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WHOLE-SITE TRAINING: A NEW APPROACH TO THE ORGANIZATION OF TRAINING

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SUMMARY

Whole-site training (WST) is an approach for meeting the learning needs of all staff at a health care service-delivery site. This paper describes WST, the advantages it offers, the challenges it faces, and examples of where it is being used. The approach has been developed in response to the training needs of health care providers working in reproductive health in developing countries. It emanates from AVSC International's practical experience working with service providers, site managers, supervisors, health care agencies, and ministries of health to improve the quality of services.

Over the years, it has become apparent to AVSC that conventional, centralized approaches are ill-suited for training large numbers of disparate providers. Furthermore, these approaches have often been vertical efforts, separated from broader institutional needs, such as capacity building or site-specific service-delivery needs. This paper discusses an alternative approach: whole-site training, with a focus on service-delivery sites, teamwork, improvement of services, and facilitative supervision. It also shows how WST is consistent with the principles of organizational development, which stress improvement of organizational effectiveness. One of the ways this is achieved is by involving workers in designing new and more effective training strategies.

INTRODUCTION

The international donor community and host governments over the past 30 years have committed substantial resources to training, infrastructure development, commodity and equipment acquisition, and technical assistance for reproductive health care programs in developing countries. As a result, contraceptive prevalence rates have risen in many countries, although a large unmet need continues to exist for family planning and other reproductive health services (Westoff and Ochoa 1991).

One of the reasons identified for this unmet need is poor quality and poor integration of services, characteristics that reflect the fragmented and vertical nature of funding and the failure to build well-supervised, comprehensive systems (Dwyer and Jezowski 1995). Developing-country governments have been swamped by a plethora of donor assistance programs. Rather than proactively building reproductive health services that their populations need and want, they have often been reactive, accepting in piecemeal fashion the support that donors have been willing to give, whether it be for centralized training, commodities, or informational programs. Several key elements have been missing: coordinated initiatives, structural support to build capacity and develop sustainable programs (including strong supervisory systems), attention to quality and client and provider needs, appropriate training strate-

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gies, and integration of family planning and other reproductive health services into mainstream health care programs (Dwyer and Jezowski 1995). As with other types of inputs, donor inputs for training, while in themselves important and necessary, have not usually facilitated organizational development that links individual staff needs to organizational goals.

The overall purpose of organizational development is to increase a facility's capacity and potential for effectiveness.

Warner Burke has described organizational development as being concerned with the following:

- Developing programs that lead to change in the organization's culture or systems
- Promoting greater organizational effectiveness through better utilization of resources, especially human resources
- More fully integrating individual needs with organizational goals
- Encouraging more involvement of organizational members in the decisions that directly affect them and their working conditions
- Responding to actual or perceived needs for change on the part of the client
- Involving the client in the planning and implementation of change

The overall purpose of organizational development is to increase a facility's capacity and potential for effectiveness (Burke 1987).

In keeping with current organizational development theory, AVSC International believes it is time that technical assistance agencies in health care begin to develop tools and approaches that empower supervisors and staff at service sites to identify their own problems, understand their clients' needs, and develop their own solutions whenever possible; this is the only way for reproductive health programs to achieve sustainable quality improvement.

AVSC's programs, particularly in Africa, have started to address some of these structural change issues by focusing on management of systems, better resource utilization, and empowerment of workers—approaches consistent with organizational development principles. AVSC supports supervisory structures that are more facilitative (Ben Salem and Beattie 1996); quality management approaches based on self-assessment by workers (Lynam, Smith, and Dwyer 1994; AVSC International 1995; Dwyer and Jezowski 1995); client involvement and staff problem-solving tools

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(Lynam, Rabinovitz, and Shobowale 1993; AVSC International 1995); and interdepartmental integration and team building at service sites (Lynam, Dwyer, and Bradley 1994). Whole-site training, the subject of this paper, is another example of our work in this area.

CONVENTIONAL TRAINING APPROACHES

Training was identified as a key need in the early years of support for health care in developing countries. In family planning, donors responded with resources for training in several areas: contraceptive technology, counseling, training skills, logistics, record keeping, and management. Usually, trainees would be selected from institutions to attend a centralized, group-based course that was held in a capital city, or even a Western country, often at considerable expense. In many respects, this type of training was appropriate at the time. Sometimes there was no knowledge of a particular skill in a country, and it was cost-effective to send trainees overseas where skilled trainers existed; sometimes local caseloads were inadequate for training purposes; and sometimes it was a good idea to gather trainees together in a central place and away from their job responsibilities where they could concentrate on learning.

