Public health emergencies workforce

STORIES AND STRATEGIES - PUBLIC HEALTH EMERGENCIES: LESSONS LEARNED FROM PILOT PHASE OF THE SEXUAL AND REPRODUCTIVE HEALTH PROGRAM IN CRISIS AND POST-CRISIS SETTINGS IN THE ASIA PACIFIC REGION (SPRINT INITIATIVE)

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Finally, we dedicate our work to all people affected by conflict and crisis, and hope it contributes to improving their sexual and reproductive health and well-being.

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CONTENTS

ACRONYMS

AusAID	Australian Agency for International Development
CERF	Central Emergency Response Fund
DRR	disaster risk reduction
HIV	human immunodeficiency virus
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
IPPF	International Planned Parenthood Federation
MISP	Minimum Initial Service Package
NGO	non-government organisation
ISDR	International Strategy for Disaster Reduction
MoH	Ministries of Health
PHE	public health emergency
SRH	sexual and reproductive health
SPRINT Initiative	Sexual and Reproductive Health Program in Crisis and Post-Crisis Settings in the Asia Pacific Region
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNSW	University of New South Wales
WHO	World Health Organization

A note about the use of acronyms in this publication

Acronyms are used in both the singular and the plural, e.g. NGO (singular) and NGOs (plural).

Acronyms are also used throughout the references and citations to shorten some organisations with long names.

ABSTRACT

Inadequate human resources—both in numbers and quality—are a well documented limitation to effective responses to public health emergencies. Although significant progress has been made in the past 15 years, the literature reveals that the lack of trained health workers continues to exacerbate the marginalised emergency response to sexual and reproductive health (SRH) needs. A comprehensive response to public health, including SRH care, is essential to minimise death, illness and disability in an emergency.

The Sexual and Reproductive Health Program in Crisis and Post-Crisis Settings in the Asia Pacific Region (SPRINT Initiative) was designed to address SRH in all phases of the disaster cycle, with a particular focus on preparedness and coordinated response. It forms the basis for this case study due to the central importance of human resources for an effective response, and the attention devoted by SPRINT to this issue.

SPRINT was developed by the International Planned Parenthood Federation (IPPF), United Nations Population Fund (UNFPA) and the University of New South Wales (UNSW), and launched in 2008 with funding from the Australian government.

An essential component of SPRINT is developing the capacity of national health and emergency management staff to coordinate and implement priority, life-saving SRH services in conflict, post-conflict and natural disaster settings.

Capacity development within the SPRINT Initiative entails training as well as on-site and remote technical support.

SPRINT's approach is a significant departure from other humanitarian training programs, in that country-level ***coordination teams*** are established and trained, rather than single individuals.

This case study specifically explores challenges faced by the SPRINT Initiative in ensuring the effective transfer of training on SRH in humanitarian emergencies to work contexts during the SPRINT pilot program from 2008 to 2010, and the evolution of the Initiative's capacity development strategy to meet these challenges.

SPRINT faced a number of challenges in building human resource capacity during its pilot phase.

An essential component of SPRINT is developing the capacity of national health and emergency management staff to coordinate and implement priority, life-saving SRH services in conflict, post-conflict and natural disaster settings.

These included identifying, engaging and supporting appropriate trainees in-country, developing context-relevant training content, and accounting for the lag time between training and application. Additional challenges involved addressing competing organisational mandates and priorities as well as working with the relative strength of in-country health and emergency management systems.

An important contribution to the evolution and adaptability of the program has been to situate four PhD students alongside the SPRINT Initiative to analyse experience and capture lessons. This embedded research component has proved valuable in developing solutions to the key challenges identified.

The following paper is a synthesis of the findings of these researchers on training transfer and efficacy. The challenges and lessons learned from implementing SPRINT are relevant to developing human resource capacity in the specific field of SRH in emergencies and may have broader application to the humanitarian and public health emergency sectors including the growing field of disaster risk reduction.

INTRODUCTION

Public health emergencies (PHEs), whether related to conflict, natural disasters, or communicable disease outbreaks, abound in the Asia Pacific region. The World Health Organization (WHO) has documented, on average each year, between 200 to 300 emerging-disease outbreaks and acute PHEs, such as cholera, dengue, and influenza H1N1, in the Western Pacific region alone [WHO 2010a].

Regional strategies to address PHEs, such as the Asia Pacific Strategy for Emerging Diseases [2010], have highlighted the linkages between PHEs and humanitarian crises such as natural disasters and armed conflict [WHO 2010b].

Hosting more than 60 per cent of the world's population [FAO 2012], the Asia Pacific is more disposed to natural disasters than any other part of the world, with a four-fold greater likelihood of being affected by natural crises than Africa [UNESCAP & UNISDR 2010]. Of the ten countries most vulnerable to disasters and climate change globally, six are located in the Asia Pacific region [Maplecroft 2011].

Between 2001 and 2010, around 70,000 individuals died annually and more than 200 million people were affected by natural crises in the region; the former represents 65 per cent of the global total and the latter 90 per cent [UNESCAP 2011].

