like it's not a priority, it's not important. Yeah, it's not for them. If you say like, during a crisis we might give you some food, some water, oh! They'll love it. Yeah, thank you, we need that. We*

give you shelter, yeah we give some canned food so you don't have to cook or look for fire wood, yeah, but we say we're going to give you condoms, what for? We don't need it (Simone).

Sujana, however, represented those participants who were speaking from their experience in addressing SRH during crises:

I was not really comfortable with the distributing condoms during an emergency because we did it and the people like, ah, questioned us 'this is emergency, why you ah, distributing condoms, it's really not appropriate'. But later on I learned that the, for preventing HIV/AIDS, we really are not directly distribute the condom, but we will make the condom available. This totally different. Previously I was thinking, why we need to distribute condom because people will complain us, we need food, we need water, this really not appropriate for you to distribute condom, then I discuss a lot with [a training facilitator] and [he] said actually MISP do not recommend to distribute condom, but we will make the condom available for the people who previously using the condom. Like we keep the condom at the health facility, put the condom at the public facility so the people can access them. Then after that I feel really really comfortable.

The influence of training transfer factors on post-training self-efficacy, post-training reaction and post-training knowledge

The individual, training, organisational and environmental factors discussed above were found to have important correlations with the three proximal training outcomes of post-training self-efficacy, post-training reaction and/or post-training knowledge. Literature on training transfer indicate that these three proximal training outcomes have a significant impact on both a trainee's intention to transfer newly developed knowledge and skills, and on the eventual transfer of training. The linkages between the *training transfer factors* described in the preceding section and three proximal training outcomes are explored in detail below. I have included this secondary analysis in order to provide insight into the influence those training transfer factors specific to SPRINT training have on proximal training outcomes and intention to transfer.

Post-training self-efficacy

The first proximal outcome considered at this stage of research was levels of participant self-efficacy for each of SPRINT's objectives. Individual participants expressed beliefs about their capacity to pursue the work SPRINT required of them throughout the interviews analysed here. These judgements of confidence were identified when participants spoke positively or negatively about levels of *confidence* in their ability to perform tasks expected of them by the SPRINT Training.

Links between individual level factors and post-training self-efficacy

As could be expected, strong correlations between *prior experience* and positive self-efficacy were found. These relationships were entirely filtered by the particular objective being discussed at that time. Those participants who had *prior experience* working in SRH for humanitarian emergencies were likely to express high self-efficacy for the training objectives of advocacy and coordination. These participants most often, however, judged their capacity for conducting further training as low. Those respondents who had *prior experience* limited to SRH only or humanitarian work only reported low self-efficacy for all three objectives-advocacy, coordination and training.

Participants who described previous experience as a trainer were likely to have higher self-efficacy for echo-training than those with no prior trainer experience. Those with prior advocacy experience reported positive feelings of self-efficacy for both advocacy and coordination, but not for training.

Those participants who reported that they were in the correct position and had the required influence to affect change in line with SPRINT's objectives were likely to report high levels of self-efficacy for advocacy and coordination and in some instances, across all three objectives.

Links between training level factors and post-training self-efficacy

Requests for post-training *support from SPRINT* were found to be negatively associated with self-efficacy in this analysis. Those participants who stated a need for help from the training providers were likely to doubt their capacity to undertake future work, particularly in regards to the advocacy objective.

Capacity within SPRINT coordination teams influenced individual participant's feelings of self-efficacy. Those who lacked experience or capacity themselves were more likely to report low confidence if they believed their team mates exhibited similarly low levels of capacity. Likewise, doubt in team members' ability to access stakeholders or decision makers who could facilitate progress toward SPRINT's objectives led to low self-efficacy for those who were themselves not in the required position or did not have needed influence.

Links between organisational level factors and post-training self-efficacy

All of the organisational level factors identified through my analysis were found to have some impact on post-training self-efficacy. Indeed, the employing organisation had a significant influence on how the trainees regarded their own ability to follow through on the work expected by SPRINT. Bundled into this association with a particular organisation are a participant's perceptions of *organisational capacity*, the *position* of an organisation and the *organisation's mandate*. Representatives from UNFPA and ministries of health were more likely than others to report confidence in their ability to advocate for and coordinate MISP preparedness and response. Trainees from both of these organisation types, however, expressed generally low levels of post-training self-efficacy concerning the echo-training objective.

Participants who worked for NGOs or INGOs expressed low levels of self-efficacy particularly in regards to the advocacy and coordination objectives, but also in terms of undertaking future training efforts.

A participant's perceptions of their specific *transfer climate* and their belief in the existence or absence of support from a direct supervisor or the organisation more generally had an influence on levels of post-training self-efficacy. In addition, their understanding of the availability of resources (including time, budget and equipment) was found to have an important association with a trainee's belief that they could undertake further training and advocacy work, but no similar association was found for coordination. Positive perceptions of opportunities to perform coordination tasks were associated with high self-efficacy for the coordination objective. Acknowledgement of existing supervisor support was identified as important in prompting positive self-efficacy for training and coordination.

Links between environmental level factors and post-training self-efficacy

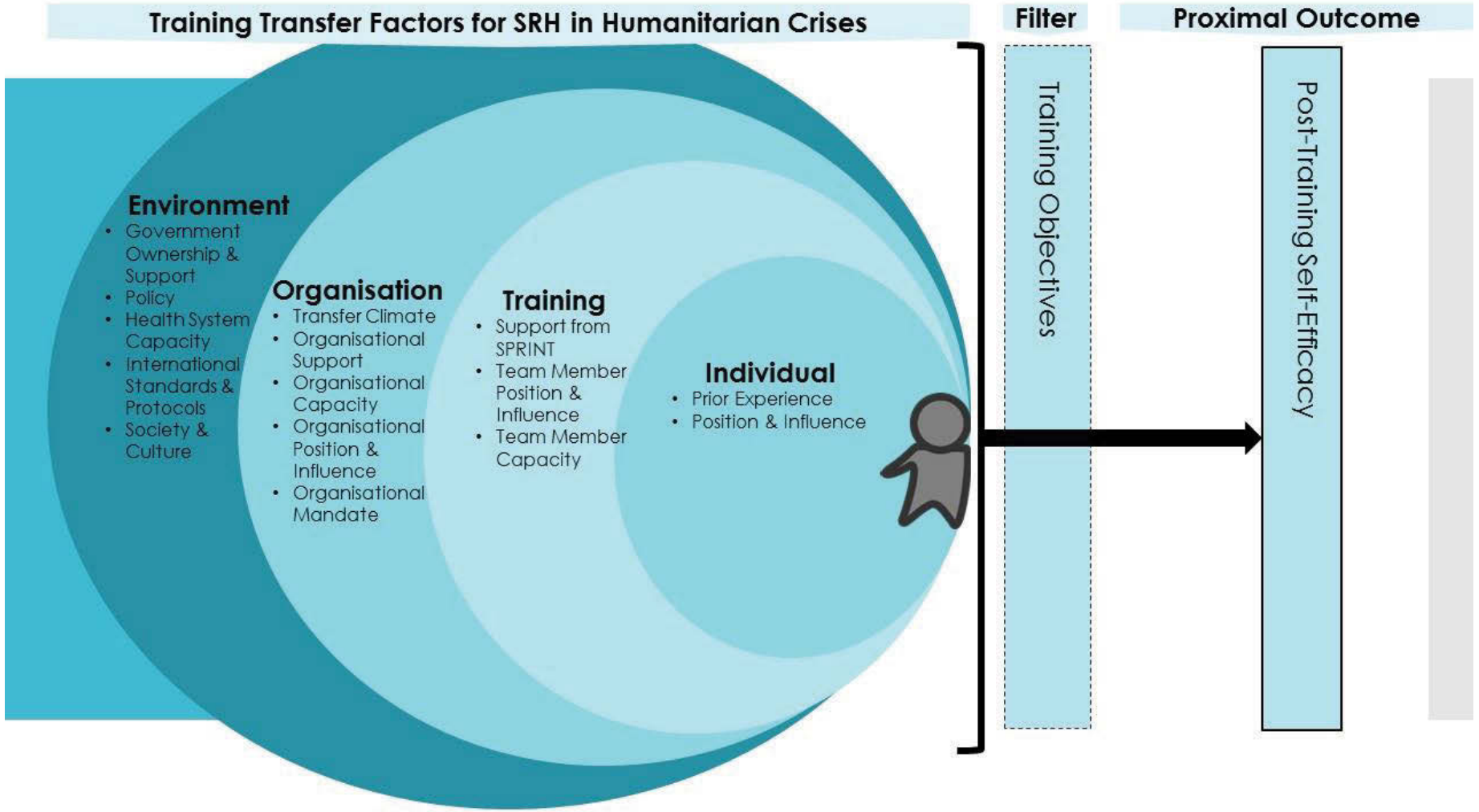
Existing *government ownership and support* for actions required by SPRINT was found to be associated with positive self-efficacy for advocacy and coordination work. Connected with this, government *policy* on SRH, health, and emergency response was related to positive self-efficacy if existing policy was supportive or if it was seen to be possible to make changes to existing policy.

Perceptions of a lack of capacity within the broader health system was found to be related to lower levels of self-efficacy. Human resource issues, including numbers of qualified staff and knowledge of important decision makers were reported by participants as potentially undermining their ability to undertake training and coordination work. Respondents linked the identification of strong health systems (at a provincial or district level) to higher levels of self-efficacy, particularly for coordination efforts. A mis-alignment between national and *international standards and protocols* compromised self-efficacy for those participants who did not believe they were in a position to achieve required change, or for trainees without the capacity needed to work around these potential barriers.

The socio-cultural context into which trainees were expected to transfer knowledge and skills developed during the training had a significant impact on participants' feelings of confidence in pursuing this work. Both from experience and expectations, respondents identified a lack of knowledge and under-appreciation of the issue amongst potential beneficiaries, an emphasis on other priorities such as food and shelter by crisis-affected populations, and a lack of trust in responders as compromising their capacity to coordinate and implement SRH services. These responses were associated with lowered levels of self-efficacy for coordination.

The links between training transfer factors and the proximal outcome of post-training self-efficacy are represented in Figure 8, below:

Figure 8: Factors Found to Influence Post-Training Self Efficacy



Post-training knowledge

The second proximal outcome reviewed for its association with the training transfer factors outlined above was post-training knowledge. Respondents expressed varying degrees of satisfaction with the level of knowledge and skills they believed they had developed as a result of attending the training, and particularly in comparison to the training objectives outlined by the SPRINT Initiative.

Links between individual level factors and post-training knowledge

Participants who had *prior experience* in SRH for humanitarian emergencies commonly expressed that they had made positive gains in knowledge as a result of attending the training. Participants who had had some involvement in advocacy work before attending the training were the next group to express confidence that they had developed their knowledge and skills, though there is overlap between these two groups.

Respondents who had *prior experience* in only one aspect of the contents covered by the training, that is, they had worked in SRH only or in humanitarian work only, were likely to comment that they had not sufficiently developed their knowledge and skills.

Links between training level factors and post-training knowledge

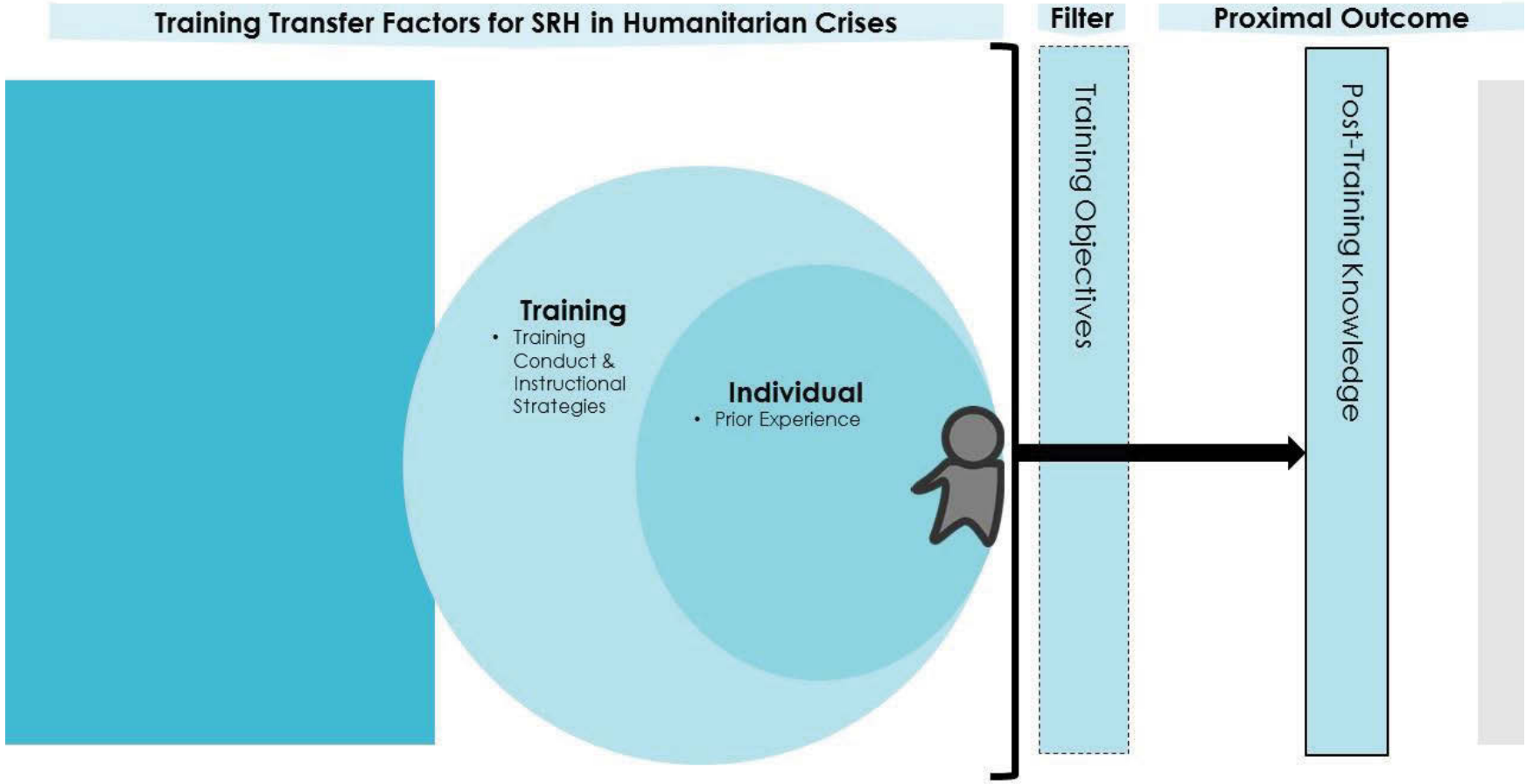
Trainees who said that they had developed their knowledge and skills as a result of attending the training were likely to remark on the quality and appropriateness of pedagogy employed. Workstations and practical, as compared to lecture-based, components of the course were particularly appreciated.

Participants who expressed some concern over their knowledge or skill development commonly remarked on the breadth of the training objectives, that it was not always clear what was expected of them as a result of undertaking the training, and that there was insufficient time for them to develop the skills needed to meet the post-training requirements of SPRINT. In terms of specific training goals, the echo-training objective was reported to be the most problematic. It was repeatedly noted that the 'training of trainers' components of the course were insufficient and would not equip trainees with the requisite skills to roll-out workshops on return to country.

More broadly, those participants who perceived a post-training deficit in their knowledge and skills mentioned that in general the training was not enough to meet the objectives but would, instead, need to be supported by robust advocacy work.

Associations between training transfer factors and the proximal outcome of post-training knowledge are represented in Figure 9, below:

Figure 9: Factors Found to Influence Post-Training Knowledge



Post-training reaction

The final proximal outcome found during this phase of research was the reaction of participants to the SPRINT Training. Individual participants reported affective and utility reactions in both positive and negative ways. They also expressed different attitudes toward the transfer behaviour expected of them by the SPRINT Training.

Links between individual level factors and post-training reaction

Participants who were positively *involved* with their work tended to react positively to the training programme. Those who were not actively involved with their jobs or were involved with work which lay outside the scope of SPRINT's content and/ or objectives were more likely to react negatively to the training.

In a similar way, respondents who expressed a *personal engagement* with the issue of SRH in humanitarian crises or with people affected by disasters consistently reported that the training was needed and useful, thereby exhibiting a positive utility reaction. Those who displayed no personal association with SRH in crises were more likely to react negatively to the training course.

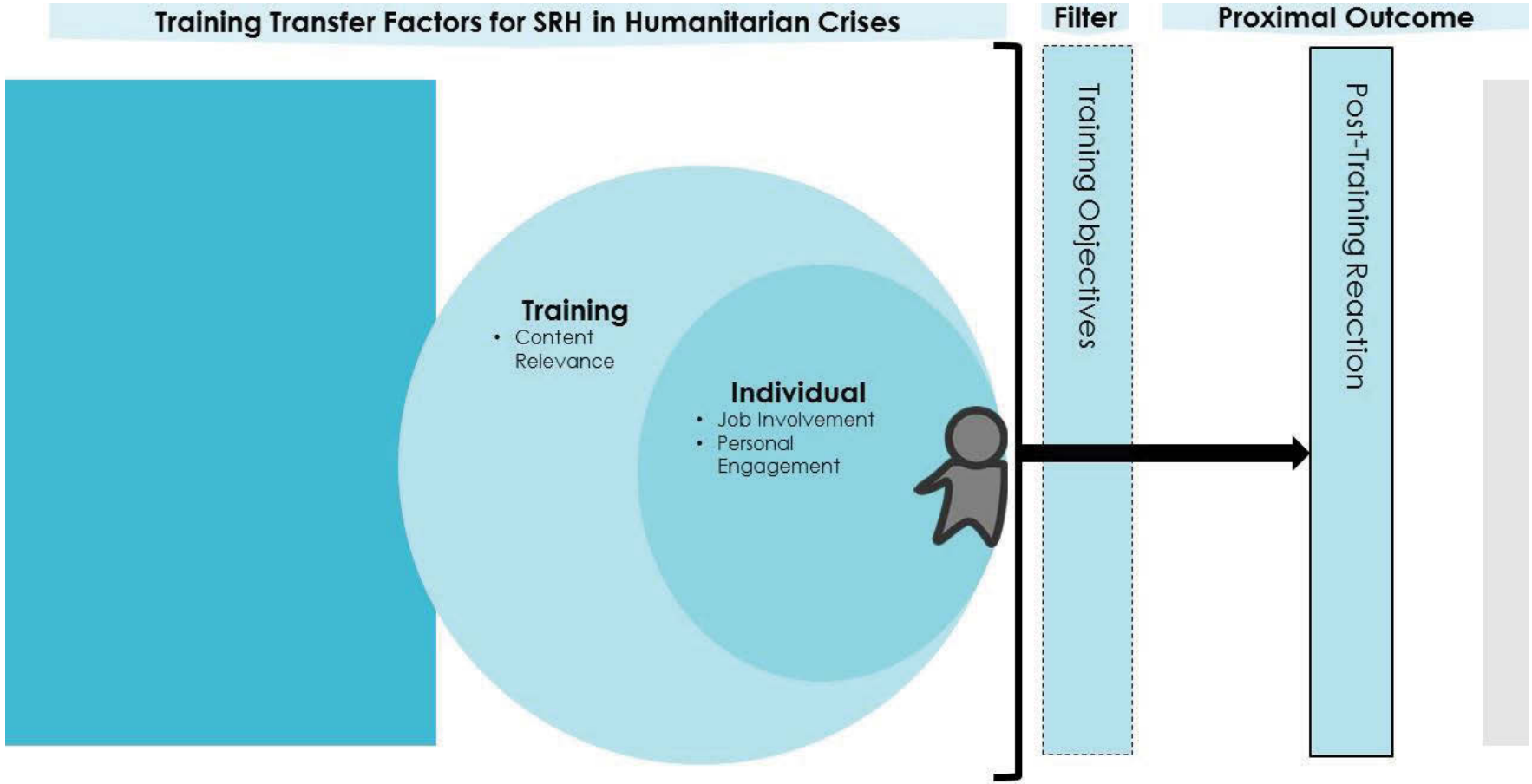
Links between training level factors and post-training reaction

A trainee's perception of the relevance of training content to their work and context was found to have a strong link to their post-training reaction. Participants presently involved in work aligned with the SPRINT Training's objectives reacted positively to the perceived utility of the training for their everyday tasks. However, those respondents who stated that the training was irrelevant to their work or national context consistently expressed a broadly negative reaction to the training. These negative reactions included statements that the training was not practical or needed, or that the subject itself was not credible or convincing.

Those participants who expressed an interest in the training contents due to its 'novelty' or newness consistently did so in association with positive remarks of their learning. In all cases, comments regarding the novelty of the content were made to show an appreciation that the training had 'taught' them a new way of approaching previous or existing work.

The figure below (Figure 10) provides a summary of factors which were found to influence a participant's post-training reaction:

Figure 10: Factors Found to Influence Post-Training Reaction



How post-training self-efficacy, post-training reaction and post-training knowledge influenced motivation and intention to transfer

Clear connections were found between the three post-training outcomes identified (post-training self-efficacy, post-training reaction and post-training knowledge) and how participants spoke of their intention to transfer or not to transfer SPRINT training on return to work. Perhaps unsurprisingly, respondents who expressed positive self-efficacy, had a positive reaction to the training and gained knowledge and skills as a result of attending the training were likely to state that they intended to use the training in their daily work. This was, however, mediated by the particular objective being discussed.

Positive post-training self-efficacy for advocacy was associated with intention and motivation to undertake both advocacy and coordination work after the training course. Positive post-training self-efficacy for coordination was linked with overall positive intention to transfer and also for the specific objectives of advocacy and coordination.

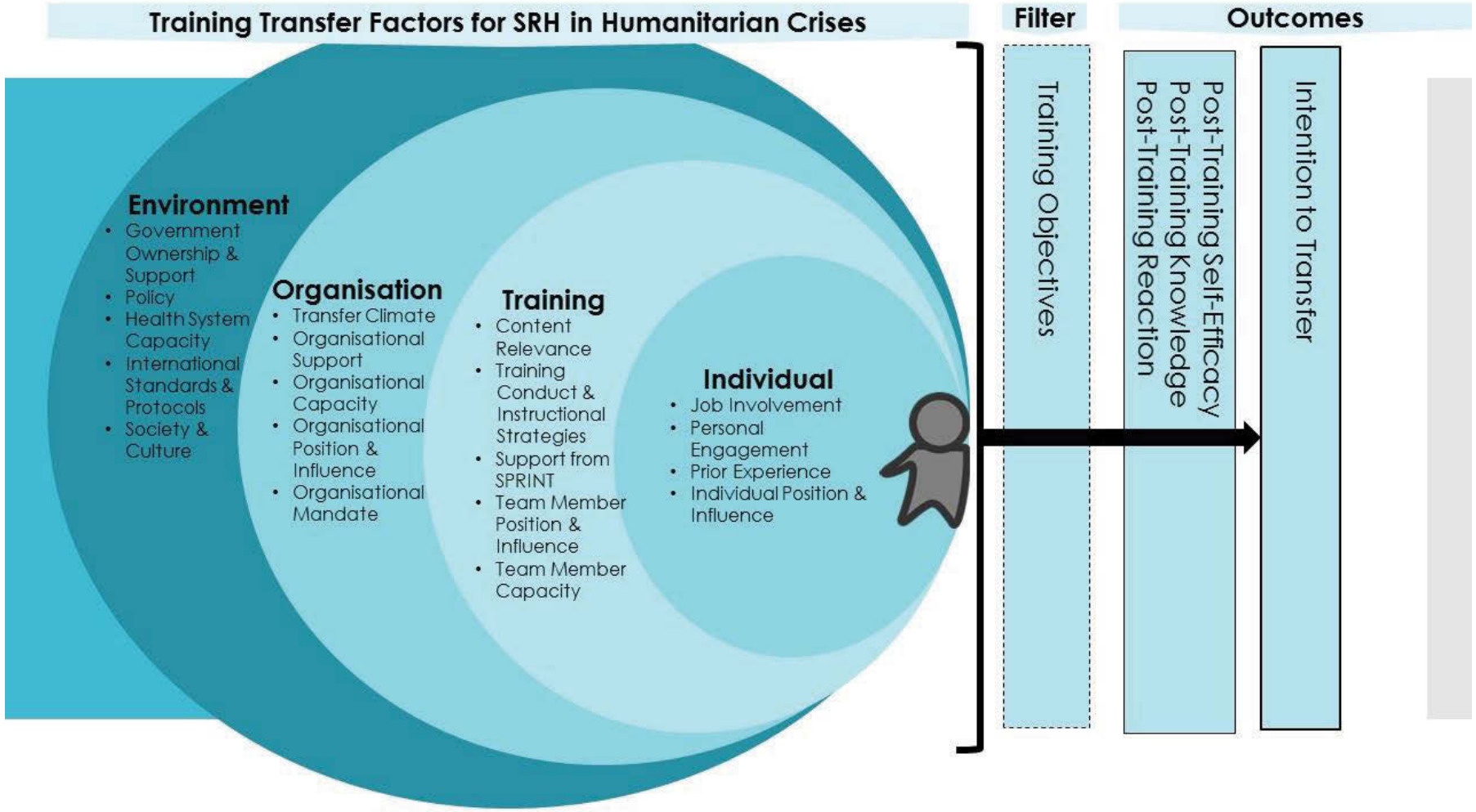
Negative post-training self-efficacy for coordination and advocacy were linked to intention in two distinct ways. First, those who expressed little confidence in their ability to advocate or coordinate MISP preparedness and response after the training often reported low general levels of intention to transfer. Second, and more specifically, participants who reported negative self-efficacy for advocacy and coordination were also more likely to express positive intention to conduct future training work, hence intending to meet the echo-training objective of the SPRINT course. A correlated affect was also noted, in that those participants who expressed negative self-efficacy for training were likely to state positive intentions to carry out advocacy and coordination work. Positive self-efficacy for training was directly related to intention and motivation to carry out future echo-training work.

In a finding consistent across the three objectives, though slightly more marked for advocacy and coordination, participants who reported a positive reaction to the training were likely to state that they intended to transfer the training to their work contexts. Those who expressed a negative reaction to the training generally did not intend to use the knowledge and skills developed during the training in their work contexts. An important, though not universal, exception to this was that some respondents who reported a negative reaction to the training still intended to conduct future echo-training work.

Post-training knowledge was found to have a clear correlation with intention to transfer. This was again mediated by the training objectives, as those who reported a sufficient increase in knowledge and skills as a result of attending the training were most likely to express both general positive intention, and intention specific to advocacy and coordination work. Interestingly, participants who expressed that they had gained an insufficient increase in knowledge and skills were likely to report general negative intention to transfer, while some also expressed a positive intention to meet the SPRINT echo-training objective.

Figure 11 (below) provides a summary of the findings presented in this chapter. The training transfer factors included on the left of the diagram are marked as antecedents to the three proximal training outcomes of post-training self-efficacy, knowledge and reaction. The influence of these moderating factors was found to be filtered by the particular SPRINT objective being discussed during the interviews. Moving to the right of the diagram, and as suggested by training transfer and intention literature, the three proximal training outcomes had a direct influence on the outcome of *intention to transfer*. As phase 1 of my research was conducted at the end of the SPRINT Training workshops, this is where my findings conclude at this stage. The next step, from intention to transfer, will be detailed in the following chapter.

Figure 11: Conceptual Model of Factors Found to Influence Proximal Training Outcomes and Intention to Transfer



Summary of Chapter 5

By analysing of interviews for phase 1 of this study, I was able to identify nineteen factors which have an influence on the intention and motivation of trainees to use newly learned knowledge and skills on return to work. These factors fell into four distinct categories- individual, training, organisational and environmental, and each had a distinct relationship with the three proximal outcomes of post-training self-efficacy, post-training reaction, and post-training knowledge. These outcomes, in turn, induced in each participant an expression of intention to or not to transfer the SPRINT training. The final step, from *intention*, to the actual *use* or *transfer* of newly trained knowledge and skills will form the basis of the chapter to follow. In the case studies which encapsulate findings from the second phase of my research, I will move from participant perceptions of factors which 'may influence' transfer to in-context realities and factors which 'did influence' the transfer process.

Chapter 6

Phase 2 Findings: The Transfer Process

Introduction

During the first phase of this study, I sought to identify and understand the factors participants believed would support or inhibit their use of the training when they returned to work. Following from this, in my second phase of research I traced the real world experiences of trainees as they attempted, or did not attempt, to transfer any learning gained through the SPRINT Regional Training of Trainers to their work settings. This was done in order to address my second research question:

> Which *training transfer factors* determine the *transfer* of learning gained through the SPRINT Training?

My focus here was two-fold. First, I was interested in understanding any relationship between a participant's intention to use the training and their levels of eventual transfer, and second, in identifying which real world training transfer factors supported or impeded any action to apply knowledge and skills developed as a result of attending the training.