When AVSC first began working in developing countries, it tended, like most agencies, to view training as separate from supervision and wider organizational development goals. There was clearly a huge unmet need for doctors to be trained in contraceptive technology, including sterilization, and for staff to be trained in family planning counseling, since these topics had not usually been covered in preservice training. AVSC paid for health care providers from India to travel to the United States for microsurgical training, from Tanzania and Rwanda to Thailand and Brazil to learn how to perform vasectomy, from Kenya to Mexico for training in postpartum IUD insertion, and from many parts of Africa to Kenya and Nigeria for training in counseling; some of these trainings relied on expatriate trainers. Later, as projects went to scale and demand for training grew from a few individuals in pilot projects to larger national programs, learning began to take place in-country, often with trainers brought in from overseas and, as time passed, more often from neighboring countries. As in-country training capacity has grown, training has more often been carried out by in-country trainers, but it still often takes place in centralized locations away from the trainees' place of work and without participation of supervisors.

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Limitations of Conventional Training Approaches

Training systems are divorced from supervisory systems. Supervisors have little role to play in identifying training needs, planning for training, selecting staff to be trained, or conducting follow-up. This increases the isolation of training systems and decreases the likelihood that training will fit local needs and help solve local problems.

Follow-up is lacking. Trainers and master trainers working in centralized systems lack the resources to stay in contact with widespread, scattered trainees; thus, it is hard for institutions to know if trainees are correctly and effectively using the knowledge and skills they have acquired. Qualified supervisors could do training follow-up, but trainers and supervisors are rarely linked. The trainer is not part of the site "team" and therefore is not helping to build capacity and solve problems locally; likewise, the supervisor is not part of the training "team" and therefore is not helping to identify and respond to local needs.

Knowledge and skills acquired during training are not applied to the trainee's work. The application of newly acquired knowledge and skills to the workplace is perhaps the most important aspect of training (Broad and Newstrom 1992), and yet it is often the most neglected. Training does not always lead to a change in performance at the service-delivery site because it usually addresses acquisition of knowledge and skills, but not the individual's role at the service-delivery site or the link between the individual's job and other jobs at the site. Studies in the United States have found that only 40% of skills learned are applied

immediately, that after six months only 25% of skills remain, and that after a year only 15% remain (Garavaglia 1993).

The application of newly acquired knowledge and skills to the workplace is perhaps the most important aspect of training.

Training focuses too much on individuals and not enough on the systems in which they work. Capacity building at local sites is limited. Most training takes place away from the service-delivery site. Colleagues and support staff who do not participate are neither oriented to the training content nor involved in decisions about how to support the trainee in improving job performance. Individual trainees may be better equipped to do the job, but unable to function in an unsupportive work environment. They sometimes face hostility aimed at them personally and at their newly acquired skills. Colleagues may be jealous. Sometimes taking trainees away from their workplaces to a centralized training location can have the effect of mystifying the course and the skills gained. Some trainees may thus feel they are the keepers of the new information and disinclined to share it. Often there is nobody on site to make sure that the skills learned are used (sometimes staff may even be put in positions where they cannot use the new skills) or to promote learning among other staff. Thus, the site has no reservoir of skills when trained staff leave the facility.

Trainees are selected inappropriately. Often in centralized training, inappropriate trainees are selected because those making the choices do not fully understand the purpose of the training, because the trip away from the site is used as a reward for staff, or because it is someone's "turn," rather than in response to site needs.

The content and timing of training are inappropriate and do not reflect the realities of the service site. Instead of participating in training that addresses the specific needs of their service sites, trainees often have to accept what is offered ("just in case" it is needed), and real site needs may never be met. Trainees may be trained in an environment that is unlike their work environment (for example, with different equipment and resources), and thus may feel that they are unable to apply newly learned knowledge and skills. Sometimes staff have no immediate opportunity to apply what they have learned; training is conducted too early or too late, rather than "just in time." Finally, training may not be the appropriate solution to problems at the site. For example, if a staff member is not performing well, senior personnel may assume that she or he needs training, when in fact lack of administrative support or shortage of equipment may be the reason for poor performance.

Off-site, centralized training is unable to meet expanded needs for training. As demand for services grows and as the types of training needed expand in scope (for example, as providers need to learn about reproductive health topics other than contraception, including prevention, diagnosis, and treatment of sexually transmitted diseases), the need for staff training increases. Yet, because formal centralized training is expensive (in terms of travel and accommodation), trainee places are limited and training demand may not be met.

Services are disrupted. When staff members are away attending training courses, services at the home site are disrupted. This is particularly true for small clinics and hospitals that rely on only one or two staff members to deliver services.

In working with staff at hospitals and clinics throughout the world, AVSC staff have realized that many training needs are not being met and that many training opportunities are being wasted because instruction is inappropriate, unresponsive to needs, ill-timed, poorly organized, or not supported by a facilitative supervisory structure. Training may be meeting national goals and quotas, but it is often not helping local service-delivery sites to build capacity and achieve their reproductive health and quality improvement goals.