In addition, a number of armed conflicts have impacted the region in the past two decades, notably those in Afghanistan, Bangladesh, Cambodia, India, Indonesia, Pakistan, Myanmar/Burma, Nepal, Philippines, Solomon Islands, Sri Lanka and Thailand [Amnesty International n.d.; IDMC 2012]. The conflicts exacerbate the already serious public health situations in many of these resource-poor settings.

While PHEs in humanitarian crises have received considerable attention, SRH issues in these settings have been historically neglected, despite demonstrably high needs.

Sexual and reproductive health problems are the leading cause of death and disability of women of reproductive age globally, and during crises, SRH needs increase while access to services decreases [UNFPA, 2005].

Approximately three-quarters of crisis-affected populations are women, children and youth, reflecting the demography of the population. They are vulnerable to and at increased risk of rape and other forms of gender-based violence, as well as unwanted pregnancy, unsafe abortion, maternal death and disability, and sexually transmitted infections including HIV [UNFPA 2000].

Sexual and reproductive health problems are the leading cause of death and disability of women of reproductive age globally, and **during crises, SRH needs increase while access to services decreases.**

Women, men and young people affected by crises need and have a right to SRH care, but appropriate and accessible services are often lacking. For example, among Afghan refugees in Pakistan, SRH-related problems were the leading cause of death among women of reproductive age [Bartlett et al. 2002].

Sexual violence has been documented in numerous conflicts in the region, including those in Afghanistan, Bangladesh, Burma/Myanmar, Cambodia, India, Indonesia, Nepal, Papua New Guinea, Philippines, Solomon Islands, Sri Lanka, Tajikistan, and Timor-Leste [Bastick et al. 2007]. Despite its evident importance, SRH has, historically, not been prioritised in humanitarian emergencies.

Significant progress has been made over the past 15 years due to coordinated international efforts by the Inter-Agency Working Group on Reproductive Health in Crises (IAWG), a consortium comprised of over 1000 members and led by an 18 member steering committee with representation from United Nations (UN) agencies, non-government organisations (NGOs) and academic institutions working to advance SRH in emergencies.

Despite these welcome developments, considerable gaps in implementation remain. A 2004 global evaluation by IAWG showed that priority SRH activities continued to be neglected by humanitarian health actors [IAWG 2004].

More recent assessments have confirmed that although improvements are being made, key SRH services have still not been systematically implemented in any humanitarian emergency to date [see for example Women's Refugee Commission 2007, 2008; CARE, International Planned Parenthood Foundation (IPPF), Save the Children & Women's Refugee Commission 2011].

Among the primary reasons for such neglect are those identified above: a lack of qualified health and related staff, and poor coordination [IAWG 2004].

This paper showcases the SPRINT Initiative, designed in part to address the human resource gap that has hindered the provision of SRH services in emergencies, and reflects on its strengths and limitations.

SPRINT was initially a three-year pilot program developed by the IPPF, UNFPA and UNSW, launched in 2008 with funding from the Australian Government.

An innovative aspect of SPRINT was the engagement of four PhD students who collaborated on a series of separate but linked studies examining different aspects of the Initiative.

This paper presents emerging research by the authors and considers the need to place training interventions within broader contexts and strategies for capacity development.

Among the primary reasons for such neglect [of SRH services] are those identified above: **a lack of qualified health and related staff, and poor coordination**.

CASE STUDY: THE SPRINT INITIATIVE

Priority SRH services form a minimum standard of care in humanitarian health service delivery. These primary services have been articulated by IAWG as the Minimum Initial Service Package (MISP) for reproductive health.

The MISP seeks to ensure the implementation of priority life-saving SRH interventions in emergency settings and forms the foundation for more comprehensive SRH services.

The MISP is endorsed as a minimum health standard by the 2004 and 2011 revision of the Sphere Humanitarian Charter and Minimum Standards in Disaster Response [Sphere Project 2011] as well as the Inter-Agency Standing Committee (IASC) Global Health Cluster [WHO 2009]. It has also been included as a life-saving criterion for the Central Emergency Response Fund (CERF) [CERF 2007]. These policy advances have not, however, translated into systematic implementation of determined life-saving SRH services on the ground.

In order to bridge this gap between global policy and in-country practice, the SPRINT pilot program was developed to increase access to SRH services and information to communities in humanitarian settings throughout the Asia Pacific region. SPRINT employed an innovative three-pronged approach to achieve its goals:

1. increasing national capacity to coordinate and implement MISP in conflict and natural disasters;
2. supporting advocacy to governments and organisations to integrate SRH into their emergency preparedness and response plans; and
3. providing funding and technical assistance for implementation of the MISP in emergencies and protracted crisis settings.

The Initiative was coordinated by the SPRINT Secretariat based at the regional IPPF office in Malaysia. A similar secretariat for the Africa region was established in 2010[1]. Key global partners included UNFPA, United Nations High Commissioner for Refugees (UNHCR), UNSW, and the Women's Refugee Commission. Activities were carried out by in-country partners including UNFPA country offices, IPPF member associations, Ministries of Health (MoH), international and local relief organisations, as well as other UN agencies.