For this phase of research, I examined a broad range of sources which were brought together between six months and more than three years after the SPRINT Regional Training of Trainers. On compiling data from these multiple sources, I discovered that I had a richness of information that would allow a deep understanding of the experience of my original informants. For this reason, I employed a multiple case study methodology, deliberately focusing on three SPRINT Training participants from different types of organisations, whose transfer experiences were illustrative of those of their colleagues. My first case study, Sujana, illustrates the experience of a number of trainees engaged from the United Nations Population Fund. Heng, my second informant, was selected due to his broadly applicable experience as a training participant from an NGO. Benedict, my final case study, demonstrates the particular process of transfer found to be common amongst government representatives trained at the SPRINT Regional Training of Trainers.

Case Study 1: Sujana

Personal profile

As a medical doctor working as a humanitarian officer for a United Nation's Population Fund country office, Sujana brought more than five years' experience in working in sexual and reproductive health, more than five years' experience as a trainer, and three to five years' experience in working in humanitarian settings to the SPRINT training. She had had some experience of implementing the MISP after two natural disasters in her country after "just learning from the available guidelines and documents" (SPRINT Regional Training of Trainers application form). Sujana had not received formal training on the MISP until the SPRINT Training of Trainers. In her application to attend the SPRINT Regional Training of Trainers, Sujana described her work in the following way:

> *Currently I am working for UNFPA as humanitarian officer. My main task is to manage UNFPA emergency programme and to manage the UNFPA responses to any emergency situations in [my country]. UNFPA support in emergency situation focuses on Reproductive health and gender aspect.*

Proximal SPRINT training outcomes

Sujana reported a generally positive increase in her levels of self-efficacy as a result of attending the training. This was confirmed in a survey I conducted approximately six months after the Regional Training of Trainers, in which she 'agreed' (the second highest response on a five point Likert scale) that she felt "more confident in her skills in sexual and reproductive health services in crisis situations because she attended the SPRINT Training of Trainers", and that she was "able to do what was expected of her by the SPRINT Secretariat because she attended the SPRINT Training of Trainers". An exception to this was found in comments about her own capacity to facilitate in-country trainings. She expressed some doubts about her expertise in the broad subject matter covered in the SPRINT trainings, but mentioned strategies such as engaging technical specialists to overcome her perceived shortcomings.

She reacted positively to the training, seeing its relevance to her current work and country context, stating in her survey response that she 'strongly agreed' (the highest response of the five point Likert scale) that "the SPRINT training of Trainers was relevant to her current work". In her application to attend the SPRINT Training of Trainers, she stated that she was interested

in attending the training "[b]ecause the topic of the training is really relevant with my daily work", and in a presentation on her work for SRH in emergencies at a regional stakeholders' meeting held approximately one year post-training, she explained that there was a need to address SRH for emergency settings in her country as it is a "hypermarket of all kinds of disasters".

Immediately after the SPRINT Training, Sujana stated that she had gained knowledge and skills in all areas related to the training's objectives, with the possible exception of echo-training for which she expressed some doubt in her ability to facilitate the broad range of content areas required by the training. In the six months immediately post-training, however, these doubts resolved and she stated in the survey that she 'strongly agreed' that "as a result of attending the SPRINT Training of Trainers, she has gained skills in coordinating the implementation of sexual and reproductive health services in crisis situations", that "as a result of attending the SPRINT Training of Trainers, she has gained skills in training others on the Minimum Initial Service Package for sexual and reproductive health in crisis situations", and that "as a result of attending the SPRINT Training of Trainers, she has gained skills in advocating for the integration of sexual and reproductive health into national and organisational emergency response plans".

Intention to transfer SPRINT training

In our first interview, and in concrete and deliberate terms, Sujana detailed her motivation and intention to use the knowledge and skills developed during the training on return to her context. In her application to attend the SPRINT Regional Training of Trainers, she stated that she already had plans to conduct MISP echo-training in six UNFPA country programme areas. In the interview I conducted for phase 1 of this research, she affirmed her intention to undertake advocacy work with her existing ministry of health contacts, and said she would work to implement the MISP in the event of a national emergency.

A number of training transfer factors were found to be influential for Sujana in forming these intentions. On an individual level, she exhibited positive *job involvement*, strong *personal engagement* with the issue of SRH in humanitarian emergencies and with people surviving in these settings, and *prior experience* with and understanding of training content areas. In addition to this, she reported positively on her position as Humanitarian Officer with the UNFPA. She also stated that her current contact with decision makers in the ministry of health was of benefit in pursuing this work.

In regards to training level factors, Sujana had consistently positive perceptions of training *content relevance* (as discussed above), but did feel that she would need technical support from the SPRINT secretariat to successfully carry out future echo-training work. She felt that she had strong support from her organisation to apply the training and that this took the form of both budgetary commitment and permission and encouragement within her organisation. Further to this, Sujana stated that the objectives and overall goal of the SPRINT Initiative aligned with her organisation's mandate and that her organisation was in a position to access the people required to support this work. Her one concern was with the limited human resource capacity of her team and the need, therefore, to rely on implementing partners and the government.

In considering factors in the wider environment, Sujana reported that the ministry of health was supportive of addressing SRH needs in crises, but that this support would need to be consolidated and formalised through future advocacy work. Part of this would need to be a change in policy to incorporate SRH into existing ministry of health and emergency management regulations and procedures. She also stated the need for other involved entities, including UN Agencies such as UNOCHA and UNICEF to be made aware of the MISP and to support its implementation. The varied capacities of health systems at a provincial level were noted as possible supports or impediments to transfer, as was the level of understanding that potential beneficiaries had of SRH services in humanitarian emergencies and the relationship between MISP implementers and these populations.

Personal and professional changes as a result of attending the SPRINT training

Sujana reported significant changes as a result of attending the SPRINT training. In our final interview, she conveyed that "the training more affected me personally" by opening her eyes, broadening her networks beyond UNFPA, increasing her personal understanding of SRH in crisis situations and inspiring her in her work toward providing services for beneficiaries. Professionally, she stated in the survey administered six months after training that both her day to day work and job description have changed as a result of attending the SPRINT Training of Trainers, in that capacity building on the MISP and conducting echo-training workshops in-country "becomes our main programme activity". This was confirmed during our final

interview, and extended to benefits she felt her organisation had gained as a result of her attending the training:

> *[A]fter the training, then we changed all of the programme strategy. Before, as I mentioned we had ad hoc programme, we just do whatever we want to do but after the training we can see we need to have a more strategic way in implementing our programme so our goal to integrate MISP is because of this training ... Of course, my organisation benefit from the training.*

Post-training transfer achievements

In the just over three years between my first interview with Sujana during the final days of the SPRINT Regional Training of Trainers and our final interview, I have followed her work through various monitoring and evaluation documents, the aforementioned survey, conversations and discussions, and my attendance at a number of her presentations during conferences and stakeholder meetings. I have seen her SPRINT coordination team disassemble and have tracked her efforts in leading her UNFPA colleagues to push forward the issue of SRH for people living in humanitarian settings and am able to provide the following outline of her achievements across SPRINT's three training objectives:

Advocacy

On return to work after the SPRINT training, Sujana explained that she recognised the need to think strategically to develop a comprehensive programme in the area of reproductive health in emergencies. She identified that the first step toward this was that *"we need to have the policy and strategy intervention because I cannot just introduce MISP and then try to implement in a national way if I don't have like a legal document for that" (final interview).* This awareness led her to review existing policies and associated documents to ultimately find that *"there was no article, anything about reproductive health in humanitarian situation" (final interview).* Her first goal then was to integrate mention of the MISP into the existing decision letter of the ministry of health, a general guidance document for health and disaster management. After two years of advocacy, Sujana reported that the MISP was incorporated into this document on its revision and that the decision letter had been upgraded from a general guidance document to a health regulation on health and disaster management. At the time of our final interview she and her colleagues were waiting for final endorsement of these new regulations by the ministry of health.

Once integration of the MISP into the key overarching legal document was achieved, Sujana stated that she was not convinced that such national guidance would translate into provincial and district level action:

> *[S]o we, we have the legal so the minister of health can ask all the people at the provincial level, at the district level to follow this regulation because in [my country] another challenge is the local autonomy, this is a like decentralisation… [W]ith the decentralisation…it's also challenging because not necessarily all the national level policy will be translated into the local policies (final interview).*

As a result, she saw the need to integrate the MISP into the technical guidelines on health response in disasters. These are the official guidance documents followed by the ministry of health's disaster centres, a system of *"regional offices to help, to make the assistance closer to the province and district because if everything is centralised, maybe to respond to acute crisis will take some time…so they use the regional office to manage to make closer the assistance and to make the response faster" (final interview).*

Sujana believed that targeting these technical guidelines was an important strategic step in ensuring that the MISP was not only recommended by regulations but addressed through technical guidance by the disaster centres. The previous version of these guidance documents was endorsed just prior to her attendance at the SPRINT Training and did not include mention of the MISP. When they were due for review, Sujana and her colleagues attended *"many workshop during the revision and then last year MISP was integrated into the national guideline plan and it was already endorsed in 2010 already printed" (final interview).*

Training

The second component of Sujana's strategy on return to her country was to *"improve the capacity of the already skilled health provider in the region but maybe they don't have the skill on MISP" (final interview).* Within the first six months after the SPRINT Training, Sujana led the facilitation of a national training of trainers, and at that time planned to roll the training out to five provinces covered by UNFPA's regular country programme. In line with her policy work, however, she and her colleagues decided on a change in strategic direction to instead *"really focus to strengthen the nine regional [disaster] centres" (final interview)*, explaining that *"we realised if we support these five provinces but disaster happen outside of these five provinces it is not really strategic because [my country] has [many] provinces" (final interview).*

On the threshold of undertaking training of staff at the nine regional ministry of health disaster centres and with funds released for this work Sujana was informed by the ministry of health that:

> *[N]ot every international training can automatically be attended, we need to like fully implement everything so we need to do adaptation, we need to make the training accredited by the national training centre and everything (final interview).*

This adaptation included a full revision of the training documents and key guidelines on SRH in humanitarian settings in order to ensure that the international standards outlined therein were brought into line with national protocols and available medicines. This process of adaptation took Sujana and her colleagues around ten months, at the end of which the SPRINT Training was accredited by the ministry of health training department and could, therefore, be implemented nationwide (SPRINT Monitoring and Evaluation Report 1; final interview). During this period of adaptation and accreditation, UNFPA used the already released funds to train local NGOs and INGO country offices instead.

After achieving accreditation of the training and at the time of our final interview, Sujana and her UNFPA colleagues had

> *[A]lready trained eight regional [disaster] centres out of nine. They have also two sub-regional crisis centre. For example because one regional [disaster] centre…covers so many provinces so they set up one sub-regional, and the other sub-regional…because this province was, is very very vulnerable to [natural disaster]. So eight regional [disaster] centre and two sub-regional [disaster] centre have been trained. In addition to this nine regional [disaster] centre, during the [natural disaster in one location] we also organised additional training for the affected area because they want to learn more (final interview).*

In addition to this, Sujana outsourced the translation of a number of key resources on SRH in humanitarian settings into the national language, including the SPRINT Facilitator's Manual, the MISP Distance Learning Module, Inter-Agency Reproductive Health Kits for Crisis Situations Guide, the IASC Guidelines for Gender-Based Violence in Humanitarian Settings, and the Inter-Agency Field Manual on Reproductive Health in Crises. Unfortunately, however,

> *She ended up having to review the [translated] documents in detail and re-write sections of them as the translator was not familiar with the context/SRH in Crisis and*

> *the translation was too literal and did not convey the messages sufficiently. This resulted in too much work and meant that [Sujana] had to translate all documents herself and [this] was highly time consuming (SPRINT Monitoring and Evaluation Report 2).*

As a complement to the above documents now translated into the national language, Sujana also developed a condensed guide to the Inter-Agency Field Manual on Reproductive Health in Crises to be used by humanitarian workers at the onset of an emergency.

MISP coordination

As mentioned above, Sujana is responsible for coordinating the UNFPA response to humanitarian crises. On return to her country after the SPRINT Training, Sujana had originally sought to establish a rapid RH response mechanism at a national level to facilitate coordination between UNFPA, the ministry of health and involved NGOs and professional organisations in the event of a crisis. This was planned so that *"in the case that there is a major disaster the team at national level can go to the affected area and we work together and we plan to provide the support" (final interview).* On discussing this proposal she was informed by the ministry of health disaster centres that a rapid response mechanism was already in place,

> *So with establishing the RH rapid response team means that we do the parallel system which already there so the solution was that we need to prepare a person to be integrated to join the rapid response team of the [disaster] centre so with this intervention everywhere the [disaster] centre go to the affected area this person will be focal point to organise the RH. So we cancel the plan to set up the rapid RH response team but we change shape to like a technical working group on RH in emergency at the national level (final interview).*

This technical working group has since been established and is led by the ministry of health. Regular meetings between the ministry of health, UNFPA and other involved organisations are thus held and guidance is cooperatively developed on updating national protocols as international guidelines are revised. In addition to this, *"there is possibility for ad hoc meeting if there is some emergency situation" (final interview).*

As part of her coordination role, Sujana and her UNFPA colleagues have worked to integrate the procurement and provision of SRH supplies into the existing logistics system of the ministry of health disaster centres. This became a priority as "in previous disasters, ordering RH kits

from overseas has been too expensive; there have been delays; the size of materials in the kits such as the condoms and speculum were not appropriate for [this country's] context; English instructions are provided; and many materials were wasted" (SPRINT Monitoring and Evaluation Report 1). At the time of our final interview, Sujana explained that this was a work in progress, that it was her

> *dream that later on, because the [disaster] centre, they have a lot of money so we try that at national level, at nine regional [disaster] centre there will be RH kit, we will stockpile at this area because if they always stay at the national level in case of emergency we always need to send the RH kit, maybe it's not really effective. So we have done like, the adaptation of the RH kit into the [country] context, ah, like the size, like the type of the equipment, …so we have to make the adaptation and maybe also some medicine, we need to use the medicine that is being used in [my country] and et cetera. … And then when we agree about the system, who will procure, how to stockpile the kit, how to like, ah, store the kit at the regional [disaster] centre once we agree on that then we can have that in [my country] (final interview).*

Obstacles to Sujana's transfer of training

In working towards the achievements outlined above, Sujana faced a number of obstacles. These fell into the broad levels I established earlier, with the exception of individual factors which were found to be absent for this participant. The following are, therefore, factors which were found by Sujana to negatively impact or inhibit her attempts to transfer her training on SRH in humanitarian emergencies to work contexts.

Training level

Training conduct and instructional strategies

Sujana commented that the broad focus of the training and its potentially diverse audience presented difficulties when attempting to meet the echo-training objective of the SPRINT Training of Trainers. This was particularly noted in relation to the difference in expertise between technical or medical participants and those with managerial or coordination functions:

[S]o sometimes this is challenging for us to accommodate different participants but if we are only getting the health providers, there is no management person, no coordinators, the aim will not be achieved…I don't know how to because the current module and training materials still very much mix up. If the training is designed for the coordinator but material is very technical, if this designed for the technical person, some material is so general, so I don't know maybe we need to separate that (final interview).

Sujana also felt that the SPRINT Training of Trainers was not sufficient to prepare her or other participants to be trainers. She noted that *"the title is ToT but there was very limited materials about how to facilitate the training" (final interview).* She felt that this posed a challenge to conducting all echo training, and particularly when it came to facilitating national level training of trainers courses in her country.

SPRINT coordination team member position, capacity and content relevance

In the period following the SPRINT Training, all participants originally trained to form the national coordination team for Sujana's country had become uninvolved. This was noted to be due to losing contact with fellow participants, resignations and movement of staff within and between organisations. As a result, she saw it necessary to immediately conduct a national level 'training of trainers' so that *"we will be able to have the national facilitators, so it will not really depend on the person attending the [Regional SPRINT]training" (final interview).*

When pressed on why she believed her SPRINT-established coordination team may have dissolved, Sujana stated that *"the participants, they are not the right person maybe. They are not really involved in the disaster, they are not really involved but they attend the training when they wrong… Maybe for other organisation, maybe not really fully focused on reproductive health, maybe that's difficult" (final interview).* This observation relates closely to the relevance of the training contents to the work and organisational direction of those participants originally selected or nominated to attend SPRINT's Training of Trainers.

Environmental level

Policy

Sujana reported that some of the most significant impediments to transferring the training lay in the domain of policy absence or restriction. It is for this reason that changes to government policies and regulations feature so prominently in her list of post-training achievements. Ensuring that policy was changed or introduced to support MISP implementation was not, however, a straightforward task. Sujana, together with her ministry of health counterpart (SPRINT Monitoring and Evaluation Report 3), recount that it took more than two years to enact initial changes (final interview) due to "the long bureaucratic process for modifying legal documents in the national system" (SPRINT Monitoring and Evaluation Report 3).

National policy regarding the training of government employees provided a further obstacle to Sujana's goal of facilitating training for the ministry of health disaster centres. As outlined above, "the issue of accreditation [of the training] was raised since accreditation was required for the training to be extended to MoH participants nationwide" (SPRINT Monitoring and Evaluation Report 3). This caused a postponement of scheduled trainings, a redirection of already released funds, and around ten months of advocacy and adaptation work to bring the SPRINT Training into compliance with national policies and standards (final interview; SPRINT Monitoring and Evaluation Report 3).

In terms of responding to a crisis situation too, Sujana noted that *"we have the law, law on disaster which is, this is globally stated that international assistance from UN, from NGO, from International NGO, from Red Cross and et cetera, it will be given upon the request of the government" (final interview).* This statement was followed by two quite distinct explanations. The first was that this position was understandable, as *"our government now is still building their capacity so if every disaster then international community helps, then the government never build their capacity" (final interview).* The second, less sympathetically, was the rationalisation that this policy of assistance by request only is in itself:

> *[S]ometimes very political. If the government requests to the international community it means that the government not able to manage. This is not good for the government sometimes so they use like the, 'the government of [my country] welcome international assistance'. This is already the green light for us, not necessarily the request. The request was happen during the … very big disaster and*

then the president declared that [our country] need the international assistance, but after that they never request, but they say 'we welcome international assistance'. So this is another way that us, UN, other can join in the supported response (final interview).

Sujana also used this comment to link to the importance of working strategically with local NGOs who would be permitted to respond, and expressed that this was one particularly detrimental aspect of working for an international agency such as UNFPA.

Health system capacity

Sujana identified a lack of knowledge amongst important decision makers about the importance of providing SRH services for people in humanitarian settings as an important reason for instituting broad ranging advocacy activities. Her success in seeing this changed is noted in her change of tense in her statement that:

[B]ased on my experience in [my country], reproductive health is, was not really considered as the priority. Maybe not just in [my country], everywhere, because people think…that at the very acute phase there is no need for the reproductive health services (final interview).

This lack of understanding was found by Sujana to extend beyond non-prioritisation, however, to include confusion around what is required to respond to SRH needs during crises, and a broad lack of knowledge about the MISP. Prior to her advocacy work, Sujana felt *that "people think that this very complicated to provide the services during the acute phase…But [I explained that] MISP can answer this question so during the acute no need to provide all the components but we really need to focus to MISP to save life of the people" (final interview).*

Also related to in-country *health system capacity* and structure, Sujana found that there was a need to build capacity at multiple levels, not just through advocacy to managerial decision makers, but by also developing the skills of service providers in SRH for emergency response. With her colleagues, Sujana *"tried to improve the capacity of the already skilled health provider in the region because maybe they don't have the skill on MISP"" (final interview).* In this she found it challenging to track past trainees, compile rosters and ensure that skilled service providers were appropriately deployed as *"maybe the one that been trained, maybe not the one that respond to disaster because the disaster can happen anywhere" (final interview).*

Further to this, she recognised a need to address capacity across administrative divisions within her country. As outlined in her list of achievements above, Sujana strategically targeted the ministry of health regional disaster centres as they were established, led by the government, and best placed to respond in times of disaster. While recognising the importance of accessing these centres and integrating MISP into their response, Sujana aimed to reach further, stating that *"our problem is we only able to train at the regional and maybe some provinces but I think people, more and more people need to be trained at the province level and the district level health provider. Very challenging yes, but slowly slowly" (final interview).*

Sujana found a lack of quality national data and deficient government systems to collect information on SRH needs during crisis to be an impediment to her advocacy work. She described this as:

> *[M]y challenge to have the evidence base [particularly] for the sexual violence because for the advocacy I say please try to prevent the sexual violence, please try to manage the camp properly, try to move the toilet separately for men and woman, and then they ask is the sexual violence case exist? They always ask the evidence…[E]ven in normal situations, it's difficult to get the data" (final interview).*

Described as *"the biggest challenge" (final interview)* of all those discussed, however, was the attrition or movement of staff in positions of strategic importance to Sujana's work. This was a recurrent theme of our conversations and interviews, and was experienced as an important impediment to Sujana being able to work effectively towards her own and the SPRINT Training's goals. She reported particularly that there was *"a very high turnover within the ministry of health, for example for the strategic position" (final interview)* with the consequence being that *"sometimes we already done advocacy we got the commitment from the person and then suddenly the person move to another directorate, another position and then we should start over and over again…we start the process and everything then suddenly the people move to another" (final interview).*

This issue of staff turnover or movement extended to those originally trained by SPRINT to form the national coordination team, and also to key members of partner NGOs. Sujana explained that what began as a productive working partnership with an important grassroots organisation was in jeopardy as *"after these two focal points left, I don't know who are the new*

person. Because we have a good collaboration in the area of training and when we are responding to disaster because as NGO they have more working with the grassroots and also they can provide the service for adolescent,…things we can not do with our regular partner from the government ... But I don't know the future, after they left" (final interview).

International standards and protocols

A difference between international standards presented during the training and national guidelines and regulations was an obstacle for Sujana in pursuing MISP training and coordination work. This was clearly evident in her need to modify the SPRINT training curriculum and resources so that the training could be accredited by the ministry of health training department. Two areas of the SPRINT training proved especially problematic in this accreditation process:

> *The first one in regard to the adolescent reproductive health services. There is a lot of controversy, the religious leader say, please do not give the education to the young people because it will promote the young people to do like the free sex, like the behaviour not good behaviour something like that... But for the young people that already married, minister says we can provide the services. But for unmarried young adolescents we can not provide the services, especially by the government. But by NGO maybe yes, even like a secret service or something like that… The second one is the abortion, because when I attended the training that if the survivor of the sexual violence get pregnant, we can provide like abortion services but in [my country], at the time it was not allowed so we need, there are some but we need to make an adaptation. This is including also the treatment for STI treatment, we have our own protocol for the drugs (final interview).*

In addition to this, the internationally supplied RH kits which accompany the MISP were found by Sujana and her colleagues to be, in some instances, incompatible with their context. This was particularly noted in regards to the type and size of equipment, the alignment of included medications to national protocols, the language (English) of included instructions, and the familiarity of health providers with kit contents. Culturally specific hygiene or dignity kits (a package of non-food commodities designed to support women in crisis situations) were also developed by Sujana and her colleagues to cater to local needs.

Enablers to Sujana's transfer of training

Given her list of achievements and the quite extensive combination of obstacles she faced, an interesting and instructive part of Sujana's journey from training to transfer was found in the factors which supported her in pursuing these goals. These again fell within the established categories, but in contrast to the obstacles discussed above, there is a preponderance of individual level factors, or characteristics within Sujana and her experiences which aided, prodded, provoked or motivated her to overcome these obstacles in pursuit of SPRINT's goals.

Individual level

Job involvement

Throughout our association, Sujana presented as an individual deeply connected to both her work and organisation. When asked why she kept working in the face of so many obstacles, Sujana's reply was twofold. First, she stated *"because it's my task [laughing]. Because I work for UNFPA and reproductive health is one of our mandate and I am the national programme officer for humanitarian. Our main intervention for our organisation is reproductive health in emergency situation. If I do not do that, then [I should] finish" (final interview).* Further to this she added that she often *"feels so tired…because in [my country], every time when we watch the television there is the next disaster happen in this place, especially during the peak season so I cannot sleep very well because I should prepare" (final interview).* She went on to state, however, she that she would continue to push forward with this work because it is *"my job and it is unfinished" (final interview).*

Personal engagement

More profoundly than in her association with the expectations of work, Sujana displayed a deep involvement with the issue of SRH in crisis and with the women, men, boys and girls surviving in humanitarian settings. This *personal engagement* came, at least in part, from her first hand experience of working with survivors of humanitarian crises. As the second part of her reply to my question about why she continued to pursue this work in spite of serious challenges, she showed her deep understanding of the need for these services and her appreciation of the programme's aims:

> *[A]nother thing, because I like the programme, the RH in emergency situation, I think it's very good because this is the area that's almost always forgotten because every*

time I respond to disaster I always meet with the women who deliver the baby during the acute phase. I collected the picture of the women who deliver the baby during the earthquake, the woman deliver the baby during the eruption, so this is very useful for me (final interview).

Individual position and influence

In addition to her dedication to her job and personal commitment to pursuing this work, Sujana reported that she worked "closely with government institution (ministry of health, Family planning board etc), UN agencies and their organisations/institution in the humanitarian setting" (SPRINT Regional Training of Trainers application form), revealing that she was well positioned to affect the change and access the stakeholders required to meet SPRINT's goals.

Training Level

Support from SPRINT

Sujana felt well supported by the SPRINT Secretariat and credited the initiative with providing guidance as she undertook this work. Beyond this too she felt that the networks which had formed through the SPRINT Training, particularly with UNFPA counterparts from other countries and head office as well as within the wider IAWG network provided a *"system where we can support each other, we can share the experiences we can help each other. Within and outside UNFPA we have a supportive system. We always in contact with [them] if there is any disaster happen they always contact me. This is a good system that can help" (final interview).*

As mentioned previously, Sujana felt inspired by the training as it directly related to the work she was involved with and issues she had experienced and understood to be important. In addition to this, she stated that she found a number of people she met through the training- both fellow participants and facilitators- *"inspiring…we inspire each other" (final interview).*

Content relevance

Referencing her experience in responding to both large and smaller-scale humanitarian disasters, Sujana expressed that the threefold objectives of SPRINT (for advocacy, training and coordination) were the *"right ones [as] these are the main priority interventions" (final*

interview). She repeatedly stated that the training matched her needs and her organisation's needs and was immediately applicable to and "relevant with my daily work" (SPRINT Regional Training of Trainers application form). She noted, however, that *"[m]aybe for other organisation, maybe not really fully focused on reproductive health, maybe that's difficult…but [the training is] perfect alignment with our priorities and that's, yeah, it's good [laughing]" (final interview).*

In all of our conversations and in Sujana's presentations and reporting for SPRINT, she reiterates the relevance of the training to the needs of her country. Describing her nation as vulnerable to natural disasters, the applicability of what she learnt during the SPRINT Training was clear to Sujana before undertaking the training, during the training and as she pursued this work on return to her organisation. An illustration of this was given when she recounted a *"unique and funny situation" (final interview)* which happened while she was facilitating an in-country SPRINT echo-training:

> *[W]e were in the middle of the MISP training in [one region] and then suddenly the volcano eruption happen. So some of the participant came up from finish the training they should go back to the affected area but I also went to the affected area so together after learning in the class and then we practise in the real situation. So we discuss together if the situation like this, how will be our intervention and you know, they are very happy they can implement what they have learnt straight away (final interview).*

The relevance of the training was, therefore, clear to these training participants too. Through advocacy and capitalising on a broad acknowledgement of the volatile natural context of her nation, Sujana has also been able to prove to decision makers that it is important to address SRH needs in crises. She gave the example of one of the ministry of health regional disaster centres which, after the training *"realised this is a very important training, [so] they allocate the local budget to conduct the training in [another district] also" (final interview).*

Organisational level

Transfer climate

Sujana was consistently positive about the material support she felt she received from her

organisation. When asked what had been most helpful for her in overcoming obstacles faced, she stated first that *"[w]e have so many resources from UNFPA" (final interview).* Human resources were noted as one possible exception to this as *"in my office we only have two staff, I and [my colleague], to manage the training, everything, and if a disaster happen if we want to implement MISP there are more stakeholder, more disaster intervention so sometimes it's so difficult" (final interview).* This negative statement is immediately, however, met with a positive in her assertion that *"my office also committed to provide support in case of major disaster and then there is possibility to recruit more people, in the affected area" (final interview).*

In terms of opportunities to perform trained skills, Sujana spoke of complete integration of the objectives of the training with her job description and work plans. In the survey conducted approximately six months after the Regional Training, she stated that her day-to-day work had changed as a result of attending the SPRINT Training, as she should now "focus to conduct the same exercise and training in [my country]" (Monitoring and Evaluation of the SPRINT Regional Training of Trainers Survey). In response to questions about changes to her job description after attending the training, Sujana stated that it too had changed and that now this work had become "our main programme activity" (Monitoring and Evaluation of the SPRINT Training of Trainers Survey).