WHOLE-SITE TRAINING: A NEW APPROACH AND EMPHASIS

If we accept that organizational development initiatives such as those described by Burke (see p. 2 of this paper) are essential for building and sustaining quality health care services, conventional training ap-

proaches fall short of expectations. A fresh approach is required where training functions in the context of organizational development. The strategies that AVSC is using to address organizational development concerns are problem identification, staff involvement and goal setting, involvement of clients in assessment of services, teamwork, facilitative supervision, performance improvement, and creation of a supportive environment for staff to carry out their tasks. Training should be viewed as part of the process of building local capacity and tightly linked to the supervision system.

As an alternative to conventional training approaches, AVSC proposes *whole-site training*, an approach that meets the learning needs of all the staff at a service-delivery site within the context of organizational development (see Figure 1). Needs are identified through self-assessment approaches, such as COPE (AVSC International 1995), or other types of needs assessment. Needs are met through different levels of learning (skills training, updates, and orientations), with instruction done at the service site whenever possible and supported by facilitative supervision. Whole-site training involves more than changing the location of most training (from centralized, off-site training to on-site training), although this is an important element. (See Figure 2 for a glossary of training terminology used in this paper.)

Whole-site training involves a fundamental shift in responsibility for planning, action, and support. It stresses the development and training of *teams* at the service-delivery site. In this way, when individuals are off-duty or on leave, the site is able to continue to effectively provide services. Those who are trained are responsible for sharing their knowledge and skills and for training others, thereby sustaining the site (AVSC International 1997).

Elements of Whole-Site Training

This section discusses the six important elements of whole-site training (see Figure 3) and highlights experiences gained by AVSC and in-country partner organizations. Figure 4 suggests practical steps that program managers can take to develop a whole-site training program.

Changing the role of the supervisor

In family planning programs, training has conventionally been the preserve of master trainers. Except for participating in trainee selection, the supervisor (whether serving at the national, regional, or site level) has often been uninvolved in training, focusing instead on supervision of activities at service-delivery sites. When supervisors are not involved in training, however, they are unable to support it or promote it in any meaningful way, to ensure that training continues at the service-delivery site, or to make the link between training, performance improvement, and quality services.

Whole-site training meets the learning needs of all the staff at a service-delivery site.

To ensure that the training needs of local sites are met, regional and site supervisors need to play a major facilitative role, helping sites identify training needs, acting as motivators for change, and sometimes serving as trainers themselves (Ben Salem and Beattie 1996). Clearly, supervisors cannot always be skilled trainers themselves, nor can they be expected to have expertise in all subject areas. Their principal role in training, therefore, is as a facilitator and catalyst, identifying where the most appropriate resources are and helping sites access them. The supervisor needs to have time and resources to spend on site with staff and written materials to help maintain training standards; he or she needs to evaluate trainees and trainers (or identify people who can) and to assist sites with researching training opportunities, either at the site or away from the site.

To ensure quality in training, supervisors need to oversee courses (monitor content and delivery, help with planning and management), be able to certify competency where necessary, and help coach local skilled practitioners to transfer their skills to others. AVSC is developing training guides and competency-based evaluation guides for supervisors to help ensure that training at service sites maintains the same standards as those met by formal, centralized training events.

Whole-site training stresses the role of both off-site and on-site supervisors in trainee follow-up, regardless of whether trainees have been trained on site or elsewhere. This helps ensure that skills gained in training are constantly upgraded and

Figure 1 Changing the Way Training Is Done: A Comparison of Conventional and Whole-Site Training Approaches

Conventional Training	Whole-Site Training
National training priorities are paramount.	Site and trainee priorities are coordinated with national priorities.
Almost all training is done at centralized locations.	Almost all training is done at service-delivery sites.
Donors or national bodies decide training content of most training.	Sites work with supervisors to identify what training is needed for their staff in a continuous process.
Training is standardized.	Training is more tailored to site and trainee needs.
Training emphasizes didactic methods.	Training emphasizes interactive methods and practice.
Training is largely skills training.	Training is a mixture of skills trainings, updates, and orientations (see Figure 2).
Training is in hands of master trainers.	Training is in hands of supervisors and skilled practitioners at sites.
Supervisors are minimally involved.	Supervisors are key players.
Site situations are addressed only through role plays and case studies.	Site situations and needs are the focus of training.
Few trainees can be trained as slots are limited.	Many trainees can be trained on an ongoing basis.
Senior staff or professional staff are principal trainees.	All staff are trainees.
Trainees are rarely followed up.	Trainees are frequently followed up.
Knowledge and skills gained are often not shared.	Knowledge and skills sharing is encouraged.
Capacity building and sustainability for the site are not stressed.	Capacity building and sustainability for the site are stressed.
Training in different content areas is undertaken through separate, specific courses.	Training can cover different content areas in one course.
Training costs per person may be high.	Training costs per person are minimized.
Services may be disrupted when staff are away.	Training is scheduled to minimize service disruption.
Staff not involved in training know little about the topic or how to support the trainee.	Colleagues and relevant nonclinical staff are oriented to the topic and helped to understand their role.
Caseload may be low in the compressed time period available for training.	Caseload may be sufficient if training occurs over time.
Training dates are set by central trainers.	Training is conducted on dates more suitable for trainees.
Trainees interact with other trainees with different backgrounds and perspectives.	Trainees have limited exposure to different backgrounds and perspectives.
Maintaining standards and quality of training is easier.	Maintaining standards and quality is more challenging.