The five objectives of the MISP include:

1. identifying a lead SRH organisation to facilitate implementation of the MISP;
2. preventing sexual violence and providing appropriate assistance to survivors;
3. reducing the transmission of HIV;
4. preventing excess maternal and newborn death and disability; and
5. planning for the provision of comprehensive SRH services, integrated into primary health care.

The SPRINT Initiative achieved many successes during its pilot phase which may be transferred to other humanitarian sectors. As with all new undertakings, it faced a variety of challenges. The following focuses on those challenges related to capacity development and explores lessons learned and strategies developed during the pilot stage to manage these challenges.

SPRINT challenges and strategies

Inter-agency collaboration and partnerships formed an underpinning strategy of the SPRINT Initiative. This was advanced in recognition that the MISP crosses multiple sectors, agencies and levels of care, and that effective coordination improves efficiency, effectiveness, and speed of response; enables strategic decision-making and problem solving; and helps avoid gaps and duplication in services [IAWG 2010].

As a result, SPRINT's primary capacity development intervention was training inter-agency *country coordination teams*, whose role it was to advance SRH in crises at the country level by working together before, during and after emergencies with support and technical assistance from the regional secretariat.

[1]The following focuses on SPRINT's work in the Asia Pacific region.

The country coordination teams were formed during SPRINT regional trainings on the MISP: three to five key representatives involved in SRH in emergencies were identified from each country to constitute the core team. These representatives were selected from Ministries of Health, National Disaster Management Units, UNFPA, WHO, national Red Cross/Crescent Societies, national and international NGOs, IPPF member associations, academic institutions, and other relevant organisations.

Selection criteria for coordination team members were based on experience in SRH in crises and willingness and ability to integrate SRH in crisis related activities in their day-to-day jobs. In-country IPPF member associations and UNFPA offices also assisted in nominating relevant candidates for the teams.

After the trainees attended a regional training and returned to their setting, other key actors per the above list were identified and introduced to the country team.

Each country coordination team developed an action plan to advance SRH in their setting, which often included conducting SPRINT trainings in-country and advocating for the integration of SRH into the national emergency preparedness and response plans. Country coordination teams also strived to collaborate during crises to ensure effective coordination of SRH related activities.

The country coordination team model is one of the most innovative aspects of SPRINT and is a significant departure from capacity development models in other areas of humanitarian response which have traditionally focused on training individuals, rather than teams. During its pilot phase the Initiative, together with in-country partners, trained 95 country coordination teams, comprising approximately 4000 national coordinators and actors globally [Butler-McPhee et al. 2011, p. 5].

Training and learning literature makes clear, however, that training efforts and numbers trained are not straightforward indicators of program effectiveness. Training cannot be regarded as an "investment" without evidence of training-induced change. Fundamentally, the implementation of training is of little value if knowledge, skills, and behaviours acquired through the training program are not generalised to the job setting [Yamnill & McLean 2001, p. 195].

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This is an important human resource consideration, as training interventions will not yield desired results or return on investment if knowledge and skills developed by those numbers trained are not appropriately transferred to the work-setting. Training, together with all organisational expenditure, must be "held accountable...and must demonstrate that the decisions and actions taken are relevant and profitable" [Pineda 2010, p. 674].

Saks 2002 [cited in Burke 2007] estimates that approximately "40% of trainees fail to transfer immediately after training, 70% falter in transfer 1 year after the program and ultimately only 50% of training investments result in organisational or individual improvements" [p. 263]. These estimates make clear that training transfer is a critical issue for human resource development in order to maximise return on training investment.

It is particularly significant for the SPRINT Initiative's work to ensure training on the MISP is translated into real world outcomes for crisis-affected girls, women, boys and men.

Just as program effectiveness is not a guaranteed result of training efforts, training transfer is not necessarily or only correlated with trainee learning. When attempting to understand reasons underlying positive transfer or the lack of transfer, it is essential not only to consider, but also look beyond, degrees of learning and the extent of training.

Training transfer theory has generally agreed that factors supporting or hindering transfer are multiple,

and operate on and between training, individual learner, organisational, and wider environmental levels [Holton et al. 2000 among others].

Research on the SPRINT Initiative's training in the pilot phase is supportive of this literature, finding that a range of moderating factors intervened between training participants and training transfer. An interplay of these factors was found to be in operation within and around the individual as they entered the training workshop, within the training room itself, and accompanying or meeting the trainee as they re-entered their working world.

This paper highlights selected training transfer moderating factors which have emerged from the research. It discusses the significance of these factors to training transfer, and specific strategies to evolve the program and address transfer challenges identified in the SPRINT Initiative's pilot phase.

Training level moderating factors:

Relevance of training content to worker's context

Participants in SPRINT training workshops were largely in agreement and able to demonstrate through pre- and post-testing that they had developed an understanding of the MISP and global mechanisms for humanitarian response as a result of attending the SPRINT training.

Despite this, some participants expressed uncertainty in determining the particular role they could play in meeting the Initiative's objectives on return to work. This was traced partly to a confusion within the curriculum between clinical and coordination aspects of MISP implementation, and a lack of clarity around training objectives and expectations.

The SPRINT training was designed to fill a coordination gap identified by previous MISP evaluations, and an over-emphasis on clinical components and medical terminology caused confusion and disengagement among some participants. It was often reported that clinicians found the clinical aspects of the training rudimentary, and non-clinicians found it complex and irrelevant to their work roles.