This integration has become even more profound in the ensuing period. As she explained in response to a question about support for this work from her organisation:

> *Now in the country programme we have output for MISP, we have one particular specific output for our country programme because in the past we did not integrate the humanitarian programme into the country programme. And the programme are our regular programme, more sustainable. Now it is in the cycle. Each cycle is five years it means now this is more sustainable so we have integrated the humanitarian component, MISP, even in one specific output. So I manage one specific output in my work plan (final interview).*

Organisational support

Closely related to *transfer climate*, Sujana explained that support from her organisation was extremely important to her transfer achievements. She saw this support as both material and in the autonomy she was given over her own work plans:

> *I manage my own budget to implement MISP so I get very much support from my office. So without the support I cannot implement because the funding everything is all attached. I manage myself, everything. I just propose this is mine, because we need to prepare like a framework want to be achieve in five years so I prepared that and then the office committed to fund all of the activities as stated in the framework. So it's integrated into the country programme, we will not have difficulty in funding from the regular funding programme because we have the regular resources (final interview).*

Organisational position and influence

Working for UNFPA provided Sujana with access to important strategic decision makers. When asked in her application to attend the SPRINT Training if she was willing to establish linkages with ministry of health and other key organisations, she replied "yes, it is part of my job and what I am doing now" (SPRINT Regional Training of Trainers application form). As can be seen in her list of achievements and the importance of strategic advocacy, this level of access was essential to her successes.

Organisational mandate

Sujana clearly linked the support she received from her organisation with the mandate of the organisation itself. In her application to attend the SPRINT Training, she asserts that "SRH is main UNFPA programme and as part of UNFPA mandates" (SPRINT Regional Training of Trainers application form), a statement reiterated throughout our interviews. Each component of the MISP is regarded by Sujana as falling under UNFPA's operating mandate, and in this way again she perceived an 'alignment' between *"our work" (final interview)* and the objectives of the MISP and the SPRINT Training.

Environmental Level

Government ownership and support

The support Sujana felt from relevant government representatives was tempered somewhat by high staff turnover. She stated that she had strong support, particularly at the onset of her programming from a Ministry of Health delegate who had attended the SPRINT Training and was *"really with me since the beginning and in every process" (final interview).* To make up for this, Sujana was able to build effective cooperation with strategically important government stakeholders through re-advocacy and building relationships with new staff.

Sujana was, in fact, able to report that this advocacy had moved from permission by the government to conduct this work to the ministry actively working to provide SRH services in humanitarian settings on its own. At the time of our final interview, she had received word that the:

> *Ministry of health also they have allocated some funds to make like the intervention more advanced, they allocate some funds for advocacy and socialisation of the MISP too at the provinces that is not just supporting UNFPA, but also allocated some funds for procurement of some supplies something like that. But, still, maybe a small amount. But in the past they never allocate any fund for the reproductive health in emergency situation (final interview).*

Health system capacity

Sujana experienced the existing capacity within her country's health system as both an impediment (as described above), and an enabler to her work. Her most significant support was found in the established ministry of health regional disaster centres, as these provided a strategic direction for the rollout of trainings, protocols incorporating the MISP, and logistics to support MISP implementation. She describes these centres as *"very very far advanced [in that] they have a very good human resources, they have a very good system [and resources], and because … regional office covers the provinces" (final interview).*

Her strategic approach also saw her work with grassroots NGOs. This was done on the understanding that relevant NGOs worked directly with target beneficiaries and could thus provide an access point and needed data for advocacy purposes. Sujana also recognised that these local organisations could continue to work in humanitarian settings without the kind of

invitation from the government that was required by international organisations, and provide services, such as those for adolescents which were not possible when working with government partners. Further to this, Sujana established a roster of "*the people [from NGOs] who have been trained so if there is a disaster in the area close to the region then we contact the people so they can go back and make the assistance" (final interview).*

Case Study 2: Heng

Personal profile

Both at the time of the SPRINT Training of Trainers and at our subsequent meeting, Heng worked as a Monitoring and Development Coordinator for a local NGO "where the main mission is to provide sexual reproductive health services through clinics and community outreach and support government health centre to improve maternal and newborn health in the [organisation's] coverage area" (SPRINT Regional Training of Trainers application form). In his application to attend the SPRINT Training of Trainers, Heng explained that his organisation was a large entity with wide coverage within his mid-sized country, and had representation in a SRH technical working group led by the national ministry of health. At the time of the training, he had not been involved in any form of humanitarian response, was not familiar with the MISP or emergency coordination mechanisms, and had not completed the pre-requisite MISP distance learning module. Heng indicated that he was interested in attending the training "because I want to learn the new approach of MISP…and try to apply in my organisation or national programme if applicable" (SPRINT Regional Training of Trainers application form). He also stated that, at the time of the SPRINT training, his NGO had "no plan and did not reserve budget for participation to attend this training course" (SPRINT Regional Training of Trainers application form).

Proximal SPRINT training outcomes

At the close of the training, Heng reported generally low levels of self-efficacy in relation to the three SPRINT Training objectives of advocacy, echo-training and coordination. Heng did not complete the survey which I administered around six months after the training, but during both of our interviews indicated that while he had gained knowledge during the training

course, he was not sure that he would be able to conduct advocacy, coordination or training work.

During our first interview at the close of the SPRINT Training, Heng expressed some doubt about the relevance of the training to both his work and his country. His post-training reaction was negative across the breadth of the topics covered by the training, with the possible exception of maternal and newborn health, which he felt was an area needing attention in his context. He particularly highlighted the difficulty he felt he would face in bringing the contents of the training to decision makers through advocacy, concerned that they would think *"what are these two guys come with this silly…[laughing]" (first interview).* In addition, Heng felt that he was not in the correct position or organisation to meet the coordination objective of the training, or to organise echo-training events.

Further to this, he stated that he would need strong follow-up from the SPRINT Initiative as he and his country team colleagues returned to work in order *"to see more clearer so that we can get, ah, more understanding" (first interview).* This brings into question the degree of learning attained by Heng during the training course. In our follow-up interview he did, however, state that he was pleased that he now *"at least [has] more knowledge from the course" (final interview).*

Intention to transfer SPRINT training

In our first interview, Heng consistently doubted his ability to use any knowledge or skills he had developed during the training course when he returned to work. This lack of self-efficacy was accompanied by an equal lack of motivation to attempt any form of transfer. He expressed no intention to utilise the training for any of the three training objectives, except in the capacity of an assistant, if required (though he doubted that this would be the case) and if granted the opportunity and permission to act by his current work.

Personal and professional changes as a result of attending the SPRINT training

Heng reported that he had had no change to his professional title or job description in the approximately three year period between our first and final interviews. He stated that

[M]y own responsibility still in overseeing monitoring and evaluation of [my NGO]. So ah, even though that time I was invite to attend that SPRINT Training, but my responsibility is still monitoring and evaluation" (final interview).

Heng also explained that, with the exception of a clearer understanding of the concepts discussed during the SPRINT Training, *"it seemed to not have any change in terms of my personal life and work in terms of impact of the training" (final interview).*

Post-training transfer achievements

Advocacy

Approximately two years after the SPRINT Training, Heng was involved in a sensitisation workshop on the MISP as a facilitator and panel member. In describing the workshop, he explained that the SPRINT coordination team had received funding from UNFPA, and led by the country director of a large INGO (also a member of the SPRINT coordination team), had:

[W]orked together as a team to organise this workshop…We sacrifice our time in the several weekend to review all the workshop [and] translation…We invited some eleven department and a senior minister in charge of disaster was chair in that meeting (final interview).

Additional participants were sourced from government ministries, INGOs and UN Agencies, but no other participants from Heng's NGO were in attendance.

This sensitisation workshop was designed to "raise awareness of the MISP; and to agree and commit to what needs to be in place to ensure a reduction in maternal mortality, morbidity and disability in crisis affected populations or situations, at the national, provincial and community levels" (Report of Proceedings: Sensitisation Workshop on Minimum Initial Service Package for Sexual and Reproductive Health in Crisis). The major recommendation to emerge from this process was that "the task ahead is to embed SRH disaster preparedness in existing strategies to further coordinate a response" (Report of Proceedings: Sensitisation Workshop on Minimum Initial Service Package for Sexual and Reproductive Health in Crisis).

When asked about the outcome of this workshop during our final interview, Heng was unable to provide further details, stating that *"we can't say frankly speaking…I don't know. Because*

we have no follow-up" (final interview). In fact, the sensitisation workshop would be the last time Heng was involved in work associated with the SPRINT Initiative.

Training

A further recommendation of the sensitisation workshop was that "current trainers [that is, those trained by SPRINT, including Heng] can begin echo SPRINT Training with provincial based [INGO] volunteers to address the immediate human resource needs" (Report of Proceedings: Sensitisation Workshop on Minimum Initial Service Package for Sexual and Reproductive Health in Crisis). This did not eventuate, however, and in our final interview Heng indicated that he was not aware that any in-country training had been conducted, or that any had been planned for the future.

In the intervening period between the sensitisation workshop and our final interview, Heng's SPRINT coordination team colleague from UNFPA, Sophea, attempted to move forward with some SPRINT echo-training events, but was advised by relevant government authorities that no standalone training was necessary, but instead that it may be possible to integrate components of the MISP into existing emergency response training curricula. I interviewed Sophea shortly after speaking with him, and at this time she stated that *"it has been three years, four years, so until now [integrating these components] is a low priority [for the government]" (final interview, Sophea).* She also expressed that *"I feel like I'm working alone because NGOs trained do not really participate [in this process]" (final interview, Sophea)* and that she had had no further contact with any SPRINT coordination team members since the sensitisation workshop.

In lieu of any organised training workshop, Heng reported that *"if my knowledge could not be offered through the formal training, I can share my knowledge with my colleagues, I just can do it with our staff during meetings" (final interview).*

MISP coordination

Heng stated that he had not been involved with coordination of the MISP in his country, and was unaware if any work towards integrating SRH into emergency preparedness and response had been undertaken.

Obstacles to Heng's transfer of training

Heng faced obstacles on all levels within the training transfer system. The following section details his explanation of difficulties he faced in utilising knowledge and skills developed during the SPRINT Training.

Individual level

Individual position and influence

Throughout our final interview, Heng made reference to his particular position and that it did not lend itself to the possibility of accessing the people needed to pursue SPRINT's objectives. He often did this to contrast his position with that of his SPRINT coordination team colleague who was, at that time, the country director of a large INGO with a strong presence in this country:

> *Like I told you, we have a group talking and we talking who to invite who, but we have [the INGO Director], she can arrange to inviting anybody because as you know [this INGO] has a lot of project in [my country] so she knew that ok, she can contact anyone easily (final interview).*

Personal engagement and job involvement

When asked about why he had chosen to work in the field of sexual and reproductive health (generally, not specifically in regards to humanitarian settings as he had no experience of this), Heng explained that *"in your business life, you have to look for the career or subject that may be needed. So reproductive health everybody is involved. So it could be a market for everybody if you want to get support for reproductive health, every donor interested" (final interview).* This response shows that Heng is involved in his work- a sentiment expressed throughout our interview- but in a way that is limited to the job itself. He showed, even on prompting, no engagement with SRH in regards to humanitarian settings. Heng believed government officials would be sceptical about the need to address SRH in crises and ask *"'why we need to think about HIV transmission rather than let them without giving something to eat?'" (final interview).* His response to this anticipated scepticism was that *"we say but we don't want to challenge them" (final interview)*, showing a lack of conviction and that he doubted whether his own position would allow him to promote interest in SRH for humanitarian settings.

When questioned about his involvement in the sensitisation workshop, Heng responded that he felt a sense of obligation to SPRINT as they had provided him with the opportunity to travel to Kuala Lumpur. He mentioned that when *"like we get invitation to attend training, sometimes we feel like we owe something for the course… I feel like I owe something to them, so I have to do it. Of course ultimate goal is help people in [my country], but you understand" (final interview).* This response is included here to further demonstrate that while Heng was involved with his work, he felt his obligation was to his organisation and the organisation which conducted the training, and not to people in humanitarian settings.

Training level

Content relevance

Heng felt that the objectives of the training were generally not applicable to his daily work. Speaking of his planned work activities, he stated that *"this kind of work for coordination, it different from my [work] plan" (final interview).* He does, however, believe that the subject matter of the training and work for SRH in emergencies falls within the scope of his organisation's remit, but that this is neither his usual work, nor *"the routine work" (final interview)* of his colleagues. This assessment was supported by Heng's UNFPA SPRINT coordination team colleague in her report that *"the NGOs trained, they don't really work related to this area [of SRH in emergencies] so they tend to forget. They not involved at all" (final interview, Sophea).*

Consistent with his reaction to the training contents at the close of the SPRINT Training of Trainers, Heng felt that only the emergency obstetric and newborn care component of the MISP was relevant to his context, or was a credible component of response in times of crises. He believed at that time, and this perception carried through to our final interview, that the training covered *"a lot of, too big disaster, displaced population. And because the training have the part like when violence, or sexual like rape, or something like that but to our situation I think only delivery should be considered in an emergency, obstetric care or something like that" (final interview).* Further to this, Heng remarked quite strongly that he felt *"the training matter sometime already not coming from the people, not coming from the assistant or the donor" (final interview)*, suggesting that this training did not meet the real priorities of the people or those involved in the field, or that it was somehow imposed onto their context by others. Again, the exception to this was that *"from my personal opinion I think that emergency*

obstetric care could be the important thing" (final interview).

Heng's motivation for attending the SPRINT Regional Training of Trainers lay outside any interest in the training contents itself. Speaking of when he was approached by his supervisor about the possibility of being a participant, Heng stated that:

> *I don't know at that time, my supervisor just told me, ok, this is the course are you interested in learning because you can apply [to attend]. So he told me if you want you have the opportunity to travel abroad, so if I go to training, is a good opportunity to know Kuala Lumpur, and at least learn something new so he asked if I am interested so I applied (final interview).*

He did not believe that the training had provided him with any new ways for conducting his work, only that it had given him a clearer understanding of SRH issues in humanitarian emergencies.

Team member position and influence

Heng revealed that after his participation in the sensitisation workshop, he had no further follow-up from or involvement with his SPRINT coordination team. He explained that this was largely because his SPRINT colleague, the country director of a large INGO, moved to a position in a different country. No further meetings were held after her departure and no collective action taken. The importance of the leadership role of this INGO country director will be discussed further below.

Organisational level

Organisational capacity

As mentioned above, Heng believed that addressing SRH in humanitarian settings was within the scope of his organisation's work but was not part of routine activities. He felt that a reason for this was that *"we have short staff so we have our own duty and we don't want to bother [people with new work] sometimes" (final interview).*

Organisational mandate

In line with the above, Heng explained that the contents of the training were within his NGO's mandate. One challenge to applying his training on return to work, however, was that while

the content area may have been relevant to his organisation (though not applied in practice), the objectives of the training were not. He saw his organisation as being more closely involved in service provision than advocacy, training activities, or coordination of the MISP.

Organisational position and influence

The position of Heng's organisation within the wider health and development systems relates directly to the discord between his routine work and the objectives of the SPRINT Training. In discussing his organisation's potential involvement in advocacy, training and coordination of the MISP, Heng states that *"I don't think so NGO could be the lead" (final interview).* He explains this with reference to other involved players, who he sees as in the correct position to pursue training objectives. He states repeatedly that he is only from civil society, and therefore his approaches to key stakeholders such as ministry representatives would carry little weight. In imagining that he was attempting to conduct advocacy or coordination work, Heng believed that the response of the government would be *"'where you are coming from?'" (final interview).*

Again, this belief was confirmed by Heng's SPRINT coordination team colleague from UNFPA. In explaining why she felt that others trained were less involved that she, Sophea stated that:

> *They need our advocacy with the government because of our organisation's position, we have very good links and we work with very high levels from the ministry of health. On the NGO side they don't have many links like that so they'd like our position to step in first before they will support from the back (final interview).*

Transfer climate

The above, together with more direct statements, show that Heng neither sought, nor believed that there were many opportunities for him to apply what he had learnt during the SPRINT Training in his daily work. He makes a clear differentiation between 'my own' work and that expected by SPRINT. His 'own' work occupied all of his working hours, and when he did participate in preparation for the sensitisation workshop, these additional activities took place in his personal time. Describing this involvement, he stated that *"usually we can't meet because we have other work here in the weekday, the working day" (final interview).* Speaking more generally, and in defence of the work he is usually involved in, Heng repeats that he has *"a lot of other work coming. How we have the mind to think about other scope? To join our*

scope. Because our work is not useless because our work is also respond to this kind of thing" (final interview).

When asked about maintaining contact with his SPRINT coordination team colleagues, Heng responded that *"they used to contact me but I never [laughing] because usually they want things and I'm busy with my work. I'm a bit lazy [laughing], but I know it's extra work come to us … Of course, ultimate goal help people but sometimes you understand we busy all the time" (final interview).*

Heng identified resources and funding as important impediments to the transfer of learning he gained through SPRINT Training. This stemmed from the nature of his organisation and their reliance on donor funding and associated requirements. He felt that he had little control over how he could allocate resources, and stated that

> *Obstacle is like this… We are viewed as the local NGO, we spend our money based on work plan, based on normal requirement. As I told you, [an international donor provides] main funding, 60-70% of funding from [them] and they have a request for application and then we try to write our proposal to fit their request for application…And we cannot have the budget reserved to do during the emergency. We cannot do that way because our plans only to donor every year. And then if we are not spend, we have to give it back because we have to clear our money…But sometimes something new, not in the work plan and then we cannot do. And sometime the [main donor] do not feel happy if they request for food or for shelter and then we give condom [laughing]! Also sensitive to them (final interview).*

Organisational support

Heng believed that he would receive support from his direct supervisor and organisation should his involvement in SPRINT activities be requested. He did not anticipate that this request would come from within his organisation itself. More pertinent to Heng than support to undertake this work was that he receive recognition for any efforts made. He was concerned that if he conducted any activities outside his work plan (including SPRINT-based work), his supervisor may not be aware of how he was spending his time. As a result, he felt that

> *Everything should flow from my director, flow from my supervisor. Sometimes I, the [SPRINT] team directly contact me and then, what I did for the team, my supervisor*

may not know, may not value me because they don't know about my work. So I spend my time. So it would be good if everything should flow through director or my direct supervisor. So what I did, they can know. So they know my time, they know my other deadline [laughing]. Recognition! (final interview)

Environmental level

Government ownership and support

During our first interview at the end of the SPRINT Regional Training of Trainers, Heng said that he was concerned that there were no participants invited from his country's ministry of health or other relevant departments. He felt that this may compromise his coordination team's ability to take any action towards meeting SPRINT's objectives. This belief was repeated in our second interview, and his prediction that the lack of government involvement may be an impediment proved salient. He asserted that *"we proposed that if there is no representative [from the government] as the part of the team, we could not go on" (final interview).* He stressed both the need for this support and that he was not in a position to garner it through the appropriate avenues.

Society and culture

Although he had no experience in implementing or coordinating SRH services during humanitarian crises, Heng's belief that potential beneficiaries would react negatively to the MISP components covered in the training continued in our final interview. Together with his perception that this training had not come *"from the people" (see above, final interview),* he also remarked that *"mostly people always think first with food, shelter, water, something like that. So if we try to engage, oh! Reproductive health! Sex! HIV transmission! Rape! And many people they don't like to have people think about sex in the disaster" (final interview).*

Enablers to Heng's transfer of training

Although Heng did not initiate action toward SPRINT's Training objectives and was involved with his coordination team only peripherally, he noted one particular training transfer factor which prompted him to act, if only briefly.

Training level factors

Team member position and influence

When looking to understand why Heng was involved in any SPRINT activities (that is, the sensitisation workshop) after the training, an important common thread emerged. Heng required leadership, direction, contact with people in the correct position, and recognition for any efforts expended. He found this, for a time, in the involvement of the country director from a large INGO detailed above. It was this member of his SPRINT coordination team who instigated action, provided a strategic approach, was in a position to access important decision makers, and would liaise directly with his supervisors to place demands on his time. Heng made his understanding of the importance of this leadership role very clear in his statement that *"to do something you need someone leading. And luckily at that time we had country director of [a large INGO]. She always very active in inviting committee or process of meeting" (final interview).* As mentioned previously, this country director was moved on shortly after the sensitisation workshop in which Heng was involved. It was at this time that all collaborative SPRINT coordination team activities ceased in this country.

When asked about how he could continue to be involved in SPRINT activities, he stated that he would be able to:

> *[G]o [and be involved in these activities] if like, [the country director], she is country director so she has power, she can contact directly to my director, my director "that ok please, I want to have meeting", and easy. We need someone in that kind of position, committed and willing to do. All this will help. Leading and invite and we ready (final interview).*

Case Study 3: Benedict

Personal profile

Benedict was the sole government representative to attend the SPRINT Regional Training of Trainers for his large and diverse nation. At the time of his participation in the training, and during our subsequent interview and discussions, he was the regional director of the department of health for a particularly crisis affected area. The hazards affecting his locale include those of natural origin, epidemics, and armed conflict. In his application to attend the SPRINT Regional Training of Trainers, Benedict described his key responsibilities as "providing

leadership and policy direction; overseeing administration and supervision of programmes/projects; and establishing public-private partnerships" (SPRINT Regional Training of Trainers application form).

In addition, Benedict is a medical doctor with master's degrees in both health care management and hospital administration. He stated that he had experience in clinical roles as a municipal health officer and medical specialist, and more recently in the management of health care facilities and administration through positions in government. Due to his leadership position in a crisis-afflicted region, Benedict reported that he had been involved in responding to health emergencies and disasters and that this was within the scope of his current work (interview). He indicated, however, that this past experience was limited to general disaster response and did not specifically include SRH. More broadly though, and in both his clinical and non-clinical work, he stated that had more than five years' experience in a number of SRH areas including maternal and newborn health, family planning, and STI/HIV prevention and response (Monitoring and Evaluation of the SPRINT Training of Trainers Survey).

He also explained that he was an experienced trainer with more than five years involvement in training in sexual and reproductive health, training in crisis response, and training in public health more generally (Monitoring and Evaluation of the SPRINT Training of Trainers Survey). His role as a trainer continued in his current position.

Proximal SPRINT training outcomes

At the close of the SPRINT Regional Training of Trainers, Benedict felt that he could and would apply knowledge and skills developed during the training when he returned to work. In the survey I administered to all SPRINT Regional Training of Trainers participants, Benedict stated that he 'strongly agreed' that he felt more confident to implement skills in emergency SRH in crisis situations as a result of attending the SPRINT Training. This high self-efficacy extended across the three SPRINT Training objectives and again, he 'strongly agreed' that he was able to do what was expected of him because he had attended this training event.

He also reported that he had gained skills and knowledge in SRH for crisis situations as a result of attending the training (Monitoring and Evaluation of the SPRINT Training of Trainers

Survey), and that he had *"learnt a lot, especially technically on how to aid in crisis" (interview).* This development of knowledge was viewed by Benedict as a *"realisation" (interview),* in that *"I discovered that while I had been responding to health emergencies and disasters, I appreciated that there is really a need for integration of this approach" (interview).*

In the monitoring and evaluation survey, Benedict 'strongly agreed' that the SPRINT Regional Training of Trainers was relevant to his current work. This was further supported during our following interview and discussions when he continually expressed that *"[before the training] we were not concerned with the needs of women in crisis, so it's a realisation on my part, as a regional director, as a manager, to really include especially in our planning and implementation during disaster response" (interview).*

Intention to transfer SPRINT training

As alluded to above, Benedict showed positive intention and strong motivation to transfer knowledge and skills gained during the SPRINT Training when he returned to work. At the end of the SPRINT Training, he felt that he would likely be most active in working towards the advocacy objective, but stated that he was committed to making himself available as a "resource person" (Monitoring and Evaluation of the SPRINT Training of Trainers Survey) to assist his SPRINT coordination team in conducting echo-trainings and coordinating MISP response in his region.

During this research, I identified a number of training transfer factors which influenced Benedict's intention and motivation to transfer SPRINT Training. On an individual level, he stated strongly that he was personally engaged with and committed to the issue of SRH in crises and more generally to people surviving in humanitarian settings. He also showed commitment to and involvement with his work, and felt that his current position would allow him to pursue SPRINT's training objectives. He had previous experience relevant to both the subject matter of the SPRINT training and its three objectives, but remarked on the novelty of the training in that it provided him with a new way to execute existing work.

In regards to training level transfer factors, Benedict expressed that the contents and objectives of the training were both relevant to his work. He also felt that the conduct of the

training was appropriate for him and he was satisfied with the support he had received from SPRINT.

Being a regional director with "some autonomy…to form policies and practices" (SPRINT Monitoring and Evaluation Report 3: summary of a presentation by Benedict), Benedict was not dependent on support from supervisors, did not require a supportive *transfer climate* and was in a position to integrate an SRH focus into his department's mandate and work plans.

On a wider environmental level, Benedict perceived that he would receive support from other regional department of health directors- where functioning disaster coordination committees existed, from representatives of other relevant government departments, and from some members of his SPRINT coordination team colleagues. He felt that socio-cultural issues may prove challenging in relation to particular aspects of the training contents, but believed that a flexible approach in allowing adaptation of the SPRINT curriculum would overcome this obstacle.

Personal and professional changes as a result of attending the SPRINT training

As discussed above, Benedict felt that the training had opened his eyes to the particular needs of women and girls in crisis situations. He linked this realisation to a new and strong *"personal commitment" (interview).* This personal change led to a professional change, with Benedict giving this as the reason he had modified his day to day work after attending the SPRINT Training of Trainers (Monitoring and Evaluation of the SPRINT Training of Trainers Survey) to integrate action towards meeting the SPRINT training objectives.

Post-training transfer achievements

Advocacy

Benedict was able to list a number of achievements which resulted from his advocacy efforts. Within his own region, he integrated the MISP into relevant health and emergency management legislation, developed a specific health emergency team for SRH response, and appointed a sexual and reproductive health coordinator to focus on the MISP in the event of a crisis (SPRINT Monitoring and Evaluation Report 3: summary of a presentation by Benedict).

Benedict also provided an orientation and advocacy session to the national director and all regional directors of health and emergency management departments. This "resulted in the commitment of the [health and emergency management national director] to integrate MISP into the public health emergency management [training]" (Monitoring and Evaluation of the SPRINT Training of Trainers Survey) which is undertaken by all reproductive health coordinators and health an emergency management staff on a national level. As a further result of his advocacy efforts, "the director also committed to support [the MISP] in the policy" (Monitoring and Evaluation of the SPRINT Training of Trainers Survey), and Benedict has made it a priority to "advocate for the passage of the National MISP Policy and its implementation down to the local level" (Integration of SRH Presentation: Benedict).

Training

Benedict's involvement with rolling out SPRINT echo-training was such that his UNFPA SPRINT coordination team colleague Ana remarked *"[he] is our primary trainer…the one who's really active in terms of training (second interview: Ana).* His contribution to facilitating and organising further training events was on multiple levels. Within his region, he sought to *"saturate all of the…area" (interview)* by leading six training sessions (personal communication 1: SPRINT coordinator). On a country level, he contributed to national training of trainers and echo-training events, and in addition to this, coordinated with other regional directors to ensure that the correct participants were given permission to attend (Monitoring and Evaluation of the SPRINT Training of Trainers Survey).

As mentioned above, Benedict was instrumental in the integration of the MISP into the public health emergency management training curriculum and facilitated this segment of the training to both a national and international audience (personal communication 2: Benedict). The importance of this was highlighted by his UNFPA colleague in her understanding that *"bringing in the MISP as a module into the regular training institutionalises the MISP for all health providers in disasters" (second interview : Ana).*

MISP coordination

Building on his experience in planning for preparedness and response in crises in his disaster-prone region, Benedict "placed MISP/SRH in crises as one of the priority programmes of [his]

office, [and] integrated MISP in the regional preparedness plan with funds back up" (Monitoring and Evaluation of the SPRINT Training of Trainers Survey).

Benedict worked with UNFPA and NGO counterparts to stockpile SRH supplies at a more local level for quick distribution during an emergency. This has included the purchase and pre-positioning of locally assembled kits.

Benedict's coordination efforts had a further impact outside his immediate area of responsibility. He:

> *Sent his team [from his region] to assist [after a disaster in another region]. These people had experience, adapted an evacuation centre, really brought in gender, [and] introduced the MISP there. So from one area, their expertise has been transferred to another area. It's a transfer of technology (final interview: Ana).*

Obstacles to Benedict's transfer of training

Benedict reported that he generally felt well supported and well able to implement the knowledge and skills he had developed during the SPRNT Training to his daily work. He mentioned just two barriers to these efforts, and these were found in organisational and wider structures.

Organisational level

Transfer climate

While Benedict's autonomy was an aid to his integration of SPRINT's objectives into his own work plans and department's strategic direction, he noted that this same independence amongst his peers in the department of health made it difficult for him to require any form of commitment or action from them or their direct reports. As he explained, *"I don't really have any supervision control over them. Even though it will be our expectation, but because they [are or have] their own regional directors, so we will still, I hope…I don't know if that will still be their obligation or their duty" (interview).*

When discussing his expectations of those who participated in training courses he facilitated or was involved in organising, Benedict further noted that they would need *"first to advocate to their own managers, to their leaders, what the MISP is and second, we hope they integrate it into their own plans…then of course we hope and expect that they will implement it"*

(interview). Benedict's SPRINT coordination team colleague Ana also mentioned this obstacle, along with his approach to overcoming it in her statement that trainees "*might have these plans now here but whether they can get it really you will need the policy and programme support from their bosses. So that's why… [Benedict] keeps on saying that the workers have been trained but their bosses are not. We have to kind of to do a debriefing…to get them to support their people who we have trained" (second interview: Ana).*

This concern extended, to a degree, to his SPRINT coordination team colleagues, as efforts to meet SPRINT's objectives involved tasks outside normal work. He worried that they may, therefore, not continue to have the opportunity to use trained knowledge and skills, but noted that this had not been an issue to date.