Figure 2 Training Terminology

Off-site training:
Training events or activities conducted at a place other than the location where the trainees will be expected to utilize the knowledge or perform the skill acquired during training. Such training is often planned at a centralized level and held far from the trainees' workplace in conditions very different from those found in the workplace.

On-site training:
Training events or activities that take place in the location where the trainees will be expected to utilize the knowledge or perform the skill acquired during training.

Orientation:
Creating awareness and providing basic information to staff (for example, informing staff about a new medical technology, about services at the site, or about their role as team members). An orientation helps site staff support other staff members who are receiving either skills trainings or updates.

Skills training:
Designed to teach a set of skills that will enable trainees to perform specific new tasks.

Update or refresher:
An event that adds or upgrades information, knowledge, or skills related to advancements and changes in knowledge or technology (for example, contraceptive technology updates or refresher training in financial management systems). An update is often all that is required to polish previously acquired knowledge or skills.

that personnel and systems at the site support trainees and the new skills they acquire. Follow-up, which focuses on constructive feedback, coaching, encouragement, understanding of constraints, and help with problem solving, is an important element in individual and collective performance improvement.

Supervisors are already playing the roles described above in AVSC-supported programs in Kenya, Tanzania, and Uganda. In Tanzania, regional and area supervisors have helped sites to develop training programs and have themselves conducted much of the initial training. Now, however, they report that site staff are working on their own to develop training strategies and are using local skilled practitioners to build capacity. Expanding capacity has been important in sites with few doctors; for example, these doctors have been able to train others to provide services when they are away.

Figure 3 The Six Elements of Whole-Site Training

- Changing the role of the supervisor
- Assessing site training needs and planning to meet them
- Focusing on teams, not just individuals
- Tailoring the level of training to the needs of different employees
- Expanding the locales where training occurs
- Building sustainable capacity

Assessing site training needs and planning to meet them

Conventionally, training is planned at the national level, and trainees are invited from individual service sites to attend centralized courses. In whole-site training, planning begins at each site, with on- and off-site supervisors and site staff identifying the training needs of the facility. In many of the sites where AVSC works, this is done as part of the COPE self-assessment process (AVSC International 1995). COPE (client-oriented, provider-efficient) includes a set of tools to help service-site staff identify and solve problems in a wide range of service-delivery areas, one of which is training. It brings together a cross section of employees from a single facility, preferably with on-site and off-site supervisors, to discuss the facility's needs. Central to these discussions is the notion that staff, as the ones who know the facility best, can best plan, prioritize, and take action as a team to make training fit their identified needs.

Figure 4 Whole-Site Training: Practical Steps for Program Managers

1. Prepare supervisors, trainers, and skilled practitioners who will offer training. Produce materials. Orient, update, or train supervisors in the basics of training. Provide them with the knowledge and skills needed to help sites identify and meet their training needs. Encourage attitudes among them that support organizational development. Ensure that written training materials are available for the site supervisors, skilled practitioners, and others who will provide training at service-delivery sites. Train supervisors to evaluate competency levels and to certify trainees where necessary, or to organize this process.
2. Orient supervisors in how to use on-the-job training guides to help formalize and standardize the transfer of knowledge and skills from skilled practitioners to learners. (Note: AVSC is currently developing a series of such guides.)
3. Encourage collaboration with other agencies. Develop a roster of local expertise.
4. Help service-site staff (including supervisors, managers, and representatives from all departments) to identify service-delivery problems and to determine if training is the answer to the identified problems. Help individuals identify their own training needs within the context of site needs.
5. Help staff to work as a team to prepare a training plan for the site.
   - What skills training, updates, and orientations are needed: content, depth
   - Who will be trained
   - Who will train, using local resources whenever possible
   - How: didactic methods v. interactive; scheduling, coaching, mentoring, one-on-one, materials
   - Where: on-site or off-site
6. Help staff and supervisors determine and identify training resources (trainers or skilled practitioners, materials, equipment).
7. Help the site undertake skills training, updates, and orientation.
8. Evaluate training in collaboration with supervisors and site staff.
9. Evaluate acquisition of knowledge and skills by trainees, and certify the trainees. Provide support and follow-up to them. Help site staff monitor and assess competencies and performance improvement.
10. Evaluate the training plan continuously (for example, every six months). Update it as needed.