A further issue was noted by participants in the divergence between global mechanisms of emergency preparedness and response presented during the training course, and systems in place at national or sub-national levels. In many instances, participants noted that international intervention was infrequent in their setting, and when a global response was activated, the humanitarian structures and mechanisms of the response were determined by national governments.

As detailed above, the SPRINT Initiative was designed to build the capacity of in-country actors for coordination of MISP activities. The lack of information and guidance on existing national and sub-national mechanisms for emergency response, and their relationship to global mechanisms represented a gap within the training contents.

Disparities between the global standards of clinical and public health interventions outlined by the MISP and national or sub-national policies, protocols and procedures provided a further opportunity for participants to question the applicability of the training to their work.

For instance, definitions of rape differ across countries; where it is illegal to provide contraceptives to unmarried persons, emergency contraception drugs outlined by the MISP for the clinical management of rape may be prohibited; the practise of screening for blood borne diseases may vary depending on national guidelines; and protocols for basic and comprehensive emergency obstetric care and referral are generally dictated by national or sub-national policies which may differ from global direction.

Research has shown that the extent to which participants judge the contents of training as reflective of their respective positions and job requirements influences the degree of transfer on return to work [Holton et al. 2000; Yamnill & McLean 2001; Burke & Hutchins 2007]. Given that participant perceptions of relevance have been found to moderate the transfer of training [Aguinis & Kraiger 2009; Noe 1986; Alvarez et al. 2004], the disjuncture within the SPRINT curriculum between training content and participant work roles and responsibilities, and the difference between global mechanisms and guidance presented during the training and in-country realities proved problematic.

SPRINT sought to overcome the challenges of maintaining relevance of content to a diverse training

audience, and translated global guidance to national purpose, through a number of strategies.

Strategy 1: Ensure relevance to all participants' work roles

First, the discord between clinical and non-clinical components of the training was mitigated through a process of curriculum revision, and a clarification and reinforcement of the training program's coordination rather than clinical goals. It was recognised by both trainers and trainees that SRH workshops necessarily involve clinical terms and concepts, but through feedback and reflection, the clinical aspects were reframed to link to participants' expected role in coordinating MISP implementation and to concentrate focus on a coordination perspective.

In addition, SPRINT developed pre-training strategies to level expectations of training content and training outcomes for participants and their supervisors, and prepare participants for both the training to come and post-training expectations.

Further, the Initiative broadened its approach to encompass coordination team planning for the skill development of clinical service providers, further differentiating the SPRINT coordination training from clinical practice training in the eyes of trainees.

Strategy 2: Effectively translate global guidance to national relevance

Participants in the regional SPRINT training returned to their settings and, *inter alia*, spearheaded the roll-out of in-country trainings. Even at the national level it was reported that certain components of the training lacked relevance to the realities in-country. This was particularly noted for presentations on global coordination mechanisms and public health and clinical response guidance. This disconnect increased as the training moved from regional to national and sub-national levels.

In response, and through a process of feedback and reflection, the SPRINT training was evolved to insist on national adaptation of training contents and the presentation of in-country mechanisms, policies and protocols wherever possible. Global response mechanisms and global guidance remained within the training curriculum as important indicators of international standards, against which national and sub-national systems were compared.

... SPRINT developed pre-training strategies to level expectations of training content and training outcomes for participants and their supervisors, and prepare participants for both the training to come and post-training expectations.

Where divergence was significant, training facilitators were instructed to highlight differences and encourage participants to work through advocacy to address shortcomings in national mechanisms and inadequate policies and protocols.

National accreditation of the SPRINT training course was a strategy encouraged by the Secretariat to open access to national budgets and systematic rollout, and also require alignment of the international standards set forth by the MISP with existing national policy and protocols where these were found to diverge.

For accreditation at the national level, it was necessary to address this discrepancy as well as contextualise the training for that particular setting, resulting in more effective and efficient programming. Indonesia is an example of a setting which gained accreditation of the SPRINT training at the national level, and other countries incorporated this strategy into their coordination teams' strategic plans.

The SPRINT Secretariat also provided a conduit through which on-the-ground coordination teams could communicate their experiences of MISP preparedness and implementation to the global level actors responsible for devising and developing these standards, including IAWG, the International Strategy for Disaster Reduction (ISDR), the regional IASC and other relevant consortia.

Individual level moderating factors:

Knowledge and skills transfer, job involvement and personal engagement

Research on the transfer of SPRINT training suggests that work commitment, which includes both job involvement and organisational commitment, may be an important pre-cursor to the application of training.

Participants in a position to define or influence individual work plans, and those who believed that pursuing SPRINT training objectives would allow them to achieve work goals more effectively often remained engaged in SPRINT activities.

Interestingly, experience from the SPRINT Initiative showed that for some training participants, engagement was related more directly to their interest in SRH in emergencies and the populations affected by crises than with their work and/or organisational mandate.

Participants who expressed a strong personal association with the issue of SRH in crisis, and/or believed that the training would assist them in better meeting the needs of beneficiaries, were found to be active in working towards SPRINT training objectives regardless of temporal distance from their attendance at the SPRINT training workshop.