Environmental level

Health system capacity

An additional concern to integration of SRH into preparedness and response plans, was the devolved nature of the national health system; made worse when there were poor local disaster coordinating mechanisms and planning. (SPRINT Monitoring and Evaluation Report 3: summary of a presentation by Benedict). In addition to this, Benedict highlighted that the autonomy of the regions meant that the priorities of local executives would determine whether they would be able to integrate the MISP into programming and planning. This concern about the negative impact of a lack of knowledge and differing priorities was repeated by Benedict's SPRINT coordination team colleague Ana (second interview: Ana). In our final interview she did state, however, that it was an ongoing goal of the SPRINT coordination team to build systemic capacity and make SRH a part of regular disaster operations at all levels (final interview: Ana).

Society and culture

As Benedict was most involved with the training of his peers and representatives of other government departments, he noted that there was a need to ensure that the training content was contextualised to the specific circumstances of each region in his diverse country, and that it would be the role of these managerial level participants to ensure that this was done. He saw his role as one to *"just encourage them to come up with their own plans and systems which are culturally acceptable" (interview).*

While he did not generally perceive this as an obstacle to meeting the MISP implementation objective of the SPRINT Training, he did express some concern that cultural sensitivities, combined with misinformation or a lack of understanding may compromise the fidelity of the package when it came to implementation. As one example, Benedict felt that many of his training participants *"don't want the emergency contraceptive. They were saying it's an abortive action when actually it's not. [So] maybe not altered but delete by them" (interview).*

Enablers to Benedict's transfer of training

Benedict credited a number of factors in his own and coordination team members' attitudes and positions, his organisational structures, and in the wider environment with supporting the transfer achievements outlined above.

Individual level

Personal engagement

Benedict responded to the training in an almost revelationary way. He stated that he was unaware of the importance of addressing SRH needs during crises before attending the training, but had since become personally commitment (interview). Ana, his UNFPA SPRINT coordination team colleague recalled that *"for [Benedict] it was a lightbulb moment…It's his passion, you know? We are really amazed, he's so committed to it" (second interview: Ana).* Both believed that this level of engagement continued when he returned to work and prompted his transfer efforts.

Individual position and influence

As regional director for the department of health, Benedict was in a position to control his own work plans and priorities and was therefore able to take action towards meeting the three SPRINT training objectives of advocacy, echo-training and coordination for SRH in crises as a priority area within his office's programming (Monitoring and Evaluation of the SPRINT Training of Trainers Survey).

He was also in a position to access those he believed were the correct participants for his national level SPRINT Training of Trainers workshops and echo-training courses (interview). His ability to contact peers at a high level within the national health structure and liaise with

national directors for health and emergency response was appreciated by his SPRINT coordination team colleagues. Ana, for example, believed that she, with her position in UNFPA and Benedict, as a representative of the government *"had access to plans, so can actually make decisions…When you pick participants, you should have participants who can do the action and those who can make decisions…someone [such as she and Benedict] who can have influence" (second interview: Ana)*.

Training and organisation level factors

Team member capacity and organisational position and influence

Benedict repeatedly referred to himself as a member of the "core [his country] team" (interview). He placed great importance on the role of both his UN and NGO SPRINT coordination team counterparts and spoke respectfully of their different but equally important roles. He stated that these three organisations- his department of health, UNFPA and a particular local NGO- had worked collaboratively to *"come up with a re-entry plan, an action plan after the training" (interview)*. From then, Benedict recalled that each team member had contributed to their particular strengths, and he listed as the first amongst factors which enabled him to carry out his work "the presence of supportive agencies, including the [department of health], UNFPA and [the local NGO], committed advocates for implementation of the MISP at the local level, strong inter-agency collaboration and committed local health workers" (SPRINT Monitoring and Evaluation Report 3: summary of a presentation by Benedict).

Indeed, his UNFPA colleague Ana similarly highlighted the important advocacy and training role of Benedict as a representative of the department of health; her key position as a UN officer in terms of funding, providing resources, advocacy and coordination; and the essential work of the local NGO as an implementing partner conducting on the ground mobilisation and service provision activities (second and final interviews: Ana).

Organisation and environment level factors

Support and government support

Along with the assistance from members of his SPRINT coordination team discussed above, Benedict remarked that he felt well supported by his manager, the director of the department

of health. He was able to present on the MISP and SPRINT at an annual implementation review to all health and emergency managers, and found that the director, who was in attendance, *"really committed to and approved the whole package" (interview)*. Together with his newly developed knowledge of the MISP and the presence of cooperative partners, Benedict believed that having supportive supervisors and cooperation from related government agencies had been the most helpful factor for him in transferring the SPRINT Training.

Summary of Chapter 6

The three case studies included above represent the wider experience of the SPRINT trainees I was able to follow from the training room to their work context over a period of more than three years. In line with my findings on *intention* to transfer (outlined in Chapter 5), I discovered that each individual trainee brought with them personal characteristics such as *job involvement* and *prior experience*, which interacted with aspects of the training, their organisation and their broader environment to determine whether they took action toward meeting any or all of the training programme's objectives. The specific factors which determined this action or inaction were identical to the anticipated factors uncovered during the first phase of my research. In all instances, and as exemplified by Sujana, Heng and Benedict, the intention a participant formed at the close of the training was in alignment with their initiation of training transfer when they returned to work. This has a number of important consequences, and these will be discussed in the chapter to follow.

Chapter 7

Discussion: A system of influence on the transfer of SRH training for humanitarian settings

Introduction

In undertaking this research I sought to understand:

1. Which *training transfer factors* determine the *intention* of training participants to transfer learning gained through SPRINT Training?
2. Which *training transfer factors* determine the *transfer* of learning gained through the SPRINT Training?
3. How can *training transfer factors* be addressed so that the transfer of learning gained through the SPRINT Training is *optimised*?

To achieve this, I conducted a multi-phase qualitative study, interviewing SPRINT trainees at the close of training programmes in Kuala Lumpur, Sydney and Suva, and following them at intervals after the training as they re-entered their working world. As the findings outlined in the previous two chapters indicate, this research allowed me to discover a broad range of responses to the training, varying levels of personal self-efficacy and differences in the degree of learning attained by participants. The association between these outcomes and their antecedent factors also became clear. So too did the forward impact of self-efficacy, reaction and post-training knowledge on the intention of participants to transfer SPRINT Training on SRH in humanitarian emergencies. My longitudinal approach also provided insight into the implication of these different forms of intention for the actual *use* of knowledge and skills developed during the SPRINT Training. In this chapter, I synthesise these findings and indicate their importance for programme managers and training professionals interested in optimising the transfer of training on SRH in humanitarian settings.

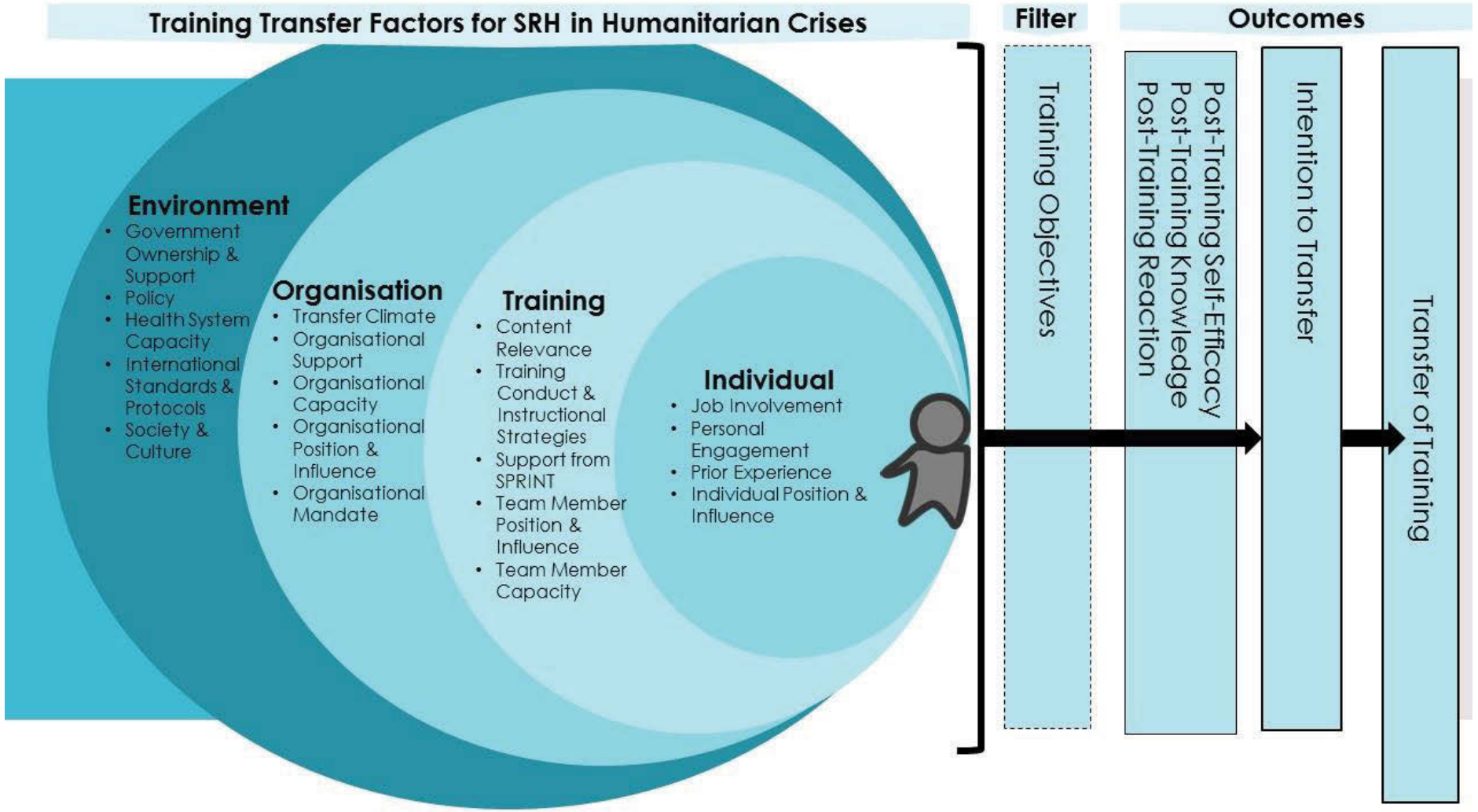
Summary of findings: A system of influences

This research found that the transfer of training on sexual and reproductive health in humanitarian emergencies is dependent on and moderated by a number of factors that relate to the individual trainee, the training program, the organisation in which the trainee is working

and the broader environment. These can be described as layers of moderators which work through the intermediary filter of the training course objectives to influence the first three training outcomes of post-training self-efficacy, post-training knowledge and post-training reaction. These three proximal outcomes were then found to have a direct influence on an individual trainee's intention to use the knowledge and skills developed during the training course, and this intention, in turn, predicted the initiation of transfer activity on return to work.

Together, these findings have informed my understanding of the process of transfer for participants in the SPRINT Training. This understanding is conceptualised in the following way (see Figure 12, below) and incorporates a system of influences which determined the transfer of training on coordinating SRH services in humanitarian emergencies.

Figure 12: The System of Influences which Determined the Transfer of Training on SRH in Humanitarian Settings



A system of factors

The breadth of factors identified through my research extends what is currently known for this specific subject area and training programmes with a similar approach and objectives. My research has provided evidence for the inclusion of an additional environmental level of transfer moderating factors, broadening the three- fold system of individual, training and organisation level factors described in the training transfer literature. It also answers calls within the training transfer field to situate training within a wider context and recognise the importance of identifying and addressing all potential factors on all levels of effect (Foxon, 1997; Kim, 2004; Nikandrou et al., 2009).

The influence of proximal training outcomes

Importantly, and as suggested by existing training transfer literature (Blume et al., 2010), the particular training course objectives pursued by the SPRINT Initiative played a significant role in influencing any proximal and eventual outcomes of the training programme. The breadth of the three training objectives (advocacy, echo-training and MISP coordination) required the trainee to have a range of capacity, experience, and support. The participants' perceptions of the training objectives after completion of the training course were found to impact upon their self-efficacy and knowledge, resulting in varied reactions to specific training components. Training objectives are therefore included in my conceptualisation of the training transfer process and the model at Figure 12 as a filter which influenced both intention to transfer and actual transfer on return to work.

My research identified three immediate outcomes of the training process which result from the convergence of all antecedent training transfer factors. These proximal outcomes are post-training self-efficacy, post-training knowledge, and post-training reaction, and have been included in my conceptual model as the first set of results arising from attending the SPRINT Training. The significance of each of these outcomes for training transfer is well established in the relevant literature (Grossman and Salas, 2011; Al-Eisa et al., 2009; Colquitt et al., 2000; Aguinis and Kraiger, 2009; Cheng and Hampson, 2008; Burke and Hutchins, 2007; Bhatti and Kaur, 2010). Importantly, the identification of these immediate training outcomes in my study provides an important focal point for planning and implementing interventions which can address the influence of training transfer factors on intention and eventual transfer. This is because, if positive self-efficacy, post-training gains in knowledge and skills, and a favourable

reaction to the training content can be optimised, participants may exhibit a positive intention to transfer and may, finally, be more likely to actually transfer the training. The central role of these proximal training outcomes provides a structure and direction for *addressing the antecedent factors of intention and transfer*, and these will, therefore be discussed in detail in the chapter to follow.

The importance of intention

This research found that a participant's *intention* to transfer was a sum result of all preceding factors, filters and proximal outcomes, and the nature of this intention directly determined whether participants initiated transfer within their work contexts. This is included as the second of the three outcomes outlined in my conceptual model of the transfer process (see Figure 12). There is a growing understanding within the training transfer field that intention to transfer may be a critical and reliable predictor of transfer (see, for example Foxon, 1997; Al-Eisa, 2009; Hutchins et al., 2013; Gegenfurtner 2013). My research strongly supports this supposition. Understanding the central role of intention both guides the development of interventions which can address its antecedent factors, and provides a valuable opportunity for the effective evaluation of training programmes immediately post-training. The first implication of this is the possibility of putting in place strategies which will support positive intention to transfer. This will be examined in relation to intention's antecedent factors in the chapter to follow. The second implication, that the evaluation of training may be effectively undertaken by looking at intention to transfer immediately post-training, answers the concerns of many human resource and training professionals who recognise the difficulties associated with long-term monitoring and evaluation (Hutchins et al., 2013). The potential of examining intention as a point for training evaluation will be considered in the following chapter.

Putting the learner at the centre of the transfer system

As expressed by Holton, Bates and Ruona (2000) in their important work developing the Learning Transfer System Inventory (LTSI), "organisations wishing to enhance return on investment from learning-training investments must understand all the factors that affect transfer of learning, and then intervene to improve factors inhibiting transfer" (p334). The inventory developed by these authors provides a set of scales to identify and measure factors within the transfer system and includes constructs related to a trainee's capacity to transfer

learning, their motivation to use knowledge and skills developed during the training, and factors within the transfer environment. My research has followed a similar systematic approach but has differed in two important ways. First, I have approached this research inductively, allowing findings to emerge from my data in contrast to theory or model testing. This has enabled the discovery of a broader system within which to situate the training programme. Second, I have placed the trainee at the centre of the system, and, in line with similar studies (such as Nikandrou et al., 2009). I have examined the process of training transfer from the perspective of the individual training participant, emphasising each person's perceptions and experience. I have taken this approach in order to uncover and explain the individual's unique understanding of all factors that accompanied them to the training place, influenced them during the course of the training, and travelled with them as they re-entered their work contexts. Due to the autonomy of participants from the training provider, it is, after all, SPRINT trainees who ultimately decide if, when and how they will apply knowledge and skills developed during the training course (Gegenfurtner et al., 2009; Yelon et al., 2004, Cheng and Hampson, 2008).

Conceptual models of training transfer: Intention and autonomy

In addition to identifying a range of potential moderating factors and including a further level of environmental influences, there are a number of other important differences between the understanding of the transfer of training process presented by existing literature and that represented by my conceptual model of findings in Figure 12. Most significant amongst these is the absence in my findings of any direct connection between training transfer factors and the eventual transfer of training. These direct connections are suggested by the literature and have been supported in a number of studies (Grohman et al., 2014).

What I found instead was consistency in the training transfer factors that participants described as affecting their ability to transfer learning immediately post-training (phase 1 research) and at intervals of between six months and three years after attending the SPRINT course (phase 2 research). All of those factors anticipated by participants at the close of the training programme were the same as those they experienced upon return to work. There appeared to be no difference in the type of factor mentioned by participants or in the way these factors were experienced. As an example, participants who expressed concern about

having the time, materials, permission and opportunity to apply newly trained skills (and had identifiably low self-efficacy as a result) were faced with these very same obstacles when they returned to work. Those who believed that their organisation would provide these resources, or that they could reasonably access them through other means, did, in fact, find that they were able to engage these resources when they re-entered their organisation.

Memories of work and intention

The consistency of factors affecting participants' intention to transfer their learning immediately after training and those they experienced when they returned to work may be explained by the research of Yelon et al., (2004; 2013) and their use of the concept "memories of work". These authors posit that autonomous professionals can form intention to use new ideas by actively connecting memories of their work and work environment, perceptions of their personal capacity based on prior work experience and their professional values and goals, with the content and conduct of the training programme. This process allows individuals to assess the credibility, practicality and need for using newly developed knowledge and skills. In so doing, individuals form an intention to use (or not use) these new ideas by the close of the training course (Yelon et al., 2004).

During interviews for the first phase of my research, participants seemed acutely aware of their own and others' capacities, and the realities of the contexts (both workplace and wider) into which they may attempt to transfer what they had learnt. They also clearly explained the many facets of their daily work and how the training did or did not align with specific job tasks. Further to this, both the career and personal goals and values of participants were expressed in relation to the relevance of the training content and objectives and their own beliefs about the prioritisation of sexual and reproductive health issues in humanitarian emergencies. These 'memories of work' and the context in which they worked proved salient, and their predictions of how this new training would align with or diverge from the realities of any attempt to transfer the training were shown to be accurate in my research.

Like Yelon et al., (2004 and 2013), I found that the memories and perceptions of self, others and environment (represented by my *training transfer factors*) expressed by participants at the end of the SPRINT Training were weighed against the contents and expectations of the training programme (training contents and objectives) to form intention to transfer (or to not transfer)

any newly developed knowledge or skills. Building on previous theories of intent to utilise training, Yelon et al. (2004 and 2013) mention a number of types of transfer intention which result from memories and perceptions of antecedent training transfer factors.

These forms of intention commonly result in some level of training transfer. The first is labelled "idea seeking during training" and is used to explain that "while taking into account their personal, training and work experience, autonomous professionals assess the credibility, practicality and need for using an idea to make a final commitment to apply an idea at work" (Yelon et al., 2004:99). A majority of informants in Yelon et al. (2004) followed this decision-making process and stated that they had chosen whether or not to apply a specific idea while in attendance at the training course. This finding is supported by Hutchins et al. (2013) in their assertion that "by the end of the training programme, trainees will usually have made the decision about the extent to which they will apply their learned knowledge to work" (p253). In my study, a number of participants in the SPRINT training course, including Sujana, represent this form of intention which is consciously directed at specific transfer targets.

The second form of transfer intention, called "opportunity seeking", is used to describe a situation in which training participants form a positive general intention to apply what they have learnt during training and then seek specific opportunities to use a new idea as they approach their work (Yelon et al., 2004). For this second form of transfer intention, a number of trainees in my study, including Benedict, showed that the development of generally positive intention can influence actual transfer achievements when opportunities to apply newly developed knowledge and skills are actively sought within the participant's organisation.

A third form of transfer intention, labelled "idea seeking at the place of work" applies to trainees who "may learn an idea, not intending to use it. However, when they are planning or are about to take on a work assignment, they think back to ideas they learned and assess their credibility, practicality and need in the situation" (Yelon et al., 2004:99). My research found no evidence of this form of transfer behaviour amongst the SPRINT trainees interviewed. In all cases, intention formed immediately after the training programme predicted action, so that only "idea seeking during training" and "opportunity seeking" on return to work were the norm for those who informed my research.

In my research, therefore, intention played a critical and central role in determining post-training action. Those who formed a positive intention to apply their learning as a result of attending the training took steps to utilise the training when they returned to work. Those who expressed a negative intention to apply did not seek to initiate transfer themselves. It is for these reasons that the direct connection between training transfer moderating factors and the actual transfer of training into practice is not indicated in the conceptual model representing my research findings (Figure 12), leaving intention as the crucial intermediary between the four levels of antecedent training transfer factors and eventual transfer.

The theory of planned behaviour and intention

For the reasons outlined above, my findings indicate that intention to transfer training should be placed at the centre of the training transfer process. This has been suggested and more recently substantiated in the training transfer literature (Chiaburu and Lindsay, 2008; Gegenfurtner et al., 2009). Along with this recent research has come a call for the expansion of training transfer theory so that it better explains this central role of intention. In looking to do this, a number of authors have encouraged the application of "a robust theory" (Cheng and Hampson, 2008: 329) such as the theory of planned behaviour (TPB) (Ajzen, 1991) to supplement our current understanding of this "first and most crucial stage in the transfer process (Al-Eisa et al., 2009: 1221). TPB "has been successfully used in predicting a wide range of behaviours with a high degree of accuracy" (Al-Eisa et al., 2009:1223) but remains underutilised in training transfer theories and research (Hutchins et al., 2013). The theory of planned behaviour posits that the formation of intention is influenced by three precursors-attitudes, subjective norms and perceived behavioural control, and that intentions formed are, in turn, "an immediate antecedent to behaviour and are likely directly proportional to an individual performing the said behaviour or action" (Hutchins et al., 2013: 253). The existing training transfer research which has incorporated the interpretations provided by TPB has done so in an integrative way, to both fill "a gap in prevailing theoretical models" (Cheng and Hampson, 2008: 335), and to provide some order and clarity to the factors which "other researchers have found important in explaining the transfer of training" (Cheng and Hampson, 2008: 335). I have followed this holistic approach and have applied TPB to help both explain and provide structure to my findings. This will be discussed in the sections to follow.

Training transfer and the autonomous learner

A further function of integrating TPB into existing theories and models on the transfer of training is to deliberately focus on the 'decision role' of trainees. As alluded to previously, the trainee is considered by my research to be an agentic learner, one who actively considers their own and others' capacities and engages dynamically with the training, memories and perceptions of work, their organisation and wider environmental influences in order to make sense of the training and what it means to transfer new behaviours. SPRINT trainees "have their right to choose what to transfer" (Cheng and Hampson, 2008: 335) in a way quite distinct from many other trainees. They are, in some respects, what Yelon et al. (2004) refer to as relatively autonomous or self-governing workers. Because the SPRINT Training programme did not originate from within their own organisation, they:

> [A]re not forced by [their] company to follow a standard procedure exactly as prescribed. Nor are they held accountable by structured supervision. These workers decide how they will operate in some or all of their tasks. They also decide if and when they will apply new ways to act that they have learned in training (Yelon et al., 2004: 83).

In the context where a course of training is not instigated by an employee's own organisation, and its outcomes are not enforced through direct organisational supervision, these trainees remain autonomous from the training itself and any subsequent action to initiate transfer becomes even more acutely dependent on personal intentions (Yelon et al., 2004; Cheng and Hampson, 2008). As shown in appendix 2, this form of extra-organisational training is not uncommon within the field of training for SRH in humanitarian settings and within wider humanitarian and development capacity building approaches.

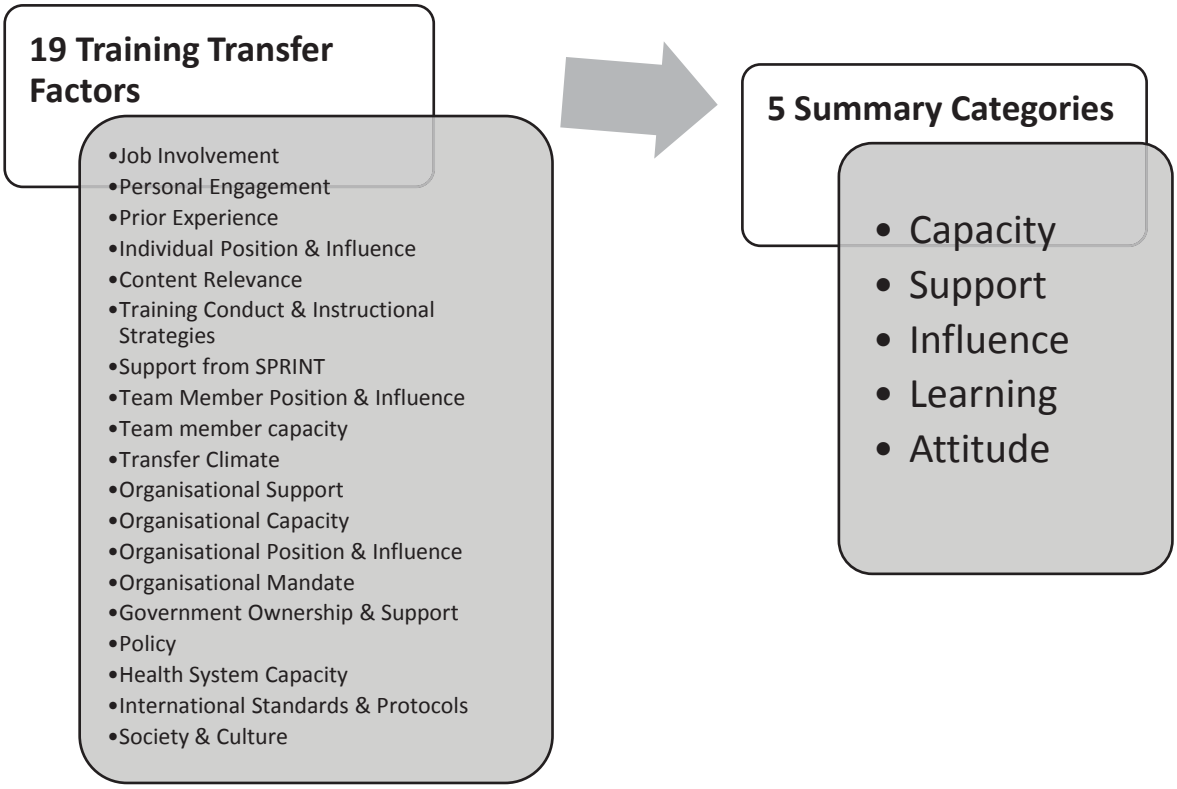
Identifying and understanding the antecedents and consequences of intention: the influence of post training self-efficacy, knowledge and reactions on intention to transfer and transfer of training

Intention to transfer SPRINT Training was found by my research to be wholly predictive of a trainee's efforts to use any newly developed knowledge and skills when they returned to work. Given this finding, it becomes important to understand how and why participants formed and settled on their particular intention to take action or to not take action to meet any of SPRINT's three training objectives. My research discovered that the most immediate influence

on intention to transfer were the three post-training outcomes of self-efficacy, knowledge and reaction. Preceding these three outcomes were the array of training transfer factors, such as *personal engagement*, *content relevance*, *transfer climate* and *health system capacity*, that have been discussed previously. In my interviews, participants connected these training transfer factors with specific post-training outcomes. For example, factors related to one's own or others' capacity were reported by trainees as impacting confidence in their ability to pursue SPRINT's objectives, and as such, were an influence on post-training self-efficacy; a participant's *prior experience* affected their degree of learning, and was therefore connected with levels of post-training knowledge; and attitudinal factors such as *personal engagement* and perceptions of *content relevance* determined how a trainee reacted to the training and are, consequently, linked with the post-training outcome of reaction.

In this section, I have placed the three proximal post-training outcomes at the centre of my discussion and will first focus on how they are influenced by training transfer factors and second, how they, in turn, shape a participant's intention and eventual transfer of training. Under each of these proximal post-training outcomes, I have included training transfer factors which influenced that particular proximal training outcome. So that the large number (nineteen) of training transfer factors identified through my research may be better understood in relation to their impact on the training outcomes, I have grouped these factors together into the summary categories (capacity, support, influence, learning and attitude) in Figure 13, below.

Figure 13: Summary Categories of Training Transfer Factors.



Each of these categories contains a number of related training transfer factors. This structure enables a deeper analysis of analogous factors and the influence they have on proximal and eventual outcomes of the training programme. The table below summarises how these factors have been grouped, and the proximal training outcome they directly influence.