One of the COPE tools is a series of guides with trigger questions that prompt group members to consider clients' rights and providers' needs. (For example: What types of services are needed to respect the rights of clients? What do providers need in order to offer such services to clients?) One of the guides regarding provider needs that specifically addresses training is the starting point for discussions on this topic. Using this guide, staff are encouraged to discuss their personal training needs, as well as the general needs of the site. In the COPE methodology, training discussions take place in the context of staff empowerment and changing organizational culture and systems.

Using COPE, staff from the Zakiganj Thana Hospital Complex in a remote rural area of Bangladesh identified a range of training needs (Faisel 1998). These needs

were met using both off-site and on-site approaches. The medical officer of maternal-child health and family planning was trained in tubal ligation and no-scalpel vasectomy in the capital city of Dhaka. At the site, six family welfare workers received updates in counseling, client screening, infection prevention, management of side effects, and IUD insertion and removal. In addition, 48 field workers and their 12 supervisors received a three-day orientation on clinical contraceptive methods. The most notable result of the training was a striking increase in vasectomy. In the preceding three years, no vasectomies had been performed at the facility. Within one year of training, 49 procedures were performed. Today, six to eight vasectomies per month, on average, are performed at Zakiganj.

Training is often thought of as the panacea for all ills and as a "quick fix." In fact, training is not always needed. AVSC staff encourage site staff to examine the causes of problems in order to determine the most appropriate solutions, which may not include training. When training is believed to be the answer (or part of the answer) to a problem, then staff can move onto the next steps: prioritizing training needs; planning who needs to receive skills training, orientations, or updates and in which subjects; setting schedules and selecting training locales; and identifying trainers.

This type of activity is now routine in AVSC-supported programs in Kenya, Tanzania, Uganda, and Zimbabwe. Sites determine their priorities and develop their plans with regional supervisors. The supervisors and site coordinators then work together to implement the training program; they can often provide training themselves. Trainers are encouraged to pass on not only particular knowledge and skills, but also tips on how the trainees in turn might train their colleagues. The development of skilled practitioners at service-delivery sites who are encouraged and assisted to coach colleagues is key to this approach.

The training plan for a service-delivery site should ideally be coordinated by a supervisor or site representative. Someone is made responsible for researching the most appropriate way of meeting the training needs for the site as a whole as well as for individuals. Flexibility, innovation, and appropriateness are emphasized. Site staff are encouraged to frequently review the training strategy and determine how well needs have been met. During COPE self-assessment exercises, training plans and activities are continuously reassessed in light of clients' rights and provider needs.

Behavioral science, adult education theory, and training and management literature all suggest that adults are more motivated and able to learn if they participate actively in their own professional development and if they have choices to make (as opposed to being summoned to a training event). At AVSC-supported sites in Tanzania, regional supervisors are helping site staff to develop their own personal training agendas based on their individual needs and to connect those agendas to the needs of the site. At the same time, an inventory of existing skills at each site is being developed. Supervisors often find that many skills already exist at the facility and that they can be shared much closer at hand than they had imagined.

Adults are more motivated and able to learn if they participate actively in their own professional development.

Focusing on teams, not just individuals

An important part of WST and other AVSC quality improvement approaches is the notion that site staff are all part of the same team serving clients; they must understand each other's roles and support each other. Through COPE, staff begin to learn the value of each team member (whether the person is a nurse, receptionist, cleaner, or doctor) in the delivery of health care services. AVSC views training through the lens of teamwork: all staff need to know what is expected of them in terms of their job performance as a team member, and they need the appropriate training to fulfill their team responsibilities.

The introduction of a new contraceptive method, such as Norplant implants, illustrates how a team focus alters the way training is done. In conventional training approaches, such training would be complete when a doctor, or perhaps a doctor-nurse team, would be trained, usually off-site at a centralized course. But with WST and its emphasis on teams, staff are encouraged to consider important linkages

In Mexico, whole-site training was used to improve the availability and use of vasectomy services.

at the site; for example, other family planning staff need to know about the implants so that they are able to counsel clients; ward staff, receptionists, and even groundskeeping staff need to learn about the new method so that they can provide accurate, basic information when clients or friends and relatives have questions or need a referral; staff members working in the requisition department need orientation so that they can assure a steady flow of commodities and other necessary supplies. Building these types of linkages is part of what AVSC calls *inreach* (Lynam, Dwyer, and Bradley 1994), and all of these linkages require some kind of training or orientation. Thus, when a doctor or nurse has learned the clinical skills required to insert the implants, he or she is supported by a service-site environment that has provided appropriate training, updates, or orientations for all team members.