Numerous studies have shown that the transfer of knowledge and skills developed during training "is positively influenced by trainees' job involvement which refers to the degree to which an employee identifies with her job, actively participates in it, and considers job performance important to her self-worth" [Burke & Hutchins 2007, p. 270].

It is suggested by research on the SPRINT Initiative that together with job involvement, personal engagement with work, organisation and/or the issue at hand may be a further antecedent to the transfer of training and continued involvement with the Initiative and its work.

The presence of such high degrees of personal engagement and/or work involvement was not, however, always sufficient to ensure transfer as other moderating factors (further discussed below) impinged on trainees' ability to pursue transfer. However, given that personal engagement and job involvement were found to be correlated to transfer, the Initiative engaged a number of strategies to ensure this affect.

Strategy 3: Participant selection and recruitment strategies

Before national training workshops, the SPRINT Secretariat liaised with UNFPA national offices, IPPF member associations, and other key agencies in each country to identify the most relevant staff to participate in the training. These individuals were then approached to attend the training, and follow-up with their supervisors was taken.

Potential trainees were obliged to meet minimum requirements for participation, such as experience in emergency settings and to have a public health or clinical background, and submit an application for consideration. However, there were numerous challenges with this process as inter- and intra-agency politics influenced some participant selections.

In response, the Secretariat further formalised participant selection strategies and worked closely with in-country contacts to identify participants who not only possessed the requisite skills and experience to learn from the training, but who were best placed within organisations and wider health and emergency management systems, and most committed to contributing to MISP preparedness and response activities.

As existing actors within country health and emergency management mechanisms, national participants from the regional training were best placed to suggest individual participants and key organisations to approach. They suggested contacts to the Secretariat staff who then followed up with further questions.

Strategy 4: Pre-training advocacy to maximise individual engagement

The experience of the SPRINT Secretariat in conducting training workshops, and input from researchers investigating the Initiative, revealed that reaction to the subject of SRH for crisis situations was mixed.

For some, direct work experience made plain the need for MISP implementation at the onset of an emergency. For others, the fraught subject of SRH both in general and in regards to certain objectives of the MISP, and/or the traditional predominance of other crucial interventions in humanitarian response, undermined trainees' commitment to the issue at the core of the training.

This has obvious implications for learning, motivation, and consequent transfer on return to work. To counter this, a strategy of pre-training sensitisation or advocacy on SRH facts, their impact on crisis-affected populations, and the particular role of

target participants was developed to help ensure that potential trainees both understood and were supportive of the purpose of the training and its underlying focuses.

Organisational level moderating factors:

Supportive climate for transferring new knowledge and skills to workplaces

For those without control over their individual scope of work, a key consideration for transfer was the support of direct supervisors; the approval of organisations for employees to work towards SPRINT objectives; and the perceived degree of alignment between daily work and organisational mandates and the expectations of the SPRINT Initiative training.

Research on the program's pilot phase therefore suggests that the core of SPRINT's innovative capacity development approach of bringing together in-country coordination teams from multiple agencies in both humanitarian and development fields also provided a fundamental challenge.

As described above, inter-agency and inter-sectoral coordination is essential for full implementation of the life-saving activities prescribed by the MISP. It can, however, bring forth challenges associated with divergent mandates, an over-emphasis on individual organisational or work goals as opposed to those of most value to beneficiaries [Tchouakeu et al. 2011], and competition for space on crowded worker schedules.

In practice, this manifested in delays in initiating an SRH response during crises by some country coordination teams. Since many trainees were working with development agencies, particularly IPPF member associations and UNFPA, they did not have the internal organisational systems and experience to quickly act in a crisis.

For example, after the 2009 West Sumatra earthquake in Indonesia and the 2009 floods in Vietnam, implementing partners took almost two months to finalise proposals, despite being provided with a standard proposal template with activities and indicators included for MISP implementation. The acute emergency phase was declared over in both settings before the proposals were finalised.

Even with continuous prompting, follow-up and offers of assistance from the Secretariat, the implementing partners did not take action quickly. When queried, the explanation was that staff were extremely busy with other activities and they did not have support from upper management. Further, the country coordination team did not collaborate and only one agency stepped forward to respond to the crisis.

To adequately and sustainably apply the knowledge and skills developed during the training, **participants needed to be provided with time, resources, opportunities, and permission to undertake preparedness activities** before a crisis occurred and to implement MISP coordination activities at the onset of a crisis.

Along with addressing differing mandates, the SPRINT Initiative was faced with the further challenge of offering a training program to external organisations. The training course proposed by SPRINT did not arise from an intra-organisational needs assessment, and as a result, buy-in and recognition of need was not assured from the outset.

Evidence from this research suggests that buy-in and practical support from participants' supervisors and organisations played an important role in moderating the transfer of SPRINT training. To adequately and sustainably apply the knowledge and skills developed during the training, participants needed to be provided with time, resources, opportunities, and permission to undertake preparedness activities before a crisis occurred and to implement MISP coordination activities at the onset of a crisis.