Table 5: Relationship between Training Transfer Factors and Proximal Training Outcomes

	Proximal Training Outcomes Influenced		
	Post-Training Self-Efficacy	**Post-Training Knowledge**	**Post-Training Reactions**
Antecedent Training Transfer Factors & Summary Categories	**Capacity** Prior Experience Team Member Capacity Organisational Capacity Health System Capacity		
	Support Support from SPRINT Transfer Climate Organisational Support Organisational Mandate Government Ownership & Support Policy International Standards & Protocols Society & Culture		
	Influence Individual Position & Influence Team Member Position & Influence Organisational Position & Influence		
		Learning Prior Experience Training Conduct & Instructional Strategies	
			Attitude Job Involvement Content Relevance Personal Engagement

Grouping the training transfer factors found in my research into these categories highlights pivotal aspects of the transfer system and shows possible points for intervention which may heighten post-training self-efficacy, post-training knowledge, and positive reactions to the training course. Implementing appropriate interventions to address these points would maximise intention to transfer and therefore actual application of trained knowledge and skills in the work place. The potential of employing interventions based on these summary categories will be discussed in the chapter to follow. In the remainder of this chapter, I will provide an overview of each proximal training outcome, the groups of antecedent factors

which were found to lead to it and the influence of these proximal outcomes on intention and eventual transfer of training.

Proximal training outcome 1: Post-training self-efficacy

Post-training self-efficacy has been found in meta-analyses to influence the transfer of training (such as Blume et al., 2010). This outcome has been associated with intention to transfer in training transfer research (Colquitt et al., 2000) and through the application of the theory of planned behaviour to the study of training where it is considered identical to Ajzen's (1991) *perceived behavioural control*, one of three important precursors to intention (Al-Eisa et al., 2009). In this research, I have understood self-efficacy as "beliefs in one's capabilities to organise and execute the courses of action required to produce given attainments" (Bandura, 1997: 3). In relation to *post-training* self-efficacy, these beliefs incorporate those which have developed as a result of attending the training course or in response to perceptions of alignment between the contents and objectives of the training course, and the situation into which participants may attempt to transfer their learning. This broad definition signifies that positive post-training self-efficacy depends on more than confidence in one's own capacity. Instead, these beliefs extend to whether a trainee perceives or remembers their experience of any surrounding capacity and support which will allow them to 'organise and execute' appropriate courses of action to meet the training course objectives. Thus, post-training self-efficacy is influenced by factors which extend beyond those related to the individual and include situational constructs. All of those factors found in my study to prompt the post-training self-efficacy beliefs of SPRINT Training participants will be explored below. These factors have naturally fallen into three categories- *capacity, support* and *influence*- within individuals, their organisations and wider contexts.

The influence of post-training self-efficacy on both intention to transfer and actual transfer of training was also well supported by my research. I found that those participants who reported generally high levels of post-training self-efficacy intended to use the training and went on to do just that. Importantly too, these participants were more likely to persevere when faced with obstacles to their transfer efforts, a finding suggested by research into operationalising self-efficacy and summarised by O'Sullivan and Strauser (2009) in their statement that "[i]ndividuals with greater self-efficacy will persist longer at a specified task in the face of adversity, whereas individuals with low self-efficacy will be much more likely to terminate the task prior to successful completion" (p252). For these reasons, it becomes crucial to optimise a

training participant's post-training self-efficacy, and for SPRINT trainees, the first step towards doing so is to analyse and address antecedents related to individual, team, organisational, and wider capacity.

Capacity related antecedents to post-training self-efficacy

Prior experience

A participant's existing capacity and the area of work they had been involved with prior to attending the training had a direct impact on their feelings of self-efficacy at the close of the training. The impact of *prior experience* on individual confidence to perform the actions requested by SPRINT was dependent on the particular training objective being discussed. As could be predicted, those with experience conducting training had high self-efficacy for the echo training objective, those with coordination experience felt sure of their capacity to undertake this work in preparedness and response phases, and those who had previously advocated to relevant decision makers were most confident in their ability to do so again. I was able to document that the varying levels of confidence which came from a participant's *prior experience* and existing knowledge and skills influenced their intention to act and that this intention carried forward into any post-training action or inaction. Participants who had experience and skills in this field were more likely to initiate action, while those who did not were less likely to undertake work relevant to the training objectives. This was true for all participants I followed longitudinally and is highlighted by the different transfer achievements of included case studies.

The scope of the three SPRINT Training objectives required participants to bring a broad range of *prior experience* with them to the training. Few were able to do so and this impacted negatively on overall self-efficacy, and therefore on intention. Meeting the demands of these three objectives was answered by SPRINT in its team approach, and it was assumed by facilitators that within each country team lay the collective capacity to achieve all training aims. The breadth of the three objectives was a concern to participants and indicates that the division of responsibility assumed by SPRINT was not made clear to all trainees: where it was known, there remained some concern over the capacity of team mates to carry out expected work. In addition, the longitudinal nature of my research showed that few assigned country coordination teams remained together, for reasons to be discussed below.

In addition to the broad training objectives, the SPRINT Training curriculum incorporated both clinical subject matter and that aimed more generally at coordination tasks. This dual focus proved confusing to some participants and took focus away from the Initiative's essential goal which was to address gaps in *coordination* of the MISP. It also required a diversity of experience that was again difficult to find in any one trainee, the result of which was lowered or negative self-efficacy for participants with non-clinical backgrounds. Those who were not clinicians were, therefore, more likely to report lower levels of transfer intention and less likely to initiate action towards the training objectives. Even for participants with clinical education and experience, the mixed focus of the training curriculum caused confusion when they attempted to facilitate echo-training workshops.

The MISP itself is broad as it addresses a range of priority responses to SRH needs in humanitarian emergencies. The number of areas included in the package also proved challenging for some participants. Many expressed a lack of confidence in one or more subject area and stated that they would require additional support- either from within or outside their team- to echo-train, coordinate or advocate for a particular topic area. Sexual and Gender Based Violence was most commonly singled out as a subject of concern in this regard. During the second phase of research, I found that low self-efficacy in relation to particular subject matter was dealt with in two broad ways. The first was to engage in-country expertise to fill this gap, particularly in relation to facilitating components of echo-training workshops. The second, and this was seen most commonly where participants had no *prior experience* of a particular area and were also not convinced that it was a priority (to be discussed in detail under *Reaction*, below), was the exclusion of particular content areas in further training programmes and preparedness and response activities.

Team member capacity

As mentioned above, participants expressed concern over the ability of fellow trainees to apply any knowledge or skills acquired during the training course, and how this would impact their own work towards the training objectives. This was again dependent on the particular objective referred to, and the background knowledge, skills and work experience of the trainee being discussed. During interviews for the first phase of this research, it was common for participants to mention that their coordination team members did not have the background needed to either take action toward meeting training objectives on their own, or to contribute

to the work of the team. This resulted in concern, particularly amongst those lacking sufficient capacity themselves, over who would be able to undertake particular aspects of the work expected by SPRINT.

In following up participants at intervals after the training, the result of this missing capacity became clear. In most cases, coordination teams had dissolved and those without necessary background capacity were no longer involved. Remaining participants, including Sujana, stated that these trainees were simply not 'the right people' for a number of reasons, including their lack of knowledge and experience in humanitarian or reproductive health work. Even for Benedict, who consistently spoke positively about being part of a SPRINT national coordination team, a number of original SPRINT team members were no longer involved with the group and had instead been replaced by those seen to be more fitting by remaining coordination team members.

Organisational capacity

In terms of *organisational capacity*, participants in both phases of this research most commonly identified human resource constraints as having the greatest impact on their confidence and ability to undertake work towards SPRINT's objectives. The impact of this factor was predicted at the close of the training and experienced by participants when they returned to work. Participants predicted and then experienced restrictions on both their own time and the time of others within their organisation to integrate new activities necessary to meet the training course objectives (this factor will be further discussed under *Support*, below).

The impact of *organisational capacity* on self-efficacy was also seen in perceptions of the alignment between an organisation's usual scope of work, the content areas covered by the training, and the tasks involved in pursuing SPRINT's training objectives. As previously discussed, the objectives of the training were broad, and given the wide-ranging nature of the MISP, so too were the training's contents. For some participants, particularly those from UNFPA, there was an obvious fit between the SRH and humanitarian preparedness and response subject areas, the three objectives of the training, and usual programmatic areas. For other trainees, their organisation had only previously been involved in either SRH development work or humanitarian preparedness and response. This lack of *organisational*

capacity in relation to one aspect of the training was widely reported by participants from non-governmental organisations, many of whom believed that they could provide SRH services, but had little or no experience in doing so in disasters. This was exemplified in the case study of Heng, who, although he believed that all of the contents of the training could fall within his organisation's scope of practice, reported that their focus was on programming for normal or stable circumstances. In addition to this, many similarly positioned trainees reported that the contents of the training aligned with their organisation's capacity to some degree but the objectives did not. This was again seen through the case study of Heng, whose organisation was experienced at SRH service provision but did not possess the capacity to undertake echo-training, advocacy or coordination work- the three objectives pursued by the SPRINT Training.

Again, the team approach of the SPRINT Training was designed to ensure that the broad contents and objectives of the course could be addressed collectively by the organisations incorporated into each team. Again, however, this assumption did not generally translate into a cohesive team approach post-training. This was due, amongst other factors, to individual *team member capacity*, but also to the division of roles and responsibilities between organisations not being made explicit during the training, and the training itself not being pitched to the varying capacities of those organisations involved.

Benedict's case study provides an instructive contrast to the experience of many participants followed in my longitudinal study. As mentioned above, the active national coordination team, of which Benedict remained an important member, was not the one originally assigned by SPRINT. It retained a number of original members, most actively those from UNFPA and the Department of Health. Meanwhile, trainees representing a local SRH NGO and an international disaster relief organisation, both of whom reported low self-efficacy and generally negative intentions to transfer at the close of the training, had become largely uninvolved. Working at a coordination level, Benedict and his UNFPA counterpart Ana sought to fill the gaps in the collective capacity of their team. They recognised that they were in the correct position and had the skills to assume coordination and advocacy roles, but also that they and/or their organisation lacked the capacity necessary to provide on-the-ground services in the time of a crisis.

To address this, they worked strategically with a local NGO, engaging with this organisation in recognition of their strengths in SRH service provision and working to develop its employees'

knowledge and skills in disaster response. In fact, the SPRINT Training of Trainers participant who represented a local SRH NGO and had not maintained her involvement with Benedict's coordination team (mentioned above) worked for the same NGO which later became so vital to the transfer achievements of Benedict and his UNFPA colleague. She did not, however, develop positive self-efficacy toward the training objectives as a result of attending the SPRINT workshop. As with Heng, the objectives of the training and the SPRINT Initiative's need for a participant to have a particular level of capacity (and influence, which will be discussed further below), did not align with her personal position, knowledge, skills or experience, or her organisation's. Benedict and Ana recognised this but also saw the value of engaging this same organisation as a vital implementing partner. This approach worked with the strengths of the NGO, and allowed Benedict, Ana and their counterparts, as a coordinating body, to harness the partner organisation's existing resources and capacity. It also recognised that the SPRINT Regional Training of Trainers content and objectives did not align with this local NGO's strengths and that alternative capacity building strategies were more appropriate for them. Sujana echoes this too in her statements that NGOs in her context play a crucial role in service provision by allowing access to disaster-affected communities when international organisations have not been granted permission to respond, and by facilitating access to SRH services for particularly vulnerable groups including adolescents. In both instances, the NGOs in question were respected as essential components of a response to SRH needs in humanitarian settings, but not as part of a coordination body, and as such, not at the level to which the SPRINT Regional Training of Trainers was pitched.

Health system capacity

At the close of the SPRINT Regional Training of Trainers, participants commonly reported that they had concerns about existing capacity within various components of their country, province, or district's health system. These concerns influenced a participant's confidence in their ability to transfer new knowledge and skills and remained the same throughout the two phases of my research. This showed that the trainee's perceptions of their wider contexts and expectations of the supports and obstacles they would face on this broader level were accurate.

During both phases of my research, participants were worried about a lack of human resource capacity at various levels within the health system. First, a number of participants reported that they believed there to be, or that they remembered there was, a lack of knowledge about

both the importance of addressing SRH needs in humanitarian settings and the MISP amongst decision makers within the health system. During the second phase of research, it became clear that these concerns were then practically experienced as a significant impediment to the transfer of training. This is exemplified in Sujana's case study, where she found that advocating to decision makers was a vital component of her post-training work.

The issue of staff movement, turnover and attrition, particularly at senior levels within health system structures was discussed by a number of participants as an important additional obstacle related to a systemic lack of human resource capacity. Efforts to build productive partnerships with important stakeholders came to nought when they left their post (see, for example, Sujana), or the driving force behind team action and cohesion was lost with staff attrition (see, for example, Heng's case). For participants such as Heng, who had negative self-efficacy for all activities at the close of the training, this resulted in a complete withdrawal from the Initiative and its work. For participants such as Sujana, who reported generally positive levels of post-training self-efficacy, human resource constraints were an obstacle to her work, but one she worked to overcome through continued advocacy and re-engagement with replacement staff.

SPRINT trainees also expressed concern over the availability of skilled health care service providers within their health care systems. This concern was again played out when participants returned to work and found a lack of capacity amongst those they would be expected to coordinate during a crisis. As discussed above, both Benedict and Sujana instituted post-training strategies to address this gap by engaging and building clinical capacity of service providers in SRH care for humanitarian settings.

Inadequate structures for collecting, managing, analysing and applying health data, particularly those related to sexual and reproductive health, were also seen to be an obstacle to meeting SPRINT's objectives. Constraints were also reported in relation to logistical and supply chains. Where these structures existed, they were seen as a potential support for conducting this work.

The issues expressed above were multiplied by trainees to match the various administrative levels in each participant's context. Trainees such as Benedict commented on the relative capacity of different geographical segments of the health system and a clear link was made

between the ability of a participant to conduct necessary work and existing health system strength prior to a humanitarian emergency. Those who spoke positively on the strengths of various health system components were more likely to exhibit generally high levels of self-efficacy. It was these participants who were more likely to initiate transfer and maintain efforts to meet SPRINT's objectives on return to work.

Support related antecedents to post-training self-efficacy

Support from SPRINT

The relationship between a participant's perceptions of support offered by the training provider and their levels of self-efficacy was complex, dependent on a number of other factors such as *personal engagement* and *content relevance*, and evolved over the course of this research. Initially, participants who expressed a strong need for ongoing support from the SPRINT Initiative tended to display low self-efficacy either generally, or in relation to the specific objective being discussed. During our first interview at the close of the SPRINT Regional Training of Trainers, Heng, for example, commented that he and his coordination team colleagues would require quite intensive *support from SPRINT* if they were to take action towards any of the training's objectives. As has been reported, he exhibited generally low levels of self-efficacy post-training. On return to his workplace, Heng stated that he could not accept any of the support which was subsequently offered by SPRINT because he was too busy with his own work. This suggests that other factors may play a role in a participant's reaction to offers of post-training support. It was clear that Heng was not involved in work related to the SPRINT Training objectives and believed that he had no time to add activities to his work schedule. He was not personally engaged with the issue of SRH in humanitarian settings, nor did he perceive an association between the training's expectations and his personal and *organisational capacity*. Considering the lack of alignment between the training contents and objectives and the realities of Heng's transfer environment, it is unsurprising that subsequent offers of *support from SPRINT* were rejected.

For other trainees, the relationship between post-training self-efficacy and *support from SPRINT* was dependent on particular objectives. Sujana provides a good example of this. After the SPRINT Training, she displayed generally high levels of self-efficacy with the single exception of lower confidence in her ability to conduct echo-training. She stated that she would require support from a SPRINT facilitator, at least initially, to ensure that she was an

adequate trainer. When I followed up with Sujana after the SPRINT Regional Training of Trainers, she reported that she felt well supported by the Initiative and had received the guidance she required to carry out further training, advocacy and coordination activities. In a way very different from Heng's experience, Sujana's *personal engagement*, positive perceptions of the alignment between her work and the training contents and objectives, and the realities of her transfer environment meant that she not only appreciated and accepted offered support, but actively sought guidance from SPRINT and wider networks involved in work for SRH in emergencies. Requests for *support from SPRINT* were, therefore, originally associated with low self-efficacy for the training objective, but characteristics found within and around Sujana meant that she was open to the support she needed to improve feelings of confidence in the conduct of future training workshops.

Transfer climate

Aspects of the organisational environment into which a trainee may attempt to transfer their training were found to have an important influence on post-training self-efficacy and consequent intention to transfer during the first phase of my research. The first category of *transfer climate* factors relate to situational cues within the work environment. Important amongst these cues was the presence of resources and equipment which would support participants in their transfer efforts. During interviews at the close of the SPRINT Training, participants expressed either concern about or confidence in the resources they believed were available within their organisation to support this work. Depending on the objective, those who expressed concern over access to funding, budget lines and equipment showed lower levels of post-training self-efficacy, while those who believed that they were materially supported by their organisations were more confident in their ability to work towards SPRINT's training objectives. Sujana provides a good example of a trainee who knew that there were funds allocated to support this work while she was attending the training. She found that the resources were available on return to her organisation as expected and believed that this was one of the most important factors enabling her to undertake transfer activities.

In contrast, Heng did not focus on the availability of funding and resources during our first interview. In terms of workplace cues, his concerns were more related to permission and his ability to allocate time to new tasks. This suggests that his recognition of more fundamental impediments to the transfer of his training stopped any consideration of practical

requirements such as funding. During our second interview he did, on pressing, explain that existing funding to his NGO was tied up in 'normal' programming, and that any further funding would be dependent on donor requirements. He had yet to see or seek any potential funding related to SRH in humanitarian emergencies. This again suggests that, for Heng and trainees employed by organisations not already directly involved in the field of SRH for crises, the issues of relevance to work and *organisational mandate* and the resulting availability of resources to support this work is a primary transfer moderating factor with influence on a collection of other training transfer factors. The collective result of this combination of factors was found to be a lack of confidence in his ability to undertake this work. In all cases, the level of a participant's post-training self-efficacy correlated first with their intention to transfer, and then through to their training transfer efforts.

As mentioned above, for Heng and others, permission and opportunity to take action toward meeting SPRINT's training objectives were found to be important components of situational cues within the *transfer climate*. During interviews immediately after the SPRINT Training, a number of participants expressed concern that the work expected by SPRINT was additional to their regular job and they perceived difficulty in integrating these new tasks into their schedules and work plans. Some explained that the expectations of the training were consistent with their existing job tasks, while other trainees expressed confidence in their ability to expand their duties to include action toward the three SPRINT training objectives. These different perceptions of roles, duties and control over work plans, which I captured during the first phase of my research, corresponded closely with levels of post-training self-efficacy. As could be expected, those who were already involved in similar activities or felt they could integrate these new tasks into their daily work were confident in their ability to transfer trained knowledge and skills. Those whose usual work roles and responsibilities did not generally incorporate tasks necessary to meet the training objectives, or trainees who believed they would not be able to integrate new activities into their scope of work were likely to express little or no confidence in their ability to transfer the training. The result of these varying levels of post-training self-efficacy were made clear during the second phase of my research. I found that those who were already involved in SRH for humanitarian emergencies, or whose job descriptions aligned with the expectations of the SPRINT Training were active in transfer. Others who felt they had autonomy in regards to their scope of practice and identified the importance of integrating action towards the training objectives into their daily work were similarly likely to initiate transfer. Remaining participants commented that what

SPRINT was asking of them was additional to their own work and they neither felt they could or should expand the scope of their work to include action towards the training's objectives. As a result, there was little or no transfer action.

I found that prompts which encouraged action towards the training objectives were another important component on situational cues within the *transfer climate*. For some participants, triggers to act in ways congruent with SPRINT's objectives were integral to their job descriptions. Others used their autonomy to build the requirements to act into their work plans. For both of these sets of participants, however, in-country counterparts and important stakeholders with whom they sought to work did not always share this same level of alignment between work plans and the SPRINT Training objectives. As SPRINT was an inter-agency initiative, the job requirements of one trainee did not necessarily align with the job requirements of their country team mates. Moreover, those who did see that working towards SPRINT's objectives was part of their scope of work had varying levels of influence over those who did not. During the first phase of my research, this lack of ability of any one person or organisation to compel action from any other person or organisation was a predicted obstacle to carrying out future work as a team. This was seen to be inherent in the inter-agency, 'outside instigated' nature of the training programme. No one team member held supervisory control over other team members, and SPRINT itself could encourage but not demand action. The result of this was the dissolution or changing membership of many SPRINT coordination teams.

The importance of team leadership to engage commitment from fellow trainees was shown through Heng's experience post-training. He had no authority to require action of himself or others trained by SPRINT. He did, however, react positively to the influence of the one SPRINT trainee from his context who he felt was in a position to request his involvement. When she was moved on, his action towards the training objectives ceased. Benedict and his UNFPA colleague Ana similarly recognised the importance of leadership in accessing in-country stakeholders they felt were necessary to continue SPRINT's work. Both stated that they would need to work closely with the 'bosses' of those they had trained at a national and district level to ensure that they remained engaged in these activities. In all cases, for training transfer to be initiated and maintained, cues which prompt action towards SPRINT objectives were needed within the workplace environment. These could come from mandatory job requirements or leadership from within or outside a participant's organisation.

Organisational support

I found the related concept of support from within an organisation also impacted a trainee's level of post-training self-efficacy. During phase one of my research, self-efficacy was influenced by a participant's perception and memory of *organisational support*, and in phase two by their experience of support when they returned to work. Support here included both the encouragement of direct supervisors and any wider indications of *organisational support*. Through interviews at the end of the SPRINT Training, I found that some participants attended the training with the full support and encouragement of their supervisors; others believed they would need to conduct advocacy within their organisations to enable them to pursue this work; still others were unsure of whether their supervisors had a clear understanding of what SPRINT expected them to do as a result of attending the training. While at the training, Sujana felt that she had support from her organisation to pursue this work, and during our follow-up interview stated that this was a very important facilitator to her transfer achievements. Heng, on the other hand, believed that his organisation was not opposed to his involvement in activities relevant to SPRINT's objectives, but, as discussed above, felt that any prompting to action would come from outside his organisation. For these participants and others interviewed during the first phase of my research, the belief that one's supervisor and organisation would be supportive of any transfer of newly trained knowledge and skills had an important influence on levels of post-training self-efficacy and intention to transfer. These varying levels of self-efficacy and intention were, in turn, related to transfer initiation.

Organisational mandate

An extension of *organisational support* was found in the training transfer factor I have labelled *organisational mandate*. A trainee's perceptions of the relationship between their own organisation's mandate and the goals and objectives of the SPRINT Initiative was an important contributor to post-training self-efficacy. During first interviews, those who were employed by UN Agencies, particularly UNFPA, were more likely to remark positively on this relationship, while those from NGOs and INGOs were less convinced of any alignment. An *organisational mandate* which was recognised by the trainee as inclusive and supportive of the transfer of training resulted in strong post-training self-efficacy and positive intention to apply training.

Once again, Heng and similarly placed trainees provide a contrast. During our second interview, he explained that the subject matter of the training- sexual and reproductive health in humanitarian settings- could be regarded as falling under his organisation's stated mandate. However, he felt that the objectives of coordination, advocacy and echo-training did not, but that his organisation was better suited to the role of implementing partner. A number of participants showed support for this position, emphasising the importance of engaging NGOs in an appropriate way by capitalising on their existing strengths in areas such as service provision and implementation, as suggested by Heng.

Government ownership and support

From my earliest conversations and interviews with SPRINT trainees, the importance of involvement from relevant government ministries- notably ministries of health and emergency management- was made very clear. The role of the government was reported as critical: for the approval of response activities; due to the government's position as lead coordinators in the event of an emergency; and for ensuring sustainability through the integration of SRH into government preparedness and response planning. During early interviews, participants varied in their responses, noting that they had this support; or that they did not currently have this support but were confident in gaining it; or that they felt it would be unlikely for them to be able to access and advocate to the correct ministry representatives to ensure buy-in. Each response had a predictable impact on post-training self-efficacy, and again this impact could be followed through intention to the likelihood of transfer initiation.

At the close of the SPRINT Training, Sujana stated that her government had committed to establishing mechanisms which would support the provision of SRH services during crises. She noted too that she would need to conduct advocacy with relevant government stakeholders in order to ensure ongoing commitment, funding and policy support for these activities. When she returned to work, Sujana found all of these circumstances to be true. She worked closely with her ministry of health counterpart, a fellow SPRINT trainee, and remarked on the importance of this relationship. Her efforts were undermined to a degree when this individual moved to a different position, but she persevered with advocacy and engaged new staff as they came into positions important to her goals. The results of this perseverance are clear in her transfer achievements.

The case study of Heng represents participants who felt they did not have government support because of the absence of a ministry representative at the training. He is also an example of a trainee who felt that it would be difficult to garner this missing support due to his position and the position of his organisation within health system hierarchies. During our second interview, he repeatedly contrasted his influence with that of a fellow SPRINT trainee who was the country director of a large international NGO. He felt that she was in a position to access and advocate to the correct people to ensure governmental support, but that he was not. The importance of position and influence in meeting the SPRINT training objectives and their relationship to post-training self-efficacy will be discussed in more detail below.

Policy

Closely related to government support is the existence of national policies and protocols which support the implementation of the MISP and training on SRH in emergencies. During the first phase of my research, many participants commented that they would need to assess existing policies and, where gaps were found, advocate for the integration of SRH components. The presence of supportive policies or a belief in one's ability to advocate for policy change were found to be related to positive post-training self-efficacy. Again, Sujana recognised that she would need to work with government representatives to ensure that SRH was addressed in emergency preparedness and response plans, but she had confidence that this task was within her means. Her transfer achievements show that she was correct in this assessment, and while it was challenging and time-consuming, Sujana was able to influence the bureaucratic process in a positive way. The result of this was integration of the MISP into overarching legal policy documents, local and national technical guidelines which governed on-the-ground implementation, and training curricula for ministry of health staff.

International standards & protocols

During the training it was quite commonly noted that there was a difference between the international standards presented and the reality of what was possible and/or permitted within each context. In some cases, participants perceived this as a serious impediment to undertaking further action towards SPRINT's objectives. These participants were less likely to feel confident in their ability to apply the training to their work contexts and therefore reported negative transfer intention. Others believed that they could adapt either the training contents or their approach to MISP coordination to account for these disparities. The

difference between these two sets of training participants lay first in their broader levels of self-efficacy. Those who exhibited generally high post-training self-efficacy, such as Sujana and Benedict, reported these differences as an obstacle, but immediately explained how they could be addressed, and went on to do so in their post-training activities. Second, participants who saw the disjunction between local and international protocols as an insurmountable obstacle to transfer generally showed little or no *personal engagement* with potential beneficiaries or the issue of SRH in crises. In contrast, those who persevered to overcome this obstacle were found to have strong *personal engagement* and conviction of the need to pursue this work. The importance of this last relationship will be discussed further under *post-training reaction*, below.

Society and culture

Existing socio-cultural norms and mores of potential beneficiaries and the trainees themselves were found to influence a participant's post-training self-efficacy. The controversies surrounding the provision of sexual and reproductive health services are well-documented for standard or stable settings, and many participants in my first phase of interviews believed that these would at least continue or be heightened in times of crises. These perceptions were expressed by contrasting SRH with the provision of traditionally prioritised humanitarian response services such as shelter, food, primary health care and water, or by stating that some aspects of the MISP would be accepted by beneficiaries while others- particularly the sexual and gender based violence components- would be more problematic. Participants reporting socio-cultural factors as a potential impediment to their transfer of training did so in two distinct ways. One group recounted their experience in attempting to provide SRH services in crises and explained the importance of addressing cultural barriers through gaining trust and adapting approaches to suit contextual realities. These participants recounted their actual experience of this factor as an impediment, but provided some strategies to overcome its affect. As such, they were more inclined to exhibit positive post-training self-efficacy and report transfer activities post-training.

The second group of interviewees who mentioned *society and culture* as an important factor did so from a point of little or no experience in attempting to provide SRH services during crises. They believed that potential beneficiaries would not accept these services should they be offered, but had little concrete to base these perceptions on. In these instances, the

trainee's own socio-cultural framing and beliefs about that of the context in which they may attempt to transfer decreased their levels of self-efficacy and resulted in diminished transfer activities.

Influence related antecedents to post-training self-efficacy

Individual position and influence and team member position and influence

The ability of an individual training participant to access and exert influence over essential stakeholders so that they can pursue SPRINT training objectives has been discussed as an important training transfer factor in the section on *government ownership and support*, above. I found during the first stage of my research that the expectations placed on trainees, particularly in terms of post-training advocacy and coordination work, often did not align with the position they held within their own organisation or within wider health system structures. As suggested above, those who had existing contact with decision makers, believed a SPRINT team member could facilitate access or felt able to gain access to key stakeholders in other ways were more likely to exhibit higher levels of post-training self-efficacy. Those who perceived that this was beyond their position and influence showed lower levels of self-efficacy.

The three case studies chosen from my research again exemplify the impact of different degrees of influence on post-training self-efficacy, intention and eventual transfer of training. Heng, who exhibited generally low levels of post-training self-efficacy, remarked during both interviews that he was not in the correct position to undertake further work towards SPRINT's objectives alone, and that he was not in a position to directly access those who could support this work. He found the connection with his country team member who led an international NGO promising, but he did not believe that he could have a role to play in the power structures necessary to affect required change, and this was confirmed when this coordination team member became uninvolved.