One of the first places that inreach was field tested was Kenya in 1993. Two hospitals were selected for a week-long series of training events. All staff received a general orientation to family planning. Family planning nurses received a contraceptive update; surgeons were trained how to perform minilaparotomy for female sterilization. At the participating missionary hospital, an orientation was held for church elders. At the end of the week, staff reported feeling an increased sense of teamwork, both between site and headquarters staff, and among departments within the site. By integrating different training activities (such as group presentations and practical sessions) and by offering different topics during the week, learning occurred and was reinforced for many different types of employees. During the week, coaching skills were effectively passed from the outside facilitator to identified on-site facilitators. Support staff and nonmedical professionals responded enthusiastically to family planning orientations; furthermore, it became clear that these staff members had been seriously misinformed before being trained and that such misinformation might have been a major barrier to contraceptive use among the hospital's client population (Association for Voluntary Surgical Contraception 1993). The project continued for two years beyond the initial training activities. An evaluation concluded that, over the course of the project, the hospitals had confronted "fundamental issues related to staff needs, organizational team building, infrastructure repair, development of financial sustainability plans, and discussions among staff about…issues that they, rather than an outside agency, felt were important" (Bradley 1996).

In Mexico, whole-site training was used to improve the availability and use of vasectomy services in a national health system. The goals for training were "not only to transfer knowledge and develop critical skills, but also to forge an effective, smoothly functioning service-delivery system and effective local teamwork" (Jezowski et al. 1995). Training doctors to provide vasectomy was only part of the training strategy. Rather, "the intervention treated the local service-delivery site as a system and personnel as members of a team that make the system function." The training strategy included developing the knowledge and skills of all personnel who were involved in providing vasectomy services: doctors and nurses who perform vasectomies, staff who might be involved in providing clients with related medical services (such as medical examinations, postoperative instructions, follow-up examinations, and treatment of complications), and staff who provided family planning information and counseled vasectomy clients. In addition, other personnel, such as top managers, medical directors, supervisors, and social workers, were oriented to the services. All training took place at service-delivery sites. Through this program, vasectomy services became well integrated into overall services, vasectomy services spread to an increased number of sites, and the number of vasectomies performed increased substantially.

Tailoring the level of training to the needs of different employees

Whole-site training considers both the content of training and the depth, or level, of training needed by different employees at a service-delivery site. It is more flexible than conventional training approaches because it involves a mixed program of skills training, updates, and orientations, as defined in

Figure 2. In the past, training resources have often been concentrated on one-time, in-depth skills training (for instance, instructing a doctor to perform minilaparotomy or training a nurse in counseling skills). Yet, AVSC has found through COPE exercises that service-delivery sites often have as much or more need for updates and orientations than for in-depth skills training.

By using the whole-site training approach, sites can decide on the levels of training needed and apportion their resources accordingly. For example, when contraceptive methods are well established, most doctors and nurses need regular updates; in-depth skills training is needed only when new clinicians arrive or when a new method is introduced. At the same time, orientations may be needed for new employees, or as the range of reproductive health services expands.

WST encourages service-delivery sites to consider the training needs of all employees, not just clinicians. As a result of client interviews conducted as a part of COPE, the Family Planning Association of Kenya (FPAK) found that many clients disliked the way they were treated by receptionists. FPAK responded by organizing short training sessions on telephone manner and greeting clients. This intervention met the identified need and was undertaken quickly; sites did not have to wait for an external course to be held (Bradley 1998).

Transfer of decision making for training to managers and staff at service sites has allowed facilities to think more broadly about their needs. In Kenya, whole-site training has led to a range of initiatives that would have been difficult to accomplish in any other way. Table 1 shows the range of skills trainings, updates, and orientations undertaken at sites of FPAK and the Christian Health Association of Kenya (CHAK) between 1993 and 1995.

Expanding the locales where training occurs

One of the key components of whole-site training is the shift away from off-site, centralized courses to training at the site. Skills training, updates, or orientations can all be done on-site. Centralized training still has its place (for example, when a new contraceptive method involving a clinical procedure is being introduced; most service- delivery facilities do not initially have a large enough caseload to support training). Preliminary evidence from Kenya (see Table 2) suggests that, for the same resources, whole-site training, with its emphasis on training at the site, can produce more trained individuals than centralized approaches. In addition, staff do not have to leave their homes, families, or work responsibilities for extended periods of time; instruction reflects local service-delivery conditions; training can be tailored to meet the exact needs of the site and its staff; and instructional time can be fitted into other schedules (for example, a counseling training for nurses may take place in the afternoons when the wards and clinics are quietest, or skills training in tubal ligation for a physician can take place in the operating room once a week when clients are scheduled).

WST encourages service-delivery sites to consider the training needs of all employees, not just clinicians.

Building sustainable capacity

Because whole-site training encourages staff to identify their own strengths and weaknesses, emphasizes on-site instruction, and involves supervisors as part of the planning team, opportunities emerge for flexibility in choosing *who can train whom*. The supervisor may look at training needs and identify an opportunity for centralized instruction, but more likely will be able to find an appropriate local trainer or other skilled practitioner who can provide instruction quickly, before a centralized course is available. In East Africa, AVSC has helped ministries of health and nongovernmental organizations compile rosters of qualified and certified instructors and distribute the lists to supervisors.