Moreover, to meet the coordination objective of the training, it was necessary for participants to be allowed to invest in country coordination team relationships and be given permission to share information, resources, and responsibilities with inter-agency colleagues in a formalised way [Tchouakeu et al. 2011].

Even when learning does occur during the course of a training intervention and trainee involvement

Pre-training advocacy was crucial to obtain supervisor and peer support so that trainees were permitted the time, space, resources and opportunities to practise necessary for positive transfer.

with work, organisation and/or the issue at hand is assured, the transfer climate can work to support or hinder the use of newly developed knowledge and skills on the job [Holton et al. 2000, p. 335].

Transfer climate is made up of a number of key factors, including cues that prompt the use of new knowledge and skills, incentives, and feedback from supervisors and peers [Burke & Hutchins 2007, p. 281]. Included here as a component of transfer climate, supervisor and peer support have been affirmed as the most consistent organisational level factor moderating the transfer of training to work.

An adjunct consideration within transfer climate is the opportunity to perform. Studies have consistently demonstrated that "positive transfer is limited when trainees are not provided with opportunities to use new learning in their work setting" [Burke & Hutchins 2007, p. 282].

Real deficit in opportunities to practise or rehearse newly developed skills has obvious implications for maintaining new learning. Perceived deficit in opportunities to practise, linked to supervisor and peer support and to organisational mandate and policies, is also an important factor [Noe 1986].

Furthermore, transfer climate has been identified as a mediating factor in the relationship between the organisational or work context and individual job involvement, discussed above [Holton 2000, p. 335]. The nature of the transfer climate thus both directly and indirectly affects the degree of training transfer.

As suggested above, the establishment of a positive transfer climate may have been particularly problematic for the SPRINT Initiative and similar training models, given that the training originated external to the involved organisations and was not the result of an institutional capacity needs analysis.

Training transfer literature states that needs analyses may play a role in engaging supervisors in transfer-supportive actions, explicitly linking training interventions to organisational goals, justifying for participants and supervisors the need for trainees to undergo this skill development, and lending authority to the training program itself.

In response to these challenges, the Initiative pursued a number of strategies.

Strategy 5: Pre-training advocacy to maximise supervisor and peer support

The need for a strategy to address supervisor support and other transfer climate deficits was recognised early by the Secretariat. In response, SPRINT developed formal guidance on involving supervisors and wider organisational stakeholders prior to the training.

This was done to ensure the participation of appropriate staff members and to 'convince' organisational decision makers that the MISP is an international life-saving standard and that all of the agencies invited to send participants have a role to play in seeing its implementation.

Pre-training advocacy was crucial to obtain supervisor and peer support so that trainees were permitted the time, space, resources and opportunities to practise necessary for positive transfer. Further, the pre-training advocacy strategy was developed to assure both participants and their supervisors that the training was not intended to add to the work of participants but, instead, that it was designed to facilitate their working in a different way: by providing a platform (the country coordination team) for integrated, comprehensive, and effective action to mitigate SRH morbidity and mortality among people affected by humanitarian emergencies.

Pre-training advocacy was designed, therefore, to promote both personal engagement and organisational commitment, and in so doing, help to establish a positive transfer climate and ameliorate organisational level impediments to the transfer of training.

Strategy 6: Post-training support to maximise transfer

After the regional training, the SPRINT Secretariat worked in partnership with country coordination teams to support their work in-country and foster

the collaborative relationships established during the training workshop.

The Secretariat staff provided both remote and on-site technical assistance; supported and guided the teams' advocacy efforts to organisational and ministerial decision makers; conducted monitoring and evaluation; oversaw the quality of in-country trainings; spearheaded linkages between team members and regional and global efforts; developed and helped disseminate locally contextualised resources; ensured teams were up-to-date with the latest developments in the field; and encouraged their continued engagement with the issue, the Initiative, and their coordination team.

SPRINT also offered funding to respond to acute emergencies and to implement the MISP in protracted settings, and further supported country coordination teams to fundraise from other sources. Some agencies, particularly UNFPA, had internal resources or were able to tap into global funding mechanisms, such as CERF, to support activities.

Organisational mandates and priorities

A number of studies have linked the successful transfer of training to opportunities for participants to relate the training program to broader organisational missions or mandates [see Lim & Johnson 2002; Watad & Ospina 1999]. This challenge was compounded for the SPRINT Initiative given the extra-organisational origin of the training, and the inclusion of participants from multiple organisations holding differing mandates and pursuing various priorities.

It has also been shown that supervisor support of transfer, discussed above as a key component of positive transfer climate, "could be improved with a better alignment of organisational and training goals" [Burke & Hutchins 2007, p. 282]. To this end, the SPRINT Initiative instigated a number of strategies, including the following, to promote buy-in and alignment.

Strategy 7: Pre-training advocacy to ensure organisational buy-in and to align mandates and goals

In addition to maximising personal engagement and supervisor and peer support, the pre-training advocacy strategy addressed divergent organisational mandates and priorities. Working with key stakeholders in the organisation prior to the training could help to promote the importance of beneficiary-focused goals that cut across organisational mandates and work plans [Tchouakeu et al. 2011], and convince organisational decision makers:

- that it is important to address SRH in crisis situations;
- that the MISP is an international life-saving standard package of activities and services which can prevent SRH related disease, disability and death in crisis situations;
- that contributing to planning for and implementing the MISP is within the scope of work or decision making of every organisation invited to provide participants for the training;
- that the contents of the training are consistent with the job requirements of their employees; and
- that the learning objectives and outcomes of the training directly support organisational goals.