In contrast, Sujana stated at our first interview and in her application to attend the SPRINT Training that she was already in regular contact with her ministry of health counterparts. She reiterated this in our follow-up discussions and her post-training achievements are evidence of these close working relationships. In his position as regional director for the department of health, Benedict was in the correct position to access those needed to

support his work towards the SPRINT objectives. This was appreciated by his SPRINT coordination team mates, and his influence was capitalised on by both UNFPA and NGO counterparts.

Organisational position and influence

Closely related to the position of an individual within their organisation and wider health system is the position and influence of the organisation they represent. During phase one of my research I discovered that participants from local NGOs and those whose organisations were involved in only certain aspects of the subject matter presented in the training were more likely to have low post-training self-efficacy. The inability of these organisations to contribute to the training objectives, particularly for coordination and advocacy, was noted by fellow SPRINT trainees. Training participants from ministries of health or UN Agencies exhibited higher levels of confidence in their ability to pursue this work, with the possible exception of the echo-training objective for some. I found that representatives from these two categories of organisations were far more likely to remain involved with the initiative in a way which aligned with the training's objectives. Across the two phases of my research, interviewees reported that this was due to the organisation's standing within the health and/or emergency management systems, their recognition by and access to government structures, and their presence 'at the table' during decision making and coordination processes.

Proximal training outcome 2: Post-training knowledge

In order for the transfer of newly trained knowledge and skills to occur, training participants must learn and retain these new capacities. Blume et al. (2010) found a small to moderate correlation between learning and transfer in their meta-analytic review of training transfer, and stated that when a training programme can increase post-training levels of knowledge, trainees will be more likely to transfer training. In addition, Colquitt et al. (2000) found an intermediary role for intention, showing that the degree of post-training knowledge acquisition contributed to positive or negative intention to transfer. In my research, levels of post-training knowledge were self-assessed by participants and these reports compared to SPRINT's pre and post-testing of participants. I found that the degree of knowledge and skill acquisition was related to the antecedent factors of *prior experience* and *training conduct and instructional strategies.*

Learning related antecedents to post-training knowledge

Prior experience

Prior experience, also related to post-training self-efficacy, was found to influence the degree to which SPRINT Training participants felt they were able to learn from materials presented during the training. During the first phase of my research there was a distinct divide between participants with clinical backgrounds and those whose education and experience lay within other fields such as coordination or health management. Medical practitioners generally reported that their prior learning facilitated understanding during the SPRINT Training. Even for these participants, however, the breadth of the training contents, the mix of clinical and coordination components, and the combination of objectives were perceived as challenging.

All three of the case studies chosen as representative of my wider research stated that they had gained knowledge and skills as a result of attending the SPRINT Training course. Confidence in some of these skills developed over time and with support for Sujana, particularly in relation to the echo-training objective, but she reported positively that the knowledge she gained through the training provided her with new ways of approaching existing tasks. Benedict stated that the training had not only provided him with the fundamental understanding that SRH should be addressed during a crisis, but that he had gained the knowledge and skills to do so on return to work. Heng, on the other hand, expressed doubt about his degree of understanding of core concepts at the close of the training. He explained during follow-up interviews that, although he felt he had gained some knowledge from attending the course, his work had not changed as a result of involvement with SPRINT. Examination of these three case studies shows that while learning is a crucial step to transfer, it is not, in itself, sufficient to ensure the application of newly developed knowledge and skills. Important to consider is whether a participant is able and willing to transfer due to the presence of positive self-efficacy (resulting from the antecedent factors discussed above), and particular attitudinal characteristics (which will be discussed below). Heng felt that he had gained some knowledge, but lacked confidence in these new skills (shown through his expressions of low self-efficacy). He also lacked the supportive structures necessary for transfer (wider antecedents to post-training self-efficacy, discussed above), and the attitudinal characteristics which may prompt action and perseverance in the face of obstacles (to be detailed below).

Training conduct and instructional strategies

Participants generally stated that the conduct and instructional strategies employed by SPRINT were appropriate for the subject matter and audience, and would be replicable during in-country echo-training workshops. Trainees particularly noted the practical aspects of the training and felt that these, together with opportunities for discussion, aided their learning. One area of concern, however, was found to be a lack of alignment between components of the training and expected training outcomes. When conducting initial interviews, it was brought to my attention that the training was promoted as a 'Training of Trainers' course, but that there was little within the conduct of the training to support this intention, or the Initiative's echo-training objective. The absence of instruction on facilitating future SPRINT training workshops was found to undermine post-training knowledge for this objective. Sujana experienced this lack of skill development as an initial impediment to her attempts at conducting in-country training workshops to the SPRINT model. She did, however, utilise offered support and actively sought input from in-country actors. Her transfer achievements regarding the training objective are testament to these supportive factors.

I noted an important relationship between a participant's *prior experience* and learning, and the impact of inadequacies in the "training of trainers" components of the training curriculum on post-training knowledge, self-efficacy and intention. I found a clear division between participants who identified themselves as trainers in their current or previous work and those who did not. The former were more likely to have low self-efficacy, compromised post-training knowledge and lessened intention to transfer generally and for the objectives of advocacy and coordination, but also concurrent higher self-efficacy and intention for the echo-training objective. The opposite was also true for those who identified primarily with a non-training work role, such as coordination. These participants more often felt they had not acquired sufficient knowledge and skills in echo-training facilitation. They were, however, likely to have more generally positive levels of self-efficacy and high general intention to transfer the training. These findings show the importance of considering each objective as a distinct filter between training transfer factors, such as *prior experience*, and post-training outcomes including knowledge and intention to transfer. They also show that the breadth of SPRINT's expectations may have posed an impediment to transfer, as the pre-requisite skill set required by any one trainee to meet all three objectives was extensive. Advocacy and coordination were more commonly considered related objectives which required participants to possess an

intertwined skill set and similar position and influence. Being a training facilitator, on the other hand could be regarded as an outlier, requiring abilities and experience quite distinct from those needed to advocate for and coordinate the MISP in humanitarian settings.

Proximal training outcome 3: Post-training reaction

A training participant's reaction to the training course is a widely studied and well supported outcome factor in the process of training transfer (see Cheng and Hampson, 2008). Post-training reactions are generally held to consist of 'utility reactions'- or how relevant and useful participants feel the training would be in helping them perform in work contexts (Burke and Hutchins, 2007); affective reactions- that is a trainee's emotional response to the training course (Bhatti and Kaur, 2010); and their reaction or attitude towards the expected transfer behaviour itself (Cheng and Hampson, 2008). In general, a trainee's reaction to the training course can be understood as the sum of what an individual believes would be the result of performing trained behaviours.

Here, the concept of instrumentality is important as it incorporates the training participant's judgement of whether transferring the training will be of benefit to something or someone the trainee values (Chiaburu and Lindsay, 2008). In my research, participants detailed how they felt applying newly developed knowledge and skills would impact themselves, their work and their beneficiaries. The antecedents to these different outcome beliefs were clear. A trainee's *job involvement* influenced how they believed applying the training would affect them professionally; their perceptions of *content relevance* dictated how they understood any transfer of the training would impact their work; and the nature of their *personal engagement* with the issue of SRH in humanitarian settings and people surviving in these situations impacted their beliefs about potential outcomes for beneficiaries of utilising newly trained knowledge and skills.

In this way, my finding that reaction to the training course was an important outcome factor, influenced by these particular types of antecedents, aligns with attitudinal constructs included by Ajzen (1991) in the theory of planned behaviour. In this work, attitudes are posited as one of three important predictors of intention. My findings are consistent with this approach, in that SPRINT participants who reported a generally positive reaction to the training programme

were more likely to exhibit positive intention to transfer newly developed knowledge and skills to their places of work.

Attitude related antecedents to post-training reaction

Job involvement

Participants who showed a positive association with their work or organisation were more likely to respond positively to the training course, on the condition that their work or organisation were involved in tasks related to the contents and objectives of the SPRINT training. If a trainee was positively involved with their job, that is, during the interviews, they identified with and spoke in a way which showed that they attained self-worth and satisfaction from their work, or felt a responsibility for and personal drive to succeed in their roles, they were more likely to report a positive reaction to the training contents and were more disposed to use the training on return to their workplaces.

An important caveat exists, however, and the contrast between Sujana and Heng is instructive here. Both of these participants expressed a commitment to and involvement in their work. Both believed in and defended the importance of their tasks. However, of the two, only Sujana reacted positively to the training and reported that she would use what she had learnt in her daily work. A clear difference between these trainees was the kind of work they were involved in and the correspondence between this work and the contents and expectations of the training course. This led to a difference in their intention to use the training- a difference that can be followed through to their post-training achievements.

Importantly then, participants needed to be actively involved in the 'right' kind of work for them to judge that using the training would be advantageous to their role and professional selves. Looking again at the case study of Heng, it is important to emphasise that he showed commitment to his work and identified strongly with his organisation. For the purposes of meeting SPRINT's training objectives, it was clear, however, that this organisation and Heng's particular role within it were not the correct fit. As such, when evaluating how any application of newly trained knowledge and skills would impact his professional life, Heng showed understandable concern. He worried that his supervisor may not be aware of his efforts; that he would not receive recognition for conducting any work additional to his work plan; and that management may wonder how he was spending his time. The result of his evaluation was,

unsurprisingly, negative intention to transfer the SPRINT Training, and consequent inaction towards meeting the objectives.

Content relevance

During both phases of my research, participants made consistent judgements about the relevance of the SPRINT Training programme's contents and objectives to their particular work and the context into which they might apply the training. The result of these evaluations of *content relevance* was for each participant to decide whether using the training would help them in the performance of their jobs. In initial interviews, those who were already involved in work for SRH in humanitarian settings were most likely to remark on the usefulness of the training programme. For some of these participants, the training provided them with new ways of executing existing tasks or addressing past challenges. For these participants, their perceptions of the relevance of the SPRINT Training positively influenced their evaluation of how using the training would help them do their work. The result of this was a generally positive reaction to the training course, stronger intention to apply the training, and a higher likelihood of actual transfer.

Judgements of relevance were, however, dependant on a number of considerations. In terms of applicability, participants spoke differently about the contents of the training, the objectives of the training, and the alignment between what was actually presented during the course and the realities of their particular context. Participants who reported that: the subject matter presented during the course was relevant to their work and their organisation's priorities; the objectives of the training aligned with their own and their organisation's capacity; and that their context was vulnerable to the impact of natural and human-induced hazards, were most likely to react positively to the training course. Sujana reported that she was satisfied with the training course (an affective reaction), felt it was immediately applicable to her work (positive utility reaction), and believed that the objectives of the training were the 'right ones' for both herself and her organisation (favourable attitude to the expected transfer behaviour). Benedict spoke in a similar way about the utility of the training, and reported his personal 'revelation' during the course, therefore showing a positive affective response.

Other participants expressed opposite views, believing that the training contents were better suited to larger or less developed contexts, or to areas experiencing frequent acute crises

(rather than the protracted or underlying emergency experienced in their setting), or that the objectives of the training did not capture what was actually needed in their country. Once again, Heng captured these wider opposing reactions. At the close of the training he exhibited a generally negative reaction to the course. During follow-up, he stated that while he believed the content areas covered during the course were within his and his organisation's scope of work, the objectives were not. This differential assessment is important, as when evaluating how transferring newly developed skills and knowledge to his work place would impact his ability to carry out duties in his work plan, Heng saw no positive potential. What was expected of him as a result of attending the training was not what was expected of him by his job description, daily work plan or organisation. There would be no positive outcome for his work if he attempted to use what he had learned during the training. His resulting low intention and little transfer achievement is therefore a reasonable response. Heng also questioned the importance of addressing all SRH components provided by the MISP in humanitarian emergencies generally and especially in his context; whether it would be better to focus on the poor SRH outcomes experienced by populations in his country in stable, non-humanitarian settings; and if these services would be seen as a priority by affected populations. These beliefs further undermined any positive reaction. The lack of credibility of the subject area for this trainee will be further explored for the *personal engagement* factor, presented below.

Personal engagement

When referring to the fundamental purpose of the SPRINT Training- responding to SRH needs in humanitarian settings- participants in both phases of my research spoke in one of three different ways. At one end of the spectrum, some participants expressed a strong conviction that it was absolutely necessary to include the MISP in any humanitarian response. Some of these participants had had previous experience in responding in humanitarian settings or reported an association with survivors of crisis situations. For others, the training course 'opened their eyes' and made them realise that SRH is a right for all, including those in humanitarian settings, and/or that threats to health and life were real for those without access to the SRH components provided by the MISP. Participants who expressed either of these beliefs were more likely to make a positive evaluation of applying their training, and this was usually done in reference to the impact it would have on the health and safety of their current or potential beneficiaries. These positive reactions resulted in positive intention, and ultimately, in an increased probability of training utilisation. Both Benedict and Sujana showed

a deep association and personal conviction of the need to address SRH in crises. For Sujana, this came from her experience in responding to previous crises and her work for UNFPA. Benedict had been involved in humanitarian response in the past, but stated that he was unaware of the importance including SRH in this work until the training. Both spoke in a way that showed an individual judgement that the outcome of applying the training would be to support those in need in crisis settings. Particularly for Sujana, this personal conviction was linked to her determination and perseverance in seeing this work through in the face of numerous obstacles.

Somewhere in the middle of the three stated levels of *personal engagement* are those participants who believed that some components of the MISP, some areas of the training content, or select training objectives were important and should be addressed when they returned to their work. Notably, maternal and newborn health was the area which received the most consistently positive response, while sexual and gender based violence was more likely to be singled out as not needing attention or intervention in a trainee's specific context. Heng hints at this in his belief that maternal and newborn health is important, while other objectives of the MISP are not needed in his country. He qualifies this, however, by stating that this is the case in standard or non-crisis times, and should always be a priority, not just in the event of an emergency. For this reason, Heng better represents the alternate end of the spectrum of *personal engagement*. During both of our interviews, Heng expressed no certainty in the need to address SRH in crises. He had no experience in this particular field and reported no association with people living in these settings. As discussed previously, he consistently referred to his work and organisation in a positive way and exhibited positive *job involvemen*t. This positivity was entirely related to his role as an employee, however, and when asked about his involvement with SRH, responded that it was an area guaranteed to provide funding and employment as everyone needed it and donors were supportive. For him, then, there was no *personal engagement* with the issue of SRH in crises, or belief in the need to provide SRH care in humanitarian settings. What is more, there were no beneficiaries in mind for whom he could evaluate the benefits of applying what he had learnt during the training. The result of this lack of conviction was to contribute to his negative reaction to the training, low intention to transfer, and little transfer action on return to work. In fact, when Heng did contribute to the work of his SPRINT coordination team after the training, it was done so due to a sense of obligation to the organisation which had paid for his travel to the regional training. Again, he was not convinced of the need to act, the contents of the training were not credible to him,

and in his evaluation of the outcomes of applying the training there was no reasonable motivation to prompt him to act, outside of this feeling of obligation.

Limitations of this research

It is important to acknowledge a number of limitations of this study. First, my research began in the final days of the first SPRINT Regional Training of Trainers and as such, I have not been able to account for some of the pre-training factors which have been found to influence transfer in the training transfer literature. These include pre-training motivation and pre-training self-efficacy (Burke and Hutchins, 2007), and the inclusion of these could further extend our understanding of the transfer process for SPRINT Trainees and suggest strategies which could add to those outlined by my research.

Training transfer has been much studied within the field of psychology and because of this, alternative models of the transfer process include a number of stable psychological states such as cognitive ability, conscientiousness, extroversion and locus of control (Burke and Hutchins, 2007). It was beyond the scope of this study to consider the influence of these factors on the transfer of the SPRINT Training. In terms of addressing these innate psychological qualities, Blume at al. (2010) conclude that "there are often logistic and political constraints to preselecting a certain group of trainees on the basis of individual characteristics. Situational variables, on the other hand, can potentially be actively managed to create environments most conducive to transfer" (p 1092). The personal characteristics which are derived from psychological research are different from the individual level factors included in my conceptual model, such as *prior experience* and *personal engagement*, as those which emerged from my research can be selected for or fostered before the training,

A methodological limitation of my research is its use of self-reported data. In their meta-analytic work on training transfer, Blume at al. (2010) found that when self-report measures are used, particularly when self-reports of training transfer factors are gathered at the same time as self-reports of transfer achievements, the significance of relationships may be inflated. I have accounted for this by collecting data from single sources (training participants) at different times after the training and by synthesising data from different sources. However, despite the limitations of self-reported data, this form of data has value, particularly in regards to capturing a training participant's intention to transfer (Hutchins et al. 2013).

Finally, my study considers the process of transfer from the end of the SPRINT Training courses in Kuala Lumpur, Sydney and Suva, to the point at which participants take action toward meeting the Initiative's training objectives. I have, therefore, defined and examined transfer in terms of *use*. While this has value given that the *initiation* of transfer is a crucial step in the transfer process, I have not investigated the *effectiveness* of the training programme. An analysis of training effectiveness is beyond the scope of my research and would require a different set of questions which could build upon the findings of this study. A look at the effectiveness of training for SRH in humanitarian settings would provide a valuable extension to our understanding of not just *how* and *why* participants apply what they have learned, but to what affect.

Summary of Chapter 7

My research found that there is a system of factors which affect an individual's perceptions, intentions and expectations of training before, during and immediately after the course of study, as well as upon their ability to transfer their learning on return to work. The way in which this system of factors interacts with each individual trainee and their circumstances influences the likelihood that they will intend to use the training, and this *intention* subsequently determines the *application* of what they have learnt. The implications of my research finding that intention to transfer was central to the transfer process for these trainees are broadly two-fold. Looking backwards, if intention to transfer plays such a strongly predictive role in the eventual transfer of training, it becomes important to identify those specific antecedents which result in the development of intention to transfer and determine how these may be addressed so that training on SRH in humanitarian emergencies may be optimised. Looking forwards, if intention to transfer plays such a strongly predictive role in the eventual transfer of training, it is important to understand how this proximal outcome may be utilised as a proxy measure of transfer initiation. Both of these implications and how they may be applied to SRH will be discussed in detail in the following chapter.

Chapter 8

Recommendations: Optimising the transfer of training by addressing training transfer factors

Introduction

It is important to ensure that training on SRH for humanitarian settings is used so that the gaps in capacity identified through global MISP evaluations (IAWG, 2004; Chynoweth, 2015) can be bridged and people living in humanitarian settings be provided the lifesaving services they need. My findings show that for transfer to be optimised, training providers need to account for nineteen training transfer factors and the influence these have on post-training self-efficacy, post-training knowledge, and post-training reaction. While it is important to identify these factors as a first step in the transfer process, it is crucial to address their influence practically and operationally.

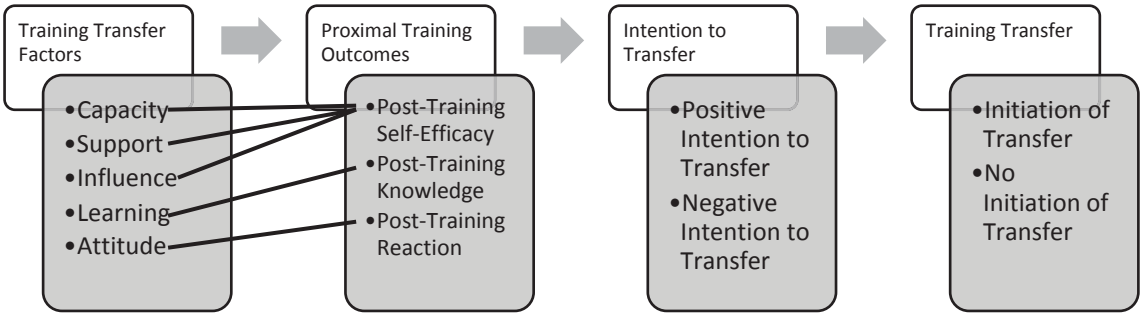
Using my findings, together with what is known in this field and for training transfer and the theory of planned behaviour more generally, I have recommended that training providers *consider* five aspects of the transfer environment and *implement* fourteen strategies to ensure that training has the best chance of being utilised by its participants.

Addressing the antecedents of intention in order to maximise transfer

My research found that the process of training transfer in the context of SPRINT was complex and multidimensional. Nineteen *training transfer factors,* grouped under the categories of *capacity, support, influence, learning* and *attitude* influenced the training participants' post-training self-efficacy, post-training knowledge or post-training reaction. These three proximal training outcomes directly informed the nature of a trainee's *intention to transfer* at the close of the SPRINT training course. Because of the longitudinal nature of my research, I was ultimately able to show that positive intention to transfer was associated with *training transfer initiation*, while negative intention to transfer corresponded with little or no action towards

meeting SPRINT's training objectives. The following diagram (Figure 14, below), summarises the process of transfer which emerged from my research into the SPRINT Initiative's Regional Training of Trainers programme.

Figure 14: The Process of Training Transfer for SPRINT Training Participants



By identifying the antecedents of training transfer for this programme, and understanding how these factors influence *proximal post-training outcomes*, *transfer intention*, and in turn, *transfer initiation*, my research makes it possible to consider interventions which should ultimately result in improved utilisation of training for SPRINT and SPRINT-like programmes. In essence, if the factors which I found to affect training outcomes (those related to capacity, support, influence, learning and attitudes) can be addressed when the training programme is being designed, conducted and followed-up, the flow on effect should be optimised proximal training outcomes, an increase in positive intention to transfer, and eventually a higher chance that participants will be able and willing to utilise newly developed knowledge and skills when they return to work. The ultimate outcome of this optimised process would be more effective application of aid dollars, and most importantly, an improvement in meeting the SRH needs of girls, women, boys and men surviving humanitarian crises.

Interventions, then, may be best aimed at addressing training transfer factors. I have collapsed the nineteen factors identified through my research into these five categories for clarity, based on their common concerns. This approach is consistent with current research on training transfer. As Holton et al. (2000) succinctly explain, "[o]rganisations wishing to enhance return on investment from learning-training investments must understand all the factors that affect transfer of learning, and then intervene to improve factors inhibiting transfer" (p334).

These five categories of *training transfer factors* are to be approached as important *considerations* for training practitioners when they are designing, conducting and following-up after the training programme as they provide some practical direction on where to aim interventions which will maximise training transfer. The following table provides an overview of strategies which address these five *considerations*. They will be discussed in some detail below but are provided here as a useable summary and signpost for what is to follow.

Table 6: Summary of Strategies to Maximise the Transfer of SPRINT Training

Consideration	Strategy
Capacity	*1. Select participants with appropriate capacity and experience* *2. Engage supplementary and complementary training programmes to increase systemic capacity* *3. Use training as a gateway to systemic capacity development*
Support	*4. Select participants from appropriate organisations* *5. Ensure supervisory support* *6. Involve government actors* *7. Work with socio-cultural constructs to foster support*
Influence	*8. Select participants with the position and influence to meet the objectives of the training* *9. Foster accountability amongst team members*
Learning	*10. Align the contents and conduct of the training to the objectives of the training programme*
Attitude	*11. Select participants who are currently and actively involved in work related to the training objectives* *12. Contextualise the training contents* *13. Promote and foster deep engagement with the issue of SRH in emergencies and beneficiaries* *14. Employ the potential of 'transfer intention' for the evaluation of training programmes*

These fourteen strategies are derived from my findings and are supported by both training transfer and wider areas of literature. They are included in this study to answer the third of my research questions:

> How can *training transfer factors* be addressed so that the transfer of learning gained through the SPRINT Training is *optimised*?

Consideration 1: Capacity

Training transfer factors related to *capacity* were found to influence the nature of a participant's post-training self-efficacy. In order to optimise feelings of confidence and capability amongst participants who undertake this training, it is important to consider the influence of capacity-related antecedents which operate on individual, training, organisation and environment levels when designing, conducting and following up after the training programme.

In order to address these capacity-related antecedents of post-training self-efficacy, a number of interventions may be implemented when designing, conducting and following-up after the training programme. In considering the impact of capacity-related factors, these should include the following:

1. Select participants with appropriate capacity and experience

In order to maximise transfer, careful attention must be paid to the selection of training participants. Potential trainees should have existing capacity in SRH and humanitarian response and previous experience in related roles in order to receive an invitation to participate in the coordination level training. If an individual does not possess capacity across the broad range of subject matter and the diverse objectives expected by the training programme (which was commonly the case for SPRINT), consideration needs to be given to the selection of 'teams' so that the existing capacity and previous experience of members are complementary and cover the entirety of the training programme's contents and expectations. This may best be achieved through identifying and consulting with key training participants prior to the training.

When deciding on what is 'appropriate' capacity and experience, it is important to keep the objectives of the training in mind. The SPRINT Training was intended to build capacity in order to fill a gap at the coordination level. It was not devised as a clinical training or to address a lack of human resources for SRH service provision, and the inclusion of purely clinical components without a coordination lens therefore proved problematic.

Thus, training providers should align the *prior experience* and existing capacity of individual trainees and teams of trainees to the objectives of the training programme. This may be done

in conjunction with key in-country actors, such as UNFPA country offices, to identify the most relevant staff to attend the training (Beek et al., 2013). Further, the contents of the training programme must build on existing individual capacity and be in line with the specific purpose of implementing this particular training programme for these particular training participants. For transfer to be possible, participants need to *have* the capacity or be able to *engage* the capacity to take action towards meeting the expectations of the training providers. As SPRINT was a coordination-level training, the skills and experience of participants attending this training needed to individually or collectively match the training's objectives of advocacy, MISP coordination and echo-training. Those who did not feel they were able to do so personally or in conjunction with referent others displayed low self-efficacy and consequently did not or did little to initiate transfer.

2. Engage supplementary and complementary training programmes to increase systemic capacity

As discussed above, the SPRINT Training presented an array of subject areas, and even for participants such as Sujana who displayed generally high levels of post-training self-efficacy, less extensive experience of particular topics caused some concern. In order to maximise confidence in one's ability to transfer newly developed knowledge and skills, it may be necessary for training providers to support access to tailored supplementary training products based on needs identified by training participants. The SPRINT Training required completion of the MISP Distance Learning Module (WRC, 2006) as a pre-requisite to attending the training course, but the completion of this was not universal, and in some instances did not provide the level of background learning requested by some participants. In appendix 2 of this thesis, I include a mapping of training manuals, curricula and courses relevant to the MISP, and this shows that there is a plethora of available material which could be utilised for this purpose. What would be required, however, is that SPRINT Training managers liaise directly with individual training participants prior to their attendance at the training so that background knowledge can be established and pre-training self-efficacy engaged. The importance of pre-training self-efficacy and its impact on post-training self-efficacy and transfer, although not included in this research, is well established (see, for example, Thayer and Teachout, 1995; Holladay and Quinones, 2003; Harrison et al., 1997; Mathieu et al., 1993; and Quinones, 1995), and the provision of pre-training learning materials is a strategy which could fill trainee-identified gaps in knowledge and help ensure positive self-efficacy. Less ideally, participants

could be surveyed at the close of the training to request feedback on any subject areas which require follow-up. I have stated that this second option is less than ideal as, due to our understanding of the importance of pre-training self-efficacy, and the reality that intention is generally settled immediately post-training, providing learning materials in follow-up to the training may represent a missed opportunity to truly develop high post-training self-efficacy.

The important 'middle' position which SPRINT Trainees were expected to take as stakeholders involved in coordination suggests that capacity, both 'up' to decision makers and 'down' to service providers is critical for them to be able to successfully execute their coordination tasks. To coordinate, participants firstly need to be sourced from organisations that sit at the coordination table. Secondly, they require the involvement of informed decision makers so that they are able and permitted to coordinate. And thirdly, they require service providers with the requisite skills to implement components of the MISP so that they have service providers and implementers to coordinate. Many SPRINT Training participants who were in the correct position to assume the coordination role clearly and repeatedly stated this need for capacity on multiple levels. This finding is supported by Teela et al. (2009) and Nelson et al. (2012), authors of papers included in my review of existing literature on SRH in humanitarian contexts (Chapter 3). Their assessment affirmed that collaboration across tiers of health workers and between government and non-government actors contributed to the success of their training programmes. This suggests that a vital role of SPRINT trainees would be to engage complementary training programmes or additional strategies to ensure that these capacities are in place. The advocacy objective covers the 'up' to decision makers, and training participants needed to feel confident in their ability and perceive themselves to be in the correct position to enable this action. This again speaks to participant selection and will be discussed further below.

For service providers, a number of clinical skills training programmes are available at an international level (as outlined in the mapping of available trainings in appendix 2), and SPRINT Training participants needed to be made aware of these or encouraged to facilitate access for service providers to local clinical skills courses in order to build on-the-ground capacity. Too often, participants at the coordination level training were service providers themselves. Their different, though crucial, capacity did not align with the contents and objectives of the training. As seen with Heng, this resulted in low post-training self-efficacy, negative intention to transfer the training, little or no following action and ultimately wasted training resources.

Most importantly, these participants could have been engaged in meeting the SRH needs of people in humanitarian settings in a way meaningful to their capacity, position, and organisation. By inviting them to attend an inappropriate training course, SPRINT risked their disengagement and compromised the opportunity to benefit from their needed skills.