Centralized training may result in trained individuals at the local level, but they are usually not part of an organized local network of trained personnel. With whole-site training, the focus on teams, supervisors, and local priority setting means that trained, certified individuals are part of a local pool of skilled individuals who not only can do the job for which they were trained, but who also can help train others.

WST encourages the sharing of knowledge and expertise both with immediate

Table 1 Skills Training, Updates, and Orientations Conducted by the Family Planning Association of Kenya and the Christian Health Association of Kenya: Number of Staff Trained, July 1993–June 1995

Content	Skills Training	Updates	Orientations
Minilaparotomy, Norplant implants, vasectomy, postpartum IUD	119	85	2
Surgical assistance	43	. . .	. . .
Infection prevention	52	55	70
General contraceptive technology	116	155	503
Reproductive health counseling	157	102	154
STD/HIV counseling	46	68	47
STD diagnosis	26	51	. . .
Supervision and COPE facilitation	27	12	. . .
Postpartum and postabortion contraception	. . .	. . .	10
Male involvement	. . .	. . .	13
Customer care	. . .	. . .	29
Quality improvement	10	4	6
Total	596	532	834

Table 2 Number of Staff Who Participated in Skills Training and Cost of Training by Approach, Family Planning Association of Kenya and Christian Health Association of Kenya, 1991–1995

	Centralized Approach, July 1991–June 1993	Whole-Site Approach, July 1993–June1995
Number of staff who participated in skills training	143	596
Training and supervision costs[1]	$212,923	$227,885[2]

[1] All training and supervision costs are included. Beginning in July 1993, resources were shifted away from centralized training approaches to whole-site training.

[2] These funds also paid to orient 834 staff and to update 532 staff.

colleagues and with neighboring institutions. The benefits are enormous. First, training skills can be demystified, so that they leave the preserve of experts and are transferred to others. Second, capacity is quickly built. And third, sustainability is promoted, as staff start to make information-sharing and training of each other part of their daily work. In Kenya, AVSC has helped the ministry of health develop training networks that include staff from different sectors (the ministry, mission hospitals, other nongovernmental organizations) in different regions of the country. Previously, managers and staff knew little of local expertise outside their own agencies, but now staff in different agencies are encouraged to work together and share their training resources.

In 1994, staff from a Kenyan mission hospital wanted to train four doctors to insert Norplant implants but found that centralized training had all but ceased due to financial constraints. The supervisor identified a local physician who had been trained to insert the implants, had training experience, and was willing to come to the hospital. He trained all four doctors (including much clinical practice) one day a week over a four-week period. While he was at the hospital, the supervisor and staff mentioned that they had clients who wanted to use the postpartum IUD. The doctor, who was skilled in the technique, offered to train maternity ward nurses how to insert an IUD in the postplacental period. Between sessions on Norplant implants with the doctors, he was able to provide postpartum IUD training to four nurses!

Whole-site training encourages team members to teach each other. In the past, skilled or experienced colleagues routinely, almost instinctively, trained one another as they worked. AVSC staff have noticed, however, that with the advent of formalized, centralized training, this practice has diminished and staff have felt increasingly inadequate as information sharers (Bradley 1998). By using a team approach, recognizing people's skills, and providing educational tools and materials, whole-site training encourages staff to once again meet the training needs of their colleagues without waiting for formal events. This approach encourages an emphasis on practical skills that can be used right away on the job. Staff members can serve as mentors and coaches to each other, providing one-on-one support and guidance.

At one FPAK clinic, nurses realized that they had skills they could share with colleagues. The nurse in charge taught the cleaner about infection prevention, how to clean the clinic properly, how to autoclave instruments, and how to dispose of waste material. The nurse and other staff also identified the need for a male vasectomy counselor. As the training with the cleaner (who was the only male staff member) had been successful, nurses at the site trained this same individual in counseling. He now serves as a resource for counseling on male contraceptive methods (Bradley 1998).

There is legitimate concern that this type of instruction is not as rigorous as centralized training and that quality may be compromised in the desire to act quickly and to train many workers. Clearly, standards must be maintained; a well-trained supervisor is essential to ensure that instruction is well structured and well planned, that appropriate materials and curricula are available and used, and that competency-based evaluations are undertaken (Sullivan 1995). AVSC is currently working with in-country partners to develop appropriate training guides and evaluation tools. Certification of competence after training, however, is still carried out by regional supervisors to ensure that standards are met.

WST encourages the sharing of knowledge and expertise both with immediate colleagues and with neighboring institutions.