Wider environmental level moderating factors:

Time lag

The first wider enivironmental level moderating factor identified through research on the SPRINT pilot program is a fundamental concern of any emergency training: preparing participants to respond to a situation which may occur tomorrow, or at any or no time in the future. The challenge of keeping knowledge and skills up-to-date and front-of-mind in the absence of opportunity to practise was reported in relation to SPRINT training efforts.

Linked to opportunity to perform, an important environmental-level transfer moderating factor is the gap which can exist between training intervention and emergency. This may have implications for the currency of knowledge and skills developed during the training, levels of personal engagement with the issue, perceptions of relevance of the training to context, and the maintenance of supervisor, peer and organisational support, all of which can influence the transfer of training.

For example, it has been shown [Lim & Morris 2006, cited in in Aguinis & Kraiger 2009] that the relationship between perceived applicability of the training and transfer "decreased as the time between training and measurement increased" [p. 464]. To

address this factor, the Initiative adopted, amongst others, the following strategy.

Strategy 8: Addressing SRH needs before, during and after emergencies

The potential challenge of a time lag between training and use of newly developed knowledge and skills was addressed by the SPRINT Initiative in its programmatic move towards a more explicit disaster risk reduction (DRR) framework.

Emergency preparedness was an important component of the SPRINT approach from the Initiative's beginning and its adoption of a broader DRR strategy accompanied the developing international articulation of this new framework.

Disaster risk reduction is based on an integrated approach to disaster management, encompassing the mitigation, preparedness, response, and recovery phases of the emergency management cycle. As indicated by the diagram below, the efficacy of each phase is influenced by the actions of the previous stage and impacts the successes of the following stage.

Capacity development requirements were not the sole reason for adopting this approach, but it is proposed by this research that DRR provides a holistic frame which encourages immediate action by training participants on return to setting (through mitigation and preparedness work). Mitigation and preparedness activities are formally planned and agreed to by participants through action planning undertaken during the training workshop.

As SPRINT evolved, the importance of preparedness planning for prompting action, maintaining coordination teams, and preparing an environment which will enable MISP implementation came to the fore. In response, coordination team action planning was broadened under a DRR framework to comprehensive mapping of existing capacity and preparedness planning for all components of the MISP.

The use of the DRR framework also promoted perceptions of relevance for training participants as it allowed all involved, regardless of their affiliation with humanitarian or development work, to identify their own space for action towards common, beneficiary-focused goals. Preparedness and response are usually associated with humanitarian action, while recovery and mitigation are generally associated with development work.

The continuation of work represented by the cycle requires coordinated action across humanitarian and development sectors to reduce vulnerability, increase capacity, and therefore minimise the impact of hazards and related disasters on the SRH of affected populations. This in turn reflects the inter-sectoral requirements of MISP preparedness and implementation.

Health and emergency management system capacity

A further environmental level moderating factor was identified in the relative strength of in-country health and emergency management systems. It is widely acknowledged that existing systems' capacity at the time of an emergency will influence the vulnerability of populations surviving crises to SRH related morbidity and mortality.

Participants regularly expressed concern that the capacity of in-country service providers to implement SRH activities in emergencies was lacking, and in some contexts, explained that the minimum emergency response activities outlined by the MISP were not in place even in standard or stable settings. Respondents identified this lack of systems-wide capacity as a factor which could potentially

undermine their ability to coordinate a MISP response in times of crisis.

Participants also reported that decision and policy makers in both government and non-governmental agencies needed to be made aware of and actively support MISP activities if they were to be able to implement a response in crises. As expressed by one training participant:

> *The gaps are down there and up there. We have the training here, this is for the technical people… but implementation-wise, we just cannot have the SRH and [Emergency Management] trained without the service providers have 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…*

Experience shows that the impact of a crisis on the SRH of affected populations will be determined by the adequacy and coverage of SRH services before the crisis occurs. As such, working to affect systemic change in the mitigation, preparedness, and recovery phases of the emergency management cycle detailed above is critical.

Further to this, systemic capacity must be assessed, unleashed, created, strengthened, adapted, and maintained [OECD 2006] first, at all levels within relevant health and emergency management systems, from service provider, through management and coordination, to policy and decision maker; and second, across the health systems building blocks of service delivery, health workforce, commodities, health information systems, governance/leadership, and financing.

For trainees to be successful in applying their newly developed knowledge and skills to MISP implementation, they must be supported by capacity 'above' and 'below', as well as horizontally.

It is suggested by this research that perceptions of health system capacity may influence perceptions of training relevance, motivation to apply training, and consequently, training transfer. More directly, a lack of capacity in any sector and/or at any level may compromise trainees' coordination and implementation efforts.