In sum, I found that a trainee's perceptions of their own capacity, the capacity within their team, their organisation, and amongst wider stakeholders impacts directly on their post-training self-efficacy. And given that "trainees must believe in their ability to perform certain skills before they can be transferred to the workplace [and that] [i]ndividuals higher in self-efficacy will be more confident in their ability to learn and apply new things, and thus will likely be more motivated to transfer training" (Grossman and Salas, 2011: 109), providers of trainings similar to the SPRINT course should engage strategies to increase capacity on these various levels in order to maximise the transfer of newly developed knowledge and skills. A single training programme should not be regarded as a one-size-fits-all or stand-alone intervention to increase needed capacity on multiple levels.

3. Use training as a gateway to systemic capacity development

During my research, I found that both perceptions and the realities of capacity in a country's health system influenced post-training self-efficacy, transfer intention, and the eventual transfer of training for SPRINT participants. This is touched upon in terms of human resource capacity under strategy number 2, above. Additional aspects of the health system, including governance issues such as policy and protocols, the collection and management of relevant health data, and whether logistics and supply chains are in place and adequate, were mentioned as potential supports or impediments to transfer by training participants I spoke to. Just as I suggested that SPRINT trainees engage supplementary and complementary training programmes to build the systemic human resource capacity required for them to successfully coordinate MISP preparedness and response activities, my research highlights the importance of engaging and developing the capacity of policy makers, commodity and supply mechanisms, and health information systems. This should be done to support the transfer of newly trained knowledge and skills, and most importantly, so that the training's objectives can be met and people in humanitarian settings be provided access to SRH services.

Capacity is necessary, therefore, across the health system to allow trainees to utilise what they have learned. Training itself is not, however, the same as capacity development. As explained in a 2006 report by the Organisation for Economic Cooperation and Development (OECD):

> Capacity development involves much more than enhancing the knowledge and skills of individuals. It depends crucially on the quality of the organisation in which they work. In turn, the operations of particular organisations are influenced by the enabling environment- the structures of power and influence and the institutions- in which they are embedded (p7).

This definition of capacity development coincides with the findings of my research. Capacity development- a term chosen over the much used 'capacity building'- is a "process whereby people, organisations and society as a whole unleash, strengthen, create, adapt and maintain capacity over time…the 'building' metaphor suggests a process starting with a plain surface and involving the step-by-step erection of a new structure, based on a preconceived design" (OECD, 2006: 7). Unfortunately however, true capacity development- that is, this wider view needed to engage and address the entire system which supports or hinders advancement toward capacity-related goals- rarely lies behind the use of the term. As mentioned at the beginning of this thesis, use of the terms capacity building or capacity development is often "merely a euphemism referring to little more than training" (Potter and Brough, 2004:336)", or more harshly, "an over-pompous synonym for training, even worse than the expressions 'staff/human resource development'" (Potter and Brough, 2004: 337). In their work on systemic capacity building, Potter and Brough (2004) explain that "so widely is the need for capacity building recognised that it has become a cliché, part of the jargon of health sector development to talk about a 'lack of capacity' or the need to develop 'more capacity'" (p336).

Rather than seeing training as an 'easy fix' substitute for something far more complex and challenging, the findings of my research show the potential of utilising training as a gateway to the capacity development that is required for real systemic change. In many instances, where SPRINT engaged training participants with the essential capacity, support and influence needed for strong post-training self-efficacy, they went on to effect broad ranging changes. In the study of specific cases, it was clear that the training programme served as a catalyst for some trainees to upskill service providers, engage decision makers, change policy, and implement strategies for the distribution of supplies and collection of data. Assuming, then, that training providers have selected appropriate participants (see strategies one, four, eight and eleven for recommendations on participant selection), they should also work to assist

trainees to engage with and develop supportive structures and mechanisms within the existing health system. This would involve a flexible approach on the part of organisations providing the training or expecting results from participants, particularly in regards to timeframes and funding. In a similar way, one of the UNDP's default principles for capacity development states that "[c]apacity development is a long-term process. It is not amenable to delivery pressures, quick fixes and short-term results seeking. Engagement for capacity development needs to have a long term horizon and be reliable" (in OECD, 2006: 44). This deeper and more comprehensive approach has different delivery demands to traditional 'training' interventions and this should be factored into the design phase of such programmes.

Training, then, should be considered as part of the capacity development process, not to be employed in lieu of attempting real systemic improvements. Aside from building individual capacity to respond to SRH needs in crises, training may serve as a gateway for developing supportive systemic capacity. This should increase the probability that the life-saving components of the MISP are available to people in humanitarian settings.

Consideration 2: Support

Training transfer factors related to support also influenced a participant's post-training self-efficacy. In order to heighten feelings of confidence and self-efficacy, it is important to consider whether supportive mechanisms exist around trainees as they attempt to apply newly developed knowledge and skills. As explained by the theory of planned behaviour (Ajzen, 1991), a participant's evaluation of support from referent others and organisations on training, organisation and environment levels within the transfer system influence their intention to transfer. My findings show that this is true through the proximal training outcome of self-efficacy.

In order to address the antecedents of post-training self-efficacy related to support, a number of interventions may be implemented before, during and after the training programme. In considering the impact of support-related factors, these should include the following strategies:

4. Select participants from appropriate organisations

In order to maximise transfer, it is important to consider not just the individual capacity of each participant, but the supports afforded to that participant by their organisation. My research found that the existence of support within the organisation was dependent on its mandate and usual scope of work, and a participant's perceptions of the existence of these supports influenced both their willingness to accept support offered by SPRINT and their post-training self-efficacy. Whether the job description to which a trainee was expected to adhere aligned with the expectations of the SPRINT Training, and whether resources such as funding, equipment and time were made available were all contingent on the usual practice of each organisation or the ability of participants to make changes to this.

The coordination aim of the SPRINT Training required particular organisational strengths and orientation, and not all organisations involved in the Regional Training of Trainers workshops were able to meet these prerequisites. As was discussed for individual trainees above, the particular strengths of organisations which operate on levels other than coordination (such as service provision) needed to be recognised, and these organisations engaged in a more meaningful way. The success of this approach can be seen through both Sujana and Benedict utilising the position and capacity of SRH NGOs within their contexts. That the objectives of the SPRINT Training did not align with these NGOs' particular strengths does not mean that they should be uninvolved in the process, just that they should be involved differently and coordinated by those in a position and with the authority to coordinate.

In their study of the transfer intentions of autonomous professionals, Yelon et al. (2004) similarly found that their participants' decisions about whether or not to use ideas learned during training were "based on their memories and perceptions of their job duties and environment: their physical and social resources and constraints at work…, their time to develop and deliver [these new ideas], and their work load" (p93).

In my study, training participants also made judgements on the acceptability of new activities to their work environment, the ease of operationalising new ideas, and whether new actions would contribute to the overall mission and values of their organisation. Supporting this last assertion, Burke and Hutchins (2007) also report that when a training programme is aligned with the strategic direction of the organisation, improved levels of transfer have been found.

More specific to this field, a 2006 OECD report on good practice in capacity development suggested donors and training providers should "avoid the trap of providing generic training on broad topics, disconnected from the capacity and performance of specific organisations" (p8). In a strategy paper on performance improvement for reproductive health services for JHPIEGO, Caiola and Sullivan (2000) also state that training which is not related to organisational objectives may not produce expected results. The strategies these authors provide for ensuring performance improvement also place consideration of the organisational context- including mission, goals, strategies and culture- at the centre of a performance improvement framework.

The SPRINT Training participants who contributed to my research made similar assessments to Yelon et al.'s participants when comparing the objectives of the course to their particular roles and the organisation they worked for. Where the training objectives and their job tasks or organisational practice and mandate were misaligned, they perceived an absence of *organisational support*. This ultimately led to low post-training self-efficacy and a disengagement from any potential contribution.

As such, training providers should engage participants from organisations whose scope of practice and mandates align with the expectations of the training. It is not, however, enough to select participants from such organisations. The link between the training programme's aims, and the trainee's job requirements and organisation's mandate and goals must be explicitly communicated to potential trainees before they attend the course. In addition, those trained with the purpose of undertaking coordination work should be supported in engaging appropriate organisations in complementary roles.

5. Ensure supervisory support

Training transfer literature has identified support within the workplace as the most consistently influential training transfer factor (Burke and Hutchins, 2007), with supervisor support featuring strongly amongst aspects of *organisational support*. Findings from my research also point to the importance of perceptions of supervisor support among SPRINT trainees and the impact of these perceptions on post-training self-efficacy. My case studies, particularly those of Sujana and Heng, exemplify the multidimensional nature of this training transfer factor. As explained by Holton et al. (2000), "supervisor support may play a dual role

in transfer. On the one hand, supervisors act as gatekeepers for employees to apply learned skills on the job through their support…A second and equally important role is that support serves as a reward to employees by signalling to them that their learning application efforts are viewed positively" (p355). The first aspect of this construct then, is for training participants to be given permission and the opportunity to apply newly developed knowledge and skills. The second is that mechanisms to cue such action and reward application be integrated into the work environment. My review of existing literature on SRH training for humanitarian emergencies showed that physical cues to act, such as checklists and written protocols, adequate resourcing, and follow-up from supervisors supported transfer efforts (Nelson et al., 2012; Sullivan et al., 2004; Smith et al., 2013). My own research supported these findings and found that perceptions of these forms of supervisory support resulted in high post-training self-efficacy.

Thus, training providers should work to ensure that trainees are well supported by their supervisors and wider organisational structures to take action towards meeting the SPRINT Training objectives. The first step to achieving this would be to level expectations of post-training action between the training providers and trainees' supervisors before the training. This should ensure that participants are given the "resources and opportunities to apply their new skills and abilities to the workplace" (Grossman and Salas, 2011:114). An important part of these situational cues for SPRINT trainees was the presence or integration of work relevant to the training objectives in job descriptions and prospective work plans. The possibility of this was, of course, contingent on an alignment between an organisation's scope of work, as discussed above, and the objectives of the training.

In addition to providing opportunities and resources to undertake work towards SPRINT's training objectives, it is important for supervisors to signal to trainees that pursuing this work is important. Organisational literature has long reported that "management actions send signals to employees that affect perceptions and influence behaviour" (Baldwin and Magjuka, 1991:25). Given that the SPRINT Training was an outside agency initiative, it is reasonable to expect that the influence of these supervisory signals of importance would be even more pertinent as, unlike a professional development course initiated by a direct employer, there is not the automatic association between training and work expectations for this type of training.

It is therefore important for supervisors, particularly those of trainees who are autonomous from the training programme itself, to signal to participants that the training has worth, that it aligns with mandates and organisationally important outcomes (Baldwin and Magjuka, 1991), and that the application of newly developed knowledge and skills is of value. There are a number of ways that this may be done. Blume et al. (2010) found, in their meta-analysis that providing 'optimistic previews', or "positive statements about the upcoming training…to trainees had a moderate, positive relationship with transfer" (p1096). And even though this finding was based on a small number of studies, it aligns with earlier research which found that "the relationships…between pre-training perceptions and post-training intentions suggest that it would be worthwhile to promote positive pre-training perceptions of importance" (Baldwin and Magjuka, 1991:35).

In addition to conducting positive discussions with employees about the upcoming training, there is evidence to suggest that supervisors should implement goal setting activities with trainees. First, these goals should be set prior to the training and be both assigned by the supervisor and made in consultation with the training participant (Burke and Hutchins, 2007). After the training course, learning goals must be set in a way that brings the expectations of the training into prospective work plans. When this is done, goal setting can "facilitate transfer by directing attention, stimulating action, increasing persistence and prompting trainees to utilise newly acquired knowledge and abilities" (Grossman and Salas, 2011: 113).

Post-training, supervisors may also communicate the importance of training to trainees in more direct ways through feedback, recognition and rewards for application and sanctions for non-application. These 'consequence cues' (Yamnill and McLean, 2001) are embedded in each trainee's *transfer climate* and may be positive, such as the recognition Heng sought from his supervisor and organisation to conduct this work; negative; punitive; or non-existent, as was Heng's actual experience due to a misalignment between his work role, organisational scope and mandate and the expectations of the training course. In order to enhance post-training self-efficacy, supervisors and wider organisational elements should actively acknowledge transfer efforts. As seen with Heng, the probability of this does depend, however, on other training transfer factors including *organisational capacity*, position and mandate, a participant's *job involvement*, and the relevance of training contents amongst others (to be discussed below). As explained by Blume et al. (2010), "[w]e do not believe that achieving higher transfer necessarily involves substantial new processes or systems in organisations.

Rather, we contend that the most significant gains in transfer will come when learning is more tightly integrated into the process and reward systems that already matter in a firm" (p1096).

It is important to work with supervisors to ensure their support so that a trainee is permitted and encouraged to use newly developed knowledge and skills. This finding is well supported by evidence in the literature and was clearly important for SPRINT trainees given their autonomy from the training providers. Providers of trainings like that of the SPRINT Initiative should, therefore, work with the supervisors of potential trainees before the training event to ensure that the resources, time and equipment are available for trainees to use what they have learnt; that a participant's job description and prospective work plan serve as cues to action; that positive signals are given about the importance of the training before a trainee enters the training room; that learning goals are set and agreed to by both trainee and supervisor; and that there are positive consequences in place for any transfer efforts. This is important in order to ensure that participants perceive that they will be supported in their transfer efforts, as these perceptions are integral to levels of post-training self-efficacy.

6. Involve government actors

The importance of support from relevant government agencies was a recurring theme from the SPRINT Training participants I interviewed. The critical role of national governments in preparing for and responding to humanitarian crises cannot be understated and this importance is underscored by a number of UN resolutions; international movements for aid effectiveness, good international engagement in fragile states, and good humanitarian donorship; agreements such as the Paris Declaration on aid effectiveness and the Rome Declaration on harmonisation of international aid; frameworks for action including the Accra Agenda and the Hyogo Framework; and more recent high level forums including that held in Busan, South Korea in 2011. As explained in ALNAP's 2010 Meeting Background Paper, functioning states have four main roles and responsibilities in regards to humanitarian aid: they are responsible for 'calling' a crisis and inviting international response; they provide protection and assistance; they coordinate and monitor external assistance; and they establish the legal frameworks which govern any response (p2). This pivotal gatekeeping role was mentioned by many SPRINT Training participants and was emphasised in Sujana's case study.

In addition to leading any response and allowing international actors to be involved, the engagement of national governmental actors is crucial for sustainability and building systemic capacity (as discussed previously). Too often, international relief efforts have "been criticised for ignoring, sidelining or actively undermining local capacities. Examples include flooding disaster zones with international workers, or poaching local government staff, failing to coordinate properly with host governments, showing scant respect for local government officials and eroding the social contract by making it possible for governments to evade their own responsibilities" (ALNAP, 2010: 4). This further explains the concerns many SPRINT trainees expressed when there was no government representative from their country involved in the training, and particularly when they felt that they and members of their team were not in a position to access such decision makers. Movements to make aid more effective recognise the importance of viewing efforts to build capacity as an "endogenous process, strongly led from within a country, with donors playing only a supportive role" (Sanyal and Babu, 2008: 4). Given the SPRINT training participants' concerns about the perceived lack of government involvement, and the feelings of some participants that the training represented the priorities of an 'outsider', these principles seem applicable to specific training events initiated by international organisations.

Related to direct *government ownership and support* is the fact that national governments set the laws, regulations, policies and protocols which dictate both national and international response. The existence of supportive policies contributed to strong post-training self-efficacy, but participants regularly commented that at least some aspects of the MISP would not be permitted under national laws and guidelines. This was also found by Smith et al. (2013) in their study of a multimedia training on clinical care for sexual assault survivors (included in chapter 3). These authors report that policy restrictions, particularly on the use of emergency contraception, were a barrier to the use of newly trained skills in a refugee setting.

In addition to this, it was highlighted in my research that government decision makers operating at sub-national levels, while not deciding the laws and regulations of humanitarian and health response, had an important role in determining more local priorities.

The importance of true *government ownership and support* of humanitarian preparedness and response initiatives, such as SPRINT, has been made clear in the international arena and was evident in my findings. The link between perceptions of such support, or the ability of a trainee

or team to garner this support, and levels of post-training self-efficacy was also clear. As such, in order to optimise a trainee's confidence in their ability to transfer new knowledge and skills, training providers need to:

- select participants who are in the right position to conduct advocacy and influence the process of policy change;
- engage important decision makers at national and sub-national levels before during and after the training programme through direct advocacy or by supporting key trainees to do so;
- provide a conduit between the international community and national actors so that first, any adaptation of global guidance to meet in-country realities does not compromise the objectives of packages such as the MISP; second, that global actors can be best aware of the challenges faced by national actors; and third, where supportive policies and protocols are in place, strategise with in-country actors to ensure that these are known and followed by service provision partners.

7. Work with socio-cultural constructs to foster support

Evidence from my research suggests that for participants to feel confident in their ability to transfer their learning, they need to believe that socio-cultural constructs in their setting are supportive of the actions required for MISP preparedness and implementation, or be aware of and able to implement strategies to foster this support. The norms and mores each trainee brought with them to the training room are also important to consider, and this will be done under *Consideration 5: Attitudinal Factors*, below.

The first of the socio-cultural impediments to transfer predicted and experienced by SPRINT Training participants was in the trust and confidence potential beneficiaries would have in the services offered by the MISP and in the people offering these services. This finding from my research was an echo of that reported in the previous studies on SRH in humanitarian settings included in my literature review chapter (see Teela et al., 2009 and Tanabe et al., 2013 in Chapter 3). When synthesising existing literature on SRH training for humanitarian settings for this review, I found that these studies described the negative impact that a lack of trust and confidence in services and their providers had on the uptake of these services. In my research

too, Sujana reported her experience of trying to coordinate MISP implementation in an area where the providers of SRH services were not known or accepted. She, and those discussed in the previous research on SRH in humanitarian contexts (see Chapter 3), highlighted the importance of building cooperative and trusting relationships with beneficiaries. For Sujana, a key strategy for this was working with established on-the-ground NGOs to cultivate these connections.

A second important socio-cultural influence on how potential beneficiaries approach SRH services in crises was found in cultural responses to the causes and consequences of SRH related ill-health. Through my literature review (Chapter 3), I found that a number of previous studies (Tanabe et al., 2013; Teela et al., 2009) linked cultural expressions such as fear of judgement, shame and shyness to a lack of willingness to seek care, particularly in regards to sexual assault. Participants in my research explained their perceptions of these socio-cultural factors in a similar way and also spoke more generally about a lack of knowledge amongst beneficiaries of the importance of addressing SRH needs in crisis situations and of seeking care. My findings also highlight broad cultural sensitivities around sexual and reproductive health issues, and particularly with regard to sexual violence, emergency contraception and condom distribution. The result of this for a training participant's post-training self-efficacy depended on a number of other training transfer factors including their *prior experience*, *position* and *personal engagement* with beneficiaries and the issue of SRH in crisis more generally.

The existing literature on providing SRH services in humanitarian settings which is synthesised in the second literature review chapter (Chapter 3) suggest that such cultural impediments to accessing services could be overcome through increasing outreach and awareness raising activities. This approach is strongly supported by research from the field of disaster risk reduction (DRR), which seeks to reduce "disaster risks through systematic efforts to analyse and manage the causal factors of disasters, including through reduced exposure to hazards, [and] lessened vulnerability of people and property" (UNISDR, 2007). It is also suggested by the recent IAWG global evaluation of SRH services in crises in the statement that future activities should include "community engagement to increase utilisation of services" (Chynoweth, 2015: 4). Further, in their policy brief on integrating sexual and reproductive health into health emergency and disaster risk management, WHO and partner

agencies (2012) identify a number of priorities for action, two of which specifically recommend working before a crisis occurs to foster awareness of SRH risks and actions at all levels, including the community, and reducing risks for vulnerable communities by addressing underlying risk factors. Working with communities to raise awareness of both the causes and consequences of SRH related morbidity and mortality in times of crises; addressing underlying cultural responses to these causes and consequences; building "strong primary health care and preventive health measures with key provisions for SRH (and advance gender equality)" (WHO, 2012: 3); and ensuring that people are aware of available services are all recommended components of reducing vulnerability to the impact of hazards on sexual and reproductive health.

For these reasons, training providers should engage established on-the-ground NGOs or other local agencies in meaningful ways (working to their inherent strengths, such as in SRH service provision) or support coordination level trainees (such as those who should be in attendance at SPRINT-like Trainings) to do so. Again, appropriate training programmes should be offered to enhance skills in the clinical components of the MISP where this capacity is lacking. The physical and infrastructural needs of these local organisations and their workers must also be considered as "the lives of health workers are jeopardized by health infrastructure expansion that is not built to hazard-resistant standards" (UNISDR, 2010:27), and service providers are likely to be equally affected as their potential beneficiaries by disasters. Strategies for contingency should therefore be addressed at a coordination level too.

Local organisations may already have a position of trust in the community they serve and this represents an important attribute for MISP coordinators to capitalise on. Where these organisations and their employees are in place but there remains some lack of confidence amongst the community, interventions may be implemented by coordinators before the onset of a crisis such as support for health promotion strategies, counselling, listening and empathy (Tanabe et al., 2013). As well as their importance as potentially trusted service providers, community-based organisations and "skilled health professionals, particularly those working in community outreach, are a key to…improving maternal and reproductive health [in disaster contexts]" (UNISDR, 2010:27). They should be utilised by coordinators for awareness raising and outreach activities which address the socio-cultural impediments to care seeking for SRH related ill-health in both stable and crisis settings. Taking this concept further, community based disaster management proposes that "the community has a central role in long and short

term disaster management…[and is] the key actor as well as primary beneficiary of disaster risk reduction" (Yodmani, 2001:9). Discussion of the strategies on which community based disaster management depends is beyond the scope of this dissertation, but training providers should consider the importance of working directly or through coordination level trainees to implement activities which will increase a community's disaster preparedness capabilities (UNISDR, 2010), thus reducing their vulnerability to SRH related death and disability should a crisis occur.

Consideration 3: Influence

My research found that in order to meet the objectives of this training programme, both individuals and their organisation need to hold a particular position within health system hierarchies. Fundamentally, for trainees to conduct advocacy, engage appropriate people for further training, and be involved in coordination of the MISP, they need to already have a seat, or be able to acquire a seat at the coordination table. For those who were in a position allowing this access, post-training self-efficacy was high. The converse was also true.

In order to address training transfer factors related to the position and influence of training participants and their organisations, and the influence these were found to have on post-training self-efficacy, a number of interventions may be implemented when designing, conducting and following-up after the training programme. In considering the impact of influence-related factors, these should include the following approaches:

8. Select participants with the position and influence to meet the objectives of the training

As with the previous aspects of participant selection discussed above, it is important to purposefully recruit training participants who have the characteristics necessary to undertake what is expected of them as a result of attending the training. Where it is obvious to participants that this is not the case, low post-training self-efficacy is highly likely. For the purposes of the SPRINT coordination level training, participants needed to be in a position to access the correct people in order to undertake advocacy activities, invite appropriate trainees to future echo-training programmes, and to be involved in coordinating MISP preparedness and response activities. Candidates from UNFPA and ministries of health and/or disaster management were most likely to meet these prerequisites. Again, this is not to discount the

important role of other organisations in ensuring that the components of the MISP are made available to populations in crisis situations. It is instead to suggest that other, non-coordination roles, and the training programmes which support these roles, may have been more appropriate for these participants.

In their guide on the design, implementation and evaluation of joint learning events, the organisation Train4Dev (2011) allude to the importance of selecting participants with "authority (decision-making and implementation power)" (p9). The inclusion of this recommendation is based on well-established research into the effective composition of high level meetings (Train4Dev, 2011), and is applicable for the SPRINT Training given its coordination aim. A commonly used device for defining training objectives, the SMART Objectives or Goals Checklist designates the 'A' in its acronym to attainability, so that objectives must be achievable given constraints (Lawlor and Hornyak, 2012). The importance of this is borne out in my research, and one significant impediment to achievability is a misalignment between the stated objectives and the influence available to some SPRINT trainees.

In order to maximise training participants' post-training self-efficacy, training providers should, therefore, ensure that the position and influence of potential trainees aligns with the objectives of the training programme. They should also carefully assess the position of the potential trainee's organisation in relation to hierarchies within the health and emergency management systems operating within each context.

9. Foster accountability amongst team members

Due to the scope of the MISP, the importance of inter-agency coordination to address SRH needs in humanitarian settings, and the diverse skillset required to meet the training's objectives, the team approach adopted by the SPRINT Training was generally regarded by participants as appropriate and useful. For some trainees, such as Heng, his team's composition meant that he had some auxiliary access to decision makers and coordination mechanisms. Importantly, however, this did not lead to positive post-training self-efficacy, and as detailed in his case study, this meant immediate disengagement from work toward SPRINT objectives when this one influential team member was no longer involved. This again suggests the importance of training transfer factors such as individual and *organisational position and*

influence, and capacity as discussed above, and *content relevance* and *personal engagement*- which are included in the section to follow- and the results of these for post-training self-efficacy.

Of more critical importance here are questions around the dissolution of SPRINT coordination teams more generally, even where training transfer factors had positive effects on the post-training self-efficacy of constituent members. Where team members were 'not the right people' (Sujana, final interview), their 'dis-involvement' was predictable and unsurprising. For those who displayed positive post-training self-efficacy but still did not continue as part of their assigned coordination team (regardless of whether they moved forward individually), my findings suggest that an important contributor to this breakdown of cooperation was a lack of overarching supervisory control and accountability mechanisms. As stated previously, SPRINT Trainees may be regarded as relatively autonomous in that they are independent from those providing the training. There are no coercive structures in place, outside those inherent in supportive job descriptions and *transfer climate*s which would 'force' action. Therefore, for teams to remain intact, structures of responsibility and accountability become important. Integrating expectations into prospective work plans and ensuring supervisor involvement may be regarded as the de facto mechanism for ensuring action and holding participants accountable for transferring training. Literature on training transfer also indicates that when supervisors hold trainees accountable for utilising their training, they are also signalling to the trainee that the training was valuable and transfer is organisationally important (Burke and Hutchins, 2007). As explained by Burke and Hutchins (2007) in their integrative literature review on training transfer, "one understudied work environment variable is…the degree to which the organisation, culture and management expects learners to use trained knowledge and skills on the job and holds them responsible for doing so" (p282). But the power of training providers to see that this happened was limited, primarily to the selection of training participants and involved organisations. While these steps in pre-training planning are crucial, literature suggests that instilling alternative forms of accountability may work in complement to these important strategies.

Where accountability mechanisms cannot be guaranteed on an organisational level, it becomes necessary to explore other ways in which cohesive teams may be formed and maintained. An integrative literature review into teamwork skill dimensions (Cannon-Bowers et al., 1995 in Salas et al., 2000) uncovered eight constructs which are generalizable across

most teams. These include adaptability, shared situational analysis, performance monitoring and feedback, leadership/ team management, interpersonal relations, coordination, communication, and decision making (pp342-343). My research suggests that these principles are important in the context of autonomous teams, such as those formed by SPRINT. Of particular significance to my findings is the principle which states that "[t]eamwork requires that members monitor each other's behaviours and action and feel free to provide and accept feedback based on monitoring behaviour" (Salas et al., 2000: 346). Given the lack of over-arching mechanisms of supervision resulting from a training programme which originated outside the participants' organisations, the limited supervisory influence of training providers, and the importance of monitoring action and ensuring leadership within teams, strategies which enable some form of mutual intra-team accountability should be implemented.

To address this need, 'socialising accountability' research suggests strategies which encourage members to monitor and provide feedback on each other's behaviour and promote meaningful mutual accountability within teams. This understanding of accountability lies less within formal, technical and hierarchical mechanisms and depends more on an "ongoing, interpersonal process grounded in dialogue and authenticity" (Chynoweth, 2014). Until recently this approach has only briefly been associated with humanitarian action (Chynoweth, 2014) but there is evidence to suggest that this form of accountability may be effective for inter-agency coordination and cooperation, making it directly applicable not just to fostering and maintaining interagency teams such as those created by SPRINT, but also to establishing effective inter-agency team functioning as an important default when a crisis occurs. In her work on rethinking humanitarian accountability, Chynoweth (2014) explains that "integrating social and personal elements into technical training curricula could enhance qualities that are critical for enabling accountability" (p283). This finding was based on feedback from informants involved in training and SRH for humanitarian settings, one of whom explained that it is important to ensure "that you create environments in learning programmes that are conducive to what you would like to see in the field" (Chynoweth, 2014: 283). For coordination of the SRH services in humanitarian settings, global evaluations of MISP implementation (IAWG, 2004) indicate that what is needed in the field includes strategic group problem solving and effective inter-agency cooperation. It therefore becomes important to integrate into the training programme strategies that will foster these teamwork skills and the processes of socialising accountability which will help to ensure their application. The pedagogical theory of identical elements (Yamnill and McLean, 2001), which encourages a close correspondence

between conditions in the training room and expected conditions on return to work, supports this premise. As summarised by Grossman and Salas (2011), evidence from the training transfer literature shows that "conducting training and practice in environments that resemble the workplace increases the likelihood that trained competencies will transfer. Providing a relevant training context essentially allows trainees to gain experience implementing targeted behaviours in the appropriate environment" (p112).

To foster accountability, training providers should work with supervisors to formalise expectations of training participants and ensure that these expectations are communicated to trainees before and after the training programmes. As discussed earlier, job descriptions and work plans which align with the objectives of the SPRINT Training are formal mechanisms which can be used to hold employees responsible for transferring knowledge and skills developed during training.

However, due to the extra-organisational origin of the SPRINT Training programme, such formal mechanisms may not be sufficient to optimise training transfer. Given this and the fact that effective team functioning is vital to the coordination of the MISP, training providers should integrate strategies which foster socialising accountability into the training curricula. The key interpersonal skills which underlie mutual accountability also underlie group problem solving and successful coordination. Activities during the training should provide the opportunity for participants to build interpersonal relationships and practice these relational tasks. Simulation and interactive exercises (both low-fidelity such as role playing and high-fidelity such as full simulations), discussions, sharing experiences and ensuring that 'the personal' is embedded within the training programme are important strategies to support these ends.

Consideration 4: Learning

For participants to take action to transfer the training, my research found that they need to have developed and retained new capacity. The degree of learning reported by participants was linked to the proximal training outcome of post-training knowledge, and as represented in my conceptual model (at Figure 12), this outcome was correlated with intention to transfer and mediated by the particular training objective being discussed.

The importance of selecting participants with appropriate capacity and *prior experience* is discussed under *Consideration 1: Capacity*, above. In addition to this, in order to optimise a training participant's post-training knowledge, and consequent intention to transfer, training providers should:

10. Align the contents and conduct of the training to the objectives of the training programme

A discussion of whether the training objectives chosen by the SPRINT Initiative were the most appropriate for the aim of increasing access to SRH information and services for persons surviving crises or living in post-crisis situations in this region is outside the scope of this dissertation. They are, however, supported by evidence of challenges to MISP implementation uncovered by global evaluation studies (IAWG, 2004; Chynoweth, 2015). What is important to consider for the design and implementation of a training programme is that objectives are explicitly communicated (Burke and Hutchins, 2007), that these objectives are supported by the actual contents and conduct of the training course, and that extraneous material does not distract from the aims of the training initiative. Equally, each objective must be deliberately supported by the contents of the training and by the pedagogical strategies employed. If one expected outcome of the training is that participants can and will conduct echo-training workshops on return to their own context, the training course must provide specific training on facilitation skills so that on completion of the course, participants are able to first, demonstrate a working knowledge of the subject matter contained in the SPRINT training curriculum and second, employ effective instructional methods based on adult learning principles to deliver this subject matter (Beek et al., 2013). As explained by Biggs (2003), "[t]he key is that the components in the teaching system, especially the teaching methods used and the assessment tasks, are *aligned* with the learning activities assumed in the intended outcomes" (p2). This may be done by first, carefully defining the desired learning outcomes; second, by choosing learning activities that will lead to these learning outcomes; and third, by assessing actual learning against intended learning outcomes (Biggs, 2003: 2). Participants who informed my research, and my own direct observation of SPRINT Training sessions indicate that such alignment was not in place. This has obvious consequences for both post-training self-efficacy and post-training knowledge.

The two remaining training objectives of coordination and advocacy were generally found to be less problematic by participants. This may be due to similarities in the skillsets, experience

and influence required to follow through on these tasks. For both, participants remarked that practical components of the training sessions, particularly group work and discussions, assisted in their learning.

As such, to optimise post-training knowledge for participants, training providers should ensure that the objectives of the training are explicitly and thoroughly supported by the contents and conduct of the training. For the SPRINT Regional Training, in addition to developing declarative and procedural knowledge, this should include facilitation skills training to support the echo-training objective; strategies for socialising accountability and fostering 'soft' coordination and inter-personal skills for the coordination objective; and practice at advocating for the inclusion of SRH in emergency preparedness and response.

Consideration 5: Attitudinal Factors

For participants to form an intention to transfer their newly developed knowledge and skills after the training, my research found that they need to react positively to the training course. I found that the nature of their reaction to the training course depended on the attitudinal constructs within the system of training transfer factors. Factors relevant to this consideration are, therefore, contained on the individual level of my conceptual model of training transfer (see Figure 12).

My finding that attitudinal factors influence transfer intention is well supported by the theory of planned behaviour and training transfer research. In their synthesis of the literature, Grossman and Salas (2011) state that a participant's utility reaction to a training course is based on their "evaluation of the credibility of the new skills for improving performance, their recognition of a need to improve job performance, their belief that applying new learning will improve performance and their perception of the practicality of the new skills for ease of transfer" (p110). Underlying all of these assessments is the judgement of instrumentality, or whether applying the training will be of benefit to something or someone that they value. This valued something or someone may be their career, work tasks, or beneficiaries they believe would benefit from training application. In their work on the transfer intentions of autonomous professionals, Yelon et al. report that their informants used these same three criteria of credibility, practicality and need to form their intention to transfer ideas learnt during a training programme. From these findings, they developed a series of

recommendations to “convince trainees that ideas are credible, practical and needed” (Yelon et al., 2004:100). These strategies are instructive and align well with the findings from my research.

As such, to promote a positive reaction to the training programme, which will then positively influence a participant’s intention to transfer newly developed knowledge and skills, training providers should implement strategies before and during the training to convince participants that the issue of SRH in humanitarian settings and the ideas and objectives presented during the training are credible, practical and needed. To operationalise these concepts in order to support training transfer, Yelon et al. (2004) explain that “performance technologists should provide exercises that ask learners to assess ideas according to those standards [of credibility, practicality and need]. During the training programme, trainers’ efforts should demonstrate that the ideas taught are indeed credible, practical and needed” (p101).

In order to promote positive attitudes and reactions to the training course, the following strategies should be incorporated into the design, delivery and follow-up of the programme.

11. Select participants who are currently and actively involved in work related to the training objectives

It is reasonable to expect that training participants who are currently involved in work related to the SPRINT Training’s contents and objectives would make positive judgements about the relevance of the training, and those who are actively involved in this work would seek opportunities to improve their performance of related tasks. The selection of participants who are already involved in relevant tasks is a feasible and necessary strategy given that the SPRINT Training is in-service, not pre-service learning. This supposition is supported by my research and lends a further dimension to the participant selection strategies outlined previously.
In sum, training providers should select training participants who are currently involved in work related to the training’s contents and objectives so that they make positive assessments of the credibility, practicality and need of the training to enhance the performance of their jobs. The result of these judgements of relevance will be positive post-training reaction, optimised intention to transfer, and a greater likelihood that eventual transfer will take place.

12. Contextualise the training contents

As an important addendum to the discussion of ensuring that the training contents and conduct align with the objectives of the training, my findings indicate that it is also important to align the contents of the training curricula with the realities of contexts into which participants will attempt to transfer their learning. Just as the pedagogy employed within the training room should support tasks and roles expected post-training, so should the material presented reflect common scenarios faced within the wider transfer environment of each trainee. As reported by participants during the first phase of my research, sessions detailing an SRH response in situations of large scale population displacement hold little meaning to, for example, participants from small island states or those working in urban contexts.

In a similar way, the contents of the training should reflect setting-specific priorities. As discussed in my review of existing literature on SRH training for humanitarian contexts, Tanabe et al. (2013) found that they needed to adjust the original contents of their training course to include the most common form of gender-based violence in that particular setting. Their willingness to do so ensured that the training was more relevant to community needs, and importantly, perceived as being so by training participants.

Training providers should, therefore, ensure a match between the contents (including statistics, visuals used in presentations, and subjects covered or emphasised) presented during the training course and the contextual realities of participants. When considering conducting a regional level training involving participants from multiple countries such as SPRINT, this will require some adaptation in approach, such as encouraging trainees to source and present context-specific information in relation to the more general ideas presented by facilitators. This should, in turn, result in participants being able to more closely assess the relevance of the training contents and its credibility, practicality and need against what is needed to advance SRH for populations in crisis settings within their countries.

A corollary of this is that training providers should evaluate whether the training curricula developed for general use is sufficiently applicable in all contexts in which they seek to increase capacity. It may be that the geographic or political realities of a potential trainee's context, SRH priority areas, or the nature and stage of crises most commonly experienced in that specific setting do not align with the contents of the standard training curriculum. In such

circumstances, training providers should carefully consider the benefits of conducting the training course in relation to the probability of transfer. Alternative capacity development strategies may be more appropriate and, as always, training should not be regarded as a panacea for all gaps in capacity.

13. Promote and foster deep engagement with the issue of SRH in humanitarian emergencies and beneficiaries

For participants to react positively to the training, I found that they need to be convinced that it is important to address SRH needs during crises; that providing SRH information and services should be a priority in humanitarian settings; and that doing so will benefit beneficiaries with whom they have some form of relationship, experience or empathy. Those participants who expressed a positive reaction to the training due to these reasons were likely to both intend to use their newly developed knowledge and skills, and exhibit perseverance and determination in the face of obstacles to this application.

Therefore, it is important for training providers to ensure that potential participants are engaged with the issue of SRH in humanitarian settings and have some knowledge of and empathy for those who would benefit from their application of new knowledge and skills. Working before the training course begins, training providers should implement strategies of pre-training personal-level sensitisation or advocacy. This should be targeted at individual trainees and their supervisors, and could involve the provision of context specific information on the SRH needs of crisis affected communities within their particular area. Providing such preparatory information has been associated with increased cognitive, skill-based and affective learning (Mesmer-Magnus and Viswesvaran, 2010) and should include personal stories along with statistics in order to foster empathy.

This approach should continue during the training programme. There is evidence to suggest that the inclusion of personalised stories in a training can increase understanding and feelings of empathy, and result in more empathic behaviour after the training event (Crabb et al., 1983; Goldstein and Michaels, 1985). Sujana's use of just such a strategy aided her advocacy efforts, and it is reasonable to expect that bringing personal experiences to trainees before and during the training course will benefit both positive post-training reaction and a participant's assessment that it is valuable to apply the ideas of the training in order to assist beneficiaries with whom an engagement has been formed.

14. Employ the potential of 'transfer intention' for the evaluation of training programmes

Organisations most commonly assess training programmes by using variants of Kirkpatrick's four level approach to training evaluation (Bates, 2004). Kirkpatrick's framework proposes an evaluation of affective reaction; improvements in knowledge, skills or attitudes; the use of knowledge, skills or attitudes at work; and results for the organisation (Kirkpatrick, 1994). Notwithstanding its popularity, this approach to evaluating the outcomes of conducting a training programme has been criticised for a number of important reasons, including its inability to account for and explain "the complex network of factors that surround and interact with the training process" (Bates, 2004: 342). Moreover, research has shown that most real-world evaluation of training begins and ends at the close of the training course, or in terms of Kirkpatrick's framework, evaluation typically only includes measures of reaction and learning (Lee and Pershing, 1999). A number of surveys of evaluation practices revealed that, "most organizations assess the first level, or reactions to training, fewer than half measure learning during training, and, depending on the survey source, only 10–30% measured changes in on-the-job behaviour or performance results" (Kraiger, 2003: 185).

An important reason behind this lack of adequate training evaluation is in the difficulty of conducting long-term evaluation processes due to the constraints of time and funding, demands for immediate proof of effectiveness and "diminishing responses commensurate with post-training transfer research" (Hutchins et al., 2013: 253). A solution to these difficulties may be found in measuring proximal training outcomes. My research suggests that post-training self-efficacy, post-training knowledge, post-training reaction, and intention to transfer are important predictors of transfer initiation. For this reason, training providers should look at ways to assess these four training outcomes at the end of the training course as they can provide a proxy evaluation of actual training transfer.

The first three of these, my proximal training outcomes, may be evaluated immediately post-training in reference to their nineteen antecedent training transfer factors. For example, my research suggests that it is pertinent to ask participants questions around *capacity*, *support* and *influence* on multiple levels to assess levels of post-training self-efficacy (although, as suggested in recommendations one to thirteen above, many of these questions should be

asked and addressed prior to, not after, the training programme). A number of more general scales and methods are also available for assessing post-training self-efficacy, post-training knowledge and post-training utility and affective reactions and their antecedents (see, for example, Holton, 2005; Kraiger et al., 1993; Alvarez et al., 2004; Pineda, 2010).

In addition to evaluating post-training self-efficacy, post-training knowledge and post-training reaction because of their impact on intention to transfer, it is possible to evaluate intention to transfer directly. This has value due to the theory of planned behaviour's well-established supposition that "intentions are an immediate antecedent to behaviour and are likely directly proportional to the individual performing the said behaviour or action" (Hutchins et al., 2013: 253). The reasons for the formation of a particular intention are manifold, as captured by the nineteen training transfer factors found in my research, but this single outcome factor may be useful in predicting the likelihood that trainees will go on to use the knowledge and skills developed during the training course. In agreement with the work of Yelon et al. (2004 and 2013) discussed previously in this study, Hutchins et al. (2013) found that trainees will produce beliefs about the transfer behaviour by the time they have completed the training course. Because of this, they suggest measuring a training participant's intent to transfer at the close of the training programme. This approach aligns with the central position that intention was found to have in the process of transferring training on SRH in humanitarian settings. All of the training transfer factors I identified in my research impacted the transfer of training *through* the intermediary outcome of intention to transfer. While this may not always be the case, the strong association between intention and actual transfer indicates that it may be useful to evaluate transfer intention as a proxy for transfer initiation. As mentioned above, this may be done by looking at post-training self-efficacy, knowledge and reaction, but a number of scales and methods have been developed for directly assessing intention. Hutchins et al. (2013), for example, adapted the Learning Transfer System Inventory (LTSI) tool for this purpose by incorporating measures such as "'I anticipate making every effort in the coming weeks to put into practice what I learned in this training' and 'As soon as it is feasible, I intend to use at work all that I learned in this training'" (p255). Further to this, Sheeran and Silverman (2003) suggest asking participants to give details on their intentions, such as "'I intend to do X at time Y and in place Z'…[as] [a]ccumulated evidence indicates that participants who form implementation intention are more likely to perform a behaviour" (p2154). A number of other frameworks, such as predictive evaluation (see, for example, Basarab, 2010) have been developed and include means of evaluating post-training transfer intention.

Given the difficulties traditionally associated with the meaningful evaluation of training programmes and the predictive power of intention to transfer, training providers should incorporate measures of post-training self-efficacy, post-training knowledge, post-training reaction based on each outcome's antecedent factors. In addition, measures of intention to transfer should be incorporated into monitoring and evaluation frameworks.

Summary of Chapter 8

The identification of training transfer factors and an understanding of how these operate to influence a training participant's intention and eventual transfer of training has allowed the development of strategies to optimise the transfer of training. The most essential recommendation to emerge from my research is that each of the nineteen training transfer factors should be understood by training providers as potential points for intervention. To operationalise this suggestion, I have grouped training transfer factors into five areas facilitators should *consider* when designing, conducting and following-up after training programmes like that provided by SPRINT. Each of these areas for *consideration- capacity, support, influence, learning* and *attitudes*- can be addressed by following the strategies outlined above. These recommendations are grounded in the experiences of my research participants and supported by literature on training transfer, training for SRH in humanitarian settings, the theory of planned behaviour, aid effectiveness, capacity development, health system strengthening, socialising accountability, and social determinants of health. They are included here in the hope that by considering the broader system of influence on the transfer of training and working strategically to enhance supportive structures and overcome impediments, training providers may increase capacity for MISP coordination and implementation. In so doing, they will reduce the vulnerability of people surviving in humanitarian settings to SRH-related disease, disability and death.

Conclusions

The sexual and reproductive health needs of people living in humanitarian settings continue and often increase in times of crisis. The result of this is a vulnerability to SRH-related disease, disability and death. The capacity of health professionals serving populations affected by conflict, natural and other hazards has an impact on the extent of this vulnerability. It is therefore critical to develop in-country capacity which will address these health care needs. Global evaluations of the state of SRH in humanitarian settings (IAWG 2004; Chynoweth, 2015) have repeatedly shown that an important capacity gap lies within human resources despite concerted training efforts. This gap has been conceptualised as 'the transfer problem' affecting the application of learning gained during training into practice. In response to this, my research sought to identify factors affecting the transfer of SPRINT Training, a programme that aimed to strengthen the coordination capacity of SRH stakeholders in the Asia Pacific region. The three pilot SPRINT Training events held in Kuala Lumpur, Sydney and Suva formed the basis of this research and participants at these workshops provided data and generously travelled with me as my understanding of their transfer efforts unfolded.

A central and unique finding which emerged from this research was that it is essential to situate the training course, both within the context of the learner and amongst strategies which will optimise its transfer. These two premises are mutually dependent. Consciously situating the trainee within their wider contexts allows consideration of the factors which surround them and an understanding of how these factors either support or hinder their use of the training offered. In turn, identifying factors within this system of influence allows training providers to address each and strategise systematically to optimise participants' use of knowledge and skills developed through their training programme.

Training providers must, therefore, take into account all of the reasons that trainees do, or do not do, what they have been trained to do. Training transfer literature suggests that these reasons are to be found on individual, training and organisational levels. While this three-level approach to understanding the transfer of training served as a conceptual basis for my study, examination of the limited literature available on training for sexual and reproductive health in humanitarian settings revealed a fourth, environmental, level of influence. The suggestion of a broader set of moderating factors which included constructs such as health system capacity, society and culture, and government ownership was supported and expanded by my research.

Taken together, I found that nineteen factors operating on four distinct levels influenced a trainee's use of the SPRINT Training programme. I also discovered that each of these factors worked through the three proximal training outcomes of post-training self-efficacy, post-training knowledge and post-training reaction to influence a participant's transfer intentions. Intention to transfer, or a participant's decision (based on their particular interaction with the nineteen training transfer factors) to use or not use the knowledge and skills they developed as a result of attending the training programme then correlated with the eventual initiation of transfer at work. These findings contribute to our understanding of training transfer by expanding conventional models of the transfer process to include a broader level of environmental influence and adding factors to individual, training and organisational levels. My research also provides guidance on how best to maximise the benefits of training in a field where the challenges of applying new learning was little considered and the role of factors affecting this application were little known.

The primary implication of my research is that training providers need to take a systems-wide view and address influential training transfer factors before, during and after the training programme. If training is to be effective, it must be used, and for it to be used, a trainee must be able and willing to do so. To ensure that a training participant has this capacity and commitment, those interested in training programme effectiveness should consider *capacity, support, influence, learning* and *attitudes* as they exist within and around each individual trainee. These five categories of training transfer factors can then guide interventions at multiple levels within the transfer environment to maximise the chance that participants will behave in the ways expected of them by the training provider. This requires action beyond the scope of simply running a training course and involves, instead, the systematic and in-depth process of "assessing, unleashing, strengthening, creating, adapting, and maintaining capacity" (OECD, 2006: 12). Training must, therefore, sit within a broader sphere of strategies which complement and support the benefits it may bring. This is crucial to lessen the capacity gaps found for coordination in this field. When trained knowledge and skills are applied and the benefits of training on SRH for humanitarian settings are realised, the right to full sexual and reproductive health may be upheld for women, girls, boys and men surviving hazards. It is hoped that the contribution of this research will help fulfil this goal.

Appendix 1

Table 7: Types and definitions of hazards

Hazard	Definition
Natural hazards	Natural hazards may include earthquakes, landslides, tsunamis, volcanic activity, avalanches, floods, extreme temperatures, drought, wildfires, cyclones, storms, blizzards and plagues (IFRC, 2015a).
Armed Conflict	"International humanitarian law distinguishes two types of armed conflicts, namely: -International armed conflicts, opposing two or more states, and -Non-international armed conflicts, between governmental forces and non-governmental armed groups, or between such groups only. It is… important to underline that a situation can evolve from one type of armed conflict to another, depending on the facts prevailing at a certain moment" (ICRC, 2015).
Political Repression	**"**Political repression is the maltreatment of an individual or group for political reasons, especially for the purpose of limiting or forbidding their ability to take part in the political life of society. It often is evidenced in the form of human rights violations, surveillance abuse, police brutality, imprisonment, involuntary settlement, stripping of citizen's rights, lustration and violent action such as the murder, summary executions, torture, forced disappearance and other extrajudicial punishment of political activists, dissidents, or general population. Where political repression is approved and coordinated by the state, it may represent state terrorism, genocide, politicide or crimes against humanity" (US Legal, 2015).
Complex emergencies	"Complex emergencies are situations of disrupted livelihoods and threats to life produced by warfare, civil disturbance and large-scale movements of people, in which any emergency response has to be conducted in a difficult political and security environment. Complex emergencies combine internal conflict with large-scale displacements of people, mass famine or food shortage, and fragile or failing economic, political, and social institutions. Often, complex emergencies are also exacerbated by natural disasters" (WHO, 2015).
Epidemics	"The occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time" (CDC, 2015).
Famine	"A famine can be declared only when certain measures of mortality, malnutrition and hunger are met. They are: at least 20 per cent of households in an area face extreme food shortages with a limited ability to cope; acute malnutrition rates exceed 30 per cent; and the death rate exceeds two persons per day per 10,000 persons. Other factors considered [in some instances] … include large-scale

	displacement, widespread destitution, disease outbreaks and social collapse (UN News Centre, 2015).
Technological hazards	"A hazard originating from technological or industrial conditions, including accidents, dangerous procedures, infrastructure failures or specific human activities, that may cause loss of life, injury, illness or other health impacts, property damage, loss of livelihoods and services, social and economic disruption, or environmental damage…Examples of technological hazards include industrial pollution, nuclear radiation, toxic wastes, dam failures, transport accidents, factory explosions, fires, and chemical spills. Technological hazards also may arise directly as a result of the impacts of a natural hazard event" (UNISDR, 2009: 29-30).

Appendix 2

Table 8: Training manuals, curricula and courses for various components of SRH preparedness and response in humanitarian settings

Resource: Training Manuals/ Curricula/ Course (& Provider)	SRH Component					
	Coordination/ leadership	Sexual Violence	HIV/ STIs	MNH	Planning for Compre-hensive SRH	Gen-eral RH/ SRH
Caring for Survivors of Sexual Violence in Emergencies Training Pack (Global Protection Cluster GBV Area of Responsibility)		√				
Clinical Care for Sexual Assault Survivors: a multimedia training tool (IRC)		√				
Emergency Contraception for Conflict Affected Settings: A Reproductive Health Response in Conflict Consortium Distance Learning Module (WRC/ RHRC Consortium)		√				
Engaging Boys and Men in GBV Prevention and Reproductive Health in Conflict and Emergency-Response Settings: A Workshop Module (CARE/ EngenderHealth)		√				
Facilitator's Guide: Training Manual for Multisectoral and Interagency Prevention and Response to Gender-based Violence (JSI/ RHRC Consortium)		√				
GBV Communication Skills Manual (FHI/ RHRC Consortium/ IRC)		√				
Training Manual: Handbook for Gender-based Violence Interventions in Humanitarian Settings (FHI/ RHRC Consortium/ IRC)		√				
Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: A Distance Learning Module (WRC)	√	√	√	√	√	
Moving from Emergency Response to Comprehensive Reproductive Health Programs: A Modular Training Series (CARE/ RHRC Consortium)					√	

Raising Awareness for Reproductive Health in Complex Emergencies: A Training Manual (CARE/ RHRC Consortium)	√					
SPRINT Facilitator's Manual (IPPF)	√	√	√	√	√	
Facilitator's Guide: Training Manual for Multisectoral and Interagency Prevention and Response to Gender-based Violence (JSI/ RHRC Consortium)		√				
HIV/AIDS Prevention and Control: A short course for humanitarian workers (WRC/ RHRC Consortium)			√			
Introduction to RHA Toolkit for Conflict Affected Women (CDC)						√
Clinical Management of Rape e-learning Programme (UNHCR/ UNPA/ WHO)		√				
Facilitator's Kit: Community Preparedness for Reproductive Health and Gender (WRC)	√	√	√	√	√	
Preventing Gender-based Violence, Building Livelihoods (WRC)		√				
Interagency and Multisectoral Prevention and Response to Gender-based Violence in Populations Affected by Armed Conflict (RHRC Consortium/ JSI)		√				
Prevention and Treatment of those on ARVs (RHRC Consortium)			√			
Preventing Sexual Exploitation and Abuse of Beneficiaries: Online course (InterAction)		√				
Managing Gender-based Violence Programmes in Emergencies: e-Learning Course & Companion Guide (UNFPA)		√				
Public Health in Complex Emergencies Course (IRC/ World Education Inc./ American University of Beirut/ ADPC/ Makerere University Kampala)						√
H.E.L.P. Courses (Health Emergencies in Large Populations) H.E.L.P. II (Health, Ethics, Law and Politics) (ICRC)						√
Certificate of Advanced Studies – Health in Humanitarian Emergencies (Geneva Centre for						√

Education and Research in Humanitarian Action)						
E-learning course on Adolescent Sexual and Reproductive Health in Humanitarian Settings (UNFPA)	√	√	√	√	√	
E-learning course on Sexual and Gender-Based Violence (UNHCR)		√				
GBV Emergency Response and Preparedness Training: Training and Webinar Learning Series (2011-2013) (IRC)		√				
Different Needs- Equal Opportunities: Increasing Effectiveness of Humanitarian Action for Women, Girls, Boys and Men (IASC): eCourse		√				
Disaster management and integration of sexual and reproductive health in disaster management in non-aligned movement countries (NIEW/ ICOMP)						√
RAISE Clinical Training (RAISE Initiative)				√		

Appendix 3

Table 9: Content areas, learning outcomes, and schedule of SPRINT Training of Trainers Course (Kuala Lumpur, Sydney and Suva, 2008)

Day 1 **MISP Overview & Coordination** **Learning outcomes:** 1. Define an emergency and explain why SH and the MISP are important in crises 2. Describe the components of the MISP 3. Know where to access key tools and resources to support implementation of SRH in crises 4. Describe the coordination mechanisms for emergencies (including SRH in crises) that are applicable to your country situation 5. Outline the sequence of events for MISP implementation 6. Link SRH and SGBV to the adequate humanitarian reform cluster	**Agenda:** Introduction, expectations, logistics and ground rules 'Women and War' film; the SPRINT Initiative, SPRINT ToT and echo-trainings Overview of SRH interventions in crises Introduction to coordination mechanisms of SRH in crises Sharing experiences Integrating SRH in crises at the national level National SRH action planning
Day 2 **Sexual & Gender-Based Violence** **Learning outcomes:** 1. Explain the definition of SGBV and sexual violence 2. Describe the link between sexual violence and violations of human rights	**Agenda:** SRH action planning matrix Adult Learning MISP pre-test & feedback Sexual violence: barriers to care and support Introduction to SGBV Group work stations: SGBV coordination game & referral mechanisms Medical response to rape survivors

3. Outline the root causes, risk factors and consequences of SGBV 4. Understand that prevention and response to SGBV requires multi-sectoral and inter-agency action 5. Understand the underlying guiding principles 6. Describe the essential components of the clinical management of rape survivors 7. Implement an appropriate clinical care setting for rape survivors within heath care services 8. Know the key tools that support implementation of clinical management of rape survivors	Group work stations: medical setup for post-rape care; documentation of sexual violence cases; case studies: treatment decisions Adult learning practice
Day 3 **Maternal & Newborn Health** **Learning outcomes:** 1. Identify key issues of maternal and newborn health services needed in crises (advocacy, the three delays, prevention of PPH) 2. Identify strategies for setting up referral mechanisms (transportation, communication, support of referral hospitals) 3. Plan for comprehensive MNH programme services (ANC, postnatal care, TBAs, monitoring and evaluation)	**Agenda:** Adult learning Maternal and Newborn health in crisis and post-crisis situations Group work stations: clean delivery kits and immediate newborn care; manual vacuum aspiration and post-abortion care; quality of care in maternal and newborn health Programming in maternal and newborn health Family Planning Adult learning practice

4. List key elements of a logical framework 5. Adapt the proposed MNH logical framework to MNH action planning in their crisis setting 6. Discuss the role of family planning in crisis and post-crisis situations	
Day 4 **HIV and STIs** **Learning outcomes:** 1. Describe the link between HIV transmission, STIs and sexual violence 2. Explain the importance of ensuring that universal precautions are implemented in all health care settings 3. Apply the measures to be taken after an occupational incident 4. identify strategies to ensure access to free condoms in crisis 5. Reinforce the rational use of blood and strategies to ensure safe blood transfusion 6. Explain the use of the IASC HIV matrix as a coordination tool	**Agenda:** Adult learning Priority interventions to address HIV/STIs in emergencies Group work stations: universal precautions; rational and safe blood transfusion Comprehensive STI and HIV programming Group work stations: condoms; STI syndromic approach Adult learning practice
Day 5 **Action Planning** **Learning outcomes:** 1. Order reproductive health kits	**Agenda:** SRH supplies and logistics Monitoring and evaluation Country action planning presentation by country team Post-test and feedback

2. Plan in-country distribution 3. Conduct basic monitoring and evaluation of the MISP implementation 4. Outline existing needs assessment tools to plan for comprehensive SRH	Debriefing on participants' training capacity
	Review of participants' expectations
	Course evaluation

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