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Building Blocks for Peer Success: Lessons Learned from a Train-the-Trainer Program

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Abstract

The National HIV/AIDS Strategy (NHAS) calls for a reduction in health disparities, a reduction in new HIV infections, and improved retention in HIV care and treatment. It acknowledges that HIV-positive peers can play an important role in supporting these aims. However, peer training must be comprehensive enough to equip peers with the knowledge and skills needed for this work. This article describes the development of a national train the trainer (TTT) model for HIV peer educators, and the results of its implementation and replication. A mixed methods evaluation identified who was trained locally as a result of TTT implementation, what aspects of the TTT were most useful to trainers in implementing local training sessions, and areas for improvement. Over the course of 1 year, 91 individuals were trained at 1 of 6 TTT sessions. These individuals then conducted 26 local training sessions for 272 peers. Factors that facilitated local replication training included the teach-back/feedback model, faculty modeling of facilitation styles, financial support for training logistics, and faculty support in designing and implementing the training. The model could be improved by providing instruction on how to incorporate peers as part of the training team. TTT programs that are easily replicable in the community will be an important asset in developing a peer workforce that can help implement the National AIDS Strategy.

Introduction

HIV-positive peers, individuals who are infected with HIV and share similar characteristics with the clients they serve, can play a vital role in the continuum of HIV care and treatment, both domestically and internationally.[1,2] While they are not clinically trained health care professionals, they are paraprofessionals often identified as community health workers, treatment educators, or peer advocates. Regardless of title, peers may serve as mentors and role models, people who are living successfully with HIV and making important contributions to the care and treatment of other persons living with HIV/AIDS.[3] They can provide critical information about HIV disease and treatment adherence without the time constraints faced by many providers. They may help bridge cultural gaps between patients and health care providers. The U.S. National AIDS Strategy, with its focus on reducing new infections, improving engagement in care, and reducing disparities, notes that peers can alleviate workplace burdens and contribute to patient retention.[4]

With the expansion of task-shifting and the use of peers, it is essential that peers are appropriately trained.[5] Much HIV peer work occurs in the context of people coping with the daily stressors of living with HIV, HIV-related stigma, poverty, addiction or recovery, homelessness, and mental illness. Helping people navigate the health care system and enhancing their understanding of HIV disease, what laboratory values mean, and teaching medication adherence is complex work. Peer training must be comprehensive enough to equip peers with the knowledge and skills needed for the job. However, in the United States and internationally, less attention is paid to the training of peers or community health workers than to the training of other health care professionals.[6]

Over the last decade the Health Resources and Services Administration has funded several HIV peer education training programs. Most of the peers who participated in these training sessions lived in the same city or state as the organization funded to provide the training, and many did not necessarily obtain employment or volunteer work once they completed the training. At the same time, many peers were working in other parts of the country with limited access to peer training. In the most recent round of funding, programs were charged with building greater capacity to train peers. The strategy chosen to accomplish this goal was a train the trainer program.

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Train the trainer (TTT) programs are a popular strategy for building training capacity in the community.[6] They are used in a wide variety of fields from public health preparedness, to nutrition education, dementia care, and end-of-life care.[7–10] TTT programs are also used for specific clinical interventions such as the diagnosis and treatment of chronic fatigue syndrome, tobacco cessation, screening for hypertension or protecting the eyes of farmworkers.[11–14] In HIV care, TTT strategies have been used primarily for education and prevention. TTT programs have trained health care providers to increase HIV counseling and testing of pregnant women,[15] to train military medical technicians about HIV prevention,[16] to train volunteers in HIV prevention,[17] and to train community health workers to conduct HIV counseling and testing in the Caribbean.[18] Most TTT strategies for HIV care and treatment described in the literature have trained clinicians, primarily doctors and nurses.[19,20]

The TTT model offers many potential advantages. By training a smaller number of people intensively, it is possible to reach a much larger audience through subsequent training activities. TTT participants may have much better connection with the people in their local communities than the TTT faculty and may be more effective in reaching them. In addition, by building knowledge and capacity at the local level, the training programs may be more sustainable over the long run.[7] However, one of the biggest obstacles for TTT programs is that many of those trained do not follow through with replication training sessions at the local level.[21] For example, in a TTT on public health preparedness, only 20% of those trained conducted a replication training 6 months later[7] and in a TTT on perinatal HIV prevention and care only 37% participants agreed to conduct training and of these only 20% actually conducted a training.[15]

Most TTT programs described in the literature describe how the TTT functioned, what it taught and what was learned, but few assessed how trainees returned to their communities to train others. This paper describes a TTT program designed to train health educators and program directors to train HIV-positive peers to support clients in accessing HIV care and treatment. A mixed method evaluation was conducted to determine the scope of post-TTT activities and factors associated with subsequent training successes and challenges.

Methods

Developing the peer training toolkit and train-the-trainer curriculum

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB), Division of Training and Technical Assistance, funded three training programs and a multisite evaluation center for the Peer Education Training Site initiative (PETS). The goal was to improve health-related outcomes and reduce health disparities among communities of color through a cadre of trained HIV peer educators who could provide information and engage other people living with HIV/AIDS in care and treatment. The PETS were located in Oakland, California (The Lotus Project), St. Louis and Kansas City, Missouri (People to People Project), and New York City (PACT Project).

Each PETS program developed a curriculum to train HIV-positive peers in their respective communities. The Lotus Project was national and trained women only, while the other two programs trained both men and women living in the Midwest (People to People) or the Northeast (PACT). The curriculum development took approximately 1 year, as each site researched training materials already in existence and developed new materials which were reviewed by existing peer workers or pilot-tested in training sessions.

The PETS curricula were designed around a common set of core competencies: HIV/AIDS content, including the viral life cycle, medications and resistance, risk and harm reduction and treatment adherence; peer roles, including workplace expectations, boundaries, confidentiality, counseling, navigating the health system, working as part of an interdisciplinary team, readiness to be a peer, and self care; and communication skills, including the stages of change, listening skills, open-ended questions, communicating with providers, cultural awareness, and nonjudgmental behaviors. Training materials were based on the principles of adult learning, requiring participatory training through diverse methodologies such as lectures, slides, videos, brainstorming sessions, small group work, case studies, role-play, and games. They included visual, auditory, and kinesthetic activities to address the different learning styles of training participants. Once the curricula were implemented in the field, master trainers from the PETS, together with trainers from Duke University Medical Center in North Carolina and the evaluation center at Boston University School of Public Health and JRI Health, assembled a peer training toolkit. The toolkit serves three main purposes: (1) It offers online access to peer training curricula in such a way that future trainers will not need to spend months developing new materials; (2) it offers a choice of training styles, formats and duration for a wide range of topics, allowing trainers to select the sessions and activities that best meet their needs, training style and time available; and (3) it serves as the foundation for the TTT program.

The toolkit groups all the training modules from the four curricula into the three core competencies: HIV/AIDS, peer roles, and communication skills, with additional sections for icebreakers, energizers, closing activities, case studies, and continuing education. Each training module was given an identical format so that future trainers could quickly identify the key objectives, the duration, training techniques, and preparation materials for each session. The same team also developed a toolkit guide to assist future trainers in designing and preparing a training and how to use the toolkit itself. The draft of the toolkit guide and the toolkit were then reviewed and critiqued by nine experienced HIV-positive peer leaders and trainers from across the country. The peer leaders pilot-tested some of the key activities, and provided feedback on the content, tone, organization, and methods of the toolkit and toolkit guide. This feedback was incorporated into the final documents.

Trainer recruitment

Information about the TTT workshops was disseminated by HRSA through newsletters to HIV/AIDS service providers. Potential participants completed an application that described their training experience, facilitation skills, experience with peer programs, and ability to participate fully in the TTT. Applicants were instructed to apply jointly with a colleague to

cofacilitate subsequent training sessions and had to describe their plan to conduct a replication training within 3–6 months of the TTT. In addition, applicants submitted an Organization Contract signed by a director or senior manager of their agency stating their approval to allow staff to conduct the