Strategy 9: Building capacity of systems for preparedness and response

The SPRINT capacity development strategy worked beyond the training program by providing country coordination teams with a platform to map existing capacity, identify weaknesses, and strategise to fill gaps on all levels and across all components of health and emergency management systems.

Each training workshop centred around mapping and action planning work, engaging in-country actors in sharing existing knowledge on the state of MISP preparedness and response in their setting, and committing to next steps for preparedness and concrete first steps for crisis response. Mapping and action planning is repeated for each objective and activity prescribed by the MISP.

From its inception, the SPRINT Initiative stressed the importance of advocacy to prepare policy and organisational environments supportive of MISP implementation. The recognition of gaps 'down there' as well as 'up there' was a broadening of this approach to include working with organisations to plan trainings for service providers in skills relevant to MISP implementation.

Country coordination team members had important contextual knowledge given that they were generally in country before, during and after a crisis occurred. They were best placed to identify, engage, and develop existing capacity and resources on the ground.

From the emerging lessons presented above, it is clear that a multitude of factors moderated the transfer of SPRINT training and that these factors worked on and between individual learner, training design and delivery, organisational, and wider environmental levels.

Transfer is a key determinant of training effectiveness. This is of significance to human resources for health practitioners and funding agencies as resources dedicated to training as a tool for capacity development cannot be deemed an effective investment without the transfer of learned skills to work settings.

IMPLICATIONS FOR POLICY, HUMAN RESOURCES AND HEALTH SYSTEM DEVELOPMENT

Transfer of training is necessary to realise the benefits of training interventions. When designing a training program for international health, emergency preparedness and response, and/or specifically SRH it is important to consider factors both within and beyond the training course in order to ensure transfer.

Training interventions must identify and address the entire system of potential transfer moderating factors within each transfer context during the design phase. The system of possible moderating factors is broad and may involve factors operating on individual learner, training design, organisational and environmental levels, including but not limited to or necessarily those outlined above. Action must be taken to counteract negative and enforce positive influences on transfer before, during, and after training.

The SPRINT model can be useful to explore for other humanitarian sectors as human resource challenges are ubiquitous in relief work. It is not limited to SRH and could be theoretically applied to any other sector.

The involvement of researchers investigating various aspects of the SPRINT Initiative and providing insights to program managers has contributed to the evolution and adaptability of the SPRINT approach.

The integration of avenues for learning and reflection into the Initiative's design has proved valuable in developing solutions and strategies to key challenges identified. In terms of capacity development, this allowed moderating factors (including but not limited to those outlined above) to be identified and steps to be taken to redress their impact.

Stronger links between program development and implementation and research are needed. Innovative projects like SPRINT can contribute significantly to our understanding of human resource capacity development, training efficacy, service implementation, and DRR.

Funding agencies and implementing organisations would benefit from supporting independent academic research in the longer term perspective.

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CONCLUSION

Inadequate human resources and the poor transition between relief and development can have detrimental effects on crisis-affected populations and can undermine humanitarian efforts initiated during the acute phase [UN 2006].

The SPRINT model evolved to address capacity development across the full disaster cycle through promoting an uninterrupted flow of DRR, emergency response, recovery and development interventions that span the different phases of an emergency cycle. This is important in and of itself, and also in relation to the transfer of training.

SPRINT's approach contributed to national health system strengthening through supporting the capacity development of in-country health and emergency management staff. The country coordination team model strengthens vertical relationships among health actors, from the highest levels of the ministry of health to community-based organisations, and horizontal connections between the various sectors required for MISP implementation.

Progress on SRH policies and funding were also advanced, which helped national level policies align with international standards. Indeed, as emergencies often open up a window of opportunity for change, the MISP could be used as an entry point to address sensitive SRH issues in non-crisis times.

SPRINT recognised that training cannot be a standalone intervention. Although the Initiative relied on training as a cornerstone of its capacity development work, it laid buttressing strategies more reflective of comprehensive capacity development through advocacy efforts to create an enabling national and organisational policy environment, and increasing awareness and capacity of actors on the ground.

It did this in recognition that "capacity development involves much more than enhancing the knowledge and skills of individuals. It depends crucially on the quality of the organisations 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" [OECD 2006, p. 7].

The SPRINT Initiative pilot program was the first undertaking of its kind in the world. No other initiative was in place to scale-up the capacity of health workers to implement the MISP in emergencies on a country by country basis.

Although SPRINT faced numerous challenges, research helped identify problems and strategise solutions, and in so doing, supported the adaptation and evolution of the Initiative.

Its programmatic strategy of the inter-agency, locally-driven country coordination team model was particularly innovative and worked to address all phases of a humanitarian response, from DRR including emergency preparedness to the onset of a crisis and through recovery and rehabilitation.

It sought to engage key actors and agencies at all levels regionally, nationally and sub-nationally, and amplify the voices of in-country actors to a global audience.

Although SPRINT faced numerous challenges, research helped identify problems and strategise solutions, and in so doing, supported the adaptation and evolution of the Initiative.

A second phase of SPRINT is underway, based on the lessons learned from the pilot program, and it deserves to be closely followed and evaluated. Effort should be made to determine the effect of the strategies and approaches outlined above in an effort to ensure crisis-affected girls, women, boys and men have access to life-saving SRH services.

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