CHALLENGES

Whole-site training brings with it a number of challenges, some of which have been mentioned above. The first challenge, and perhaps the most important, is how to ensure that WST, with its emphasis on practical, on-site instruction, is a quality product. As part of this approach, several things can be done to help ensure the quality of training content and methods. Evaluators (for example, supervisors) can use competency-based approaches to ensure that trainers have the attitudes, knowledge, and skills needed to perform effectively. Similarly, competency-based approaches can be used to assess the performance of trainees and to certify those who are qualified. Adequate time is needed for training on-site, with

Competency-based approaches can be used to assess the performance of trainees and to certify those who are qualified.

staff able to take time from their regular jobs and concentrate on learning.

The second challenge is how to promote needs assessment and priority setting at service-delivery sites. Clearly, if a site has assimilated other organizational development processes, such as facilitative supervision and quality-improvement approaches like COPE, this challenge will more easily be met, as some of the groundwork for site-based planning and decision making will already have been laid. However, even where this is not the case, supervisors can still help sites plan for training and start building their local capacity.

The third challenge is how to change the preconceptions people have about how training ought to be done. Training needs to be demystified, so that staff are encouraged to work with each other, share skills, share knowledge, and become mentors to each other. Part of the answer to this challenge lies in recognition and encouragement of staff trained on-site. Attending off-site training events has been considered a reward and source of stimulation; when this perquisite is taken away, it is sometimes hard to motivate staff to learn or to teach colleagues locally. However, staff surprise themselves when they start to teach others; they begin to find gratification from and to receive recognition for these efforts. As one Kenyan nurse commented, "For me, teaching provides a challenge. I am enjoying learning and sharing information with my colleagues."

Staff also need to be adequately prepared for training. In Africa, AVSC stresses the decentralization of training skills; supervisors and site staff learn how to plan for training, use different methodologies and materials, and measure competency. To support this decentralization, sites need assistance with materials, and supervisors need support to spend more time at sites to assist with needs assessments and to conduct competency-based evaluation; only in this way will commitment for the approach match the shift in the burden of responsibility.

The fourth challenge is how to limit the confusion that results when different donor organizations and development agencies bring different training approaches to the same service-delivery sites. At the very least, our philosophies need not to conflict, but rather to complement and strengthen each other. At the site level, organizations must work together to coordinate their approaches.

The fifth challenge is to determine whether WST helps institutions develop well-trained, effective staff so that they can do a better job of responding to client needs. In general, most training evaluation efforts have focused on the training event and the skills and knowledge acquired at that event. Few efforts have formally assessed trainees once they return to work, or the relationship of training to service delivery.

AVSC will begin formal evaluation of whole-site training in 1998. Several issues are important to consider:

- How effective and skillful are whole-site trainers? What is needed to improve their skills?
- What do trainees think about WST? How do they view it in comparison to conventional training approaches?
- Do trainers and trainees have the materials they need for instruction and evaluation?
- Does WST improve teamwork at the facility? In which ways?
- How easy or difficult is it to build local training capacity? How is this local capacity perceived?
- How crucial is an established supervisory system to successful WST?
- Does the central system provide the support that WST requires?
- How are trainees followed and assessed after training occurs? Who plays this role, and how effectively do they carry out their responsibilities?
- Do personnel trained through the WST approach perform to standards?
- What are the costs associated with whole-site training? In addition to calculating the costs of skills training, updates, and orientations, what are the opportunity costs? What are the consequences of using clinical settings for training purposes? Are important other duties neglected if service site staff are involved in training activities?

- Does whole-site training help a program reach more clients? Theoretically, since WST increases the pool of trained personnel, the number of clients served should increase.
- Does WST help providers better respond to client needs?

CONCLUSIONS

This working paper has outlined an exciting new approach to the growing demand for trained personnel in many developing countries. Not limited to reproductive health services, whole-site training can be used to address a variety of instructional needs in different disciplines. Consistent with its other organizational development initiatives, AVSC believes that priority setting and responsibility for training should be the purview of teams at the site level, ideally supported by a facilitative supervisory system. WST complements other quality improvement initiatives that also seek to shift responsibility of action to frontline workers. Its focus is to help individuals and teams to identify their needs and meet them, and ultimately to improve organizational effectiveness and services for clients.

Whole-site training faces many challenges, for it involves a fundamental shift in the way we look at training. It is much more than merely changing the location of training from centralized sites to local service-delivery sites. Many think that current training systems are too deeply entrenched for change to be effected. But AVSC's work has shown that change can occur in a variety of geographic and cultural contexts. Funds are not the critical issue, for money has always been allocated for training. What is needed is commitment, time, patience, and evaluation, for organizational development is not a short-term proposition. We need to shift training resources to the local level and to a stronger supervisory structure that actively involves supervisors as facilitators and catalysts for training. We need to make a commitment to the approach at all levels, and provide financial, material, evaluative, and emotional support for supervisors and staff to do what they are perfectly capable of doing.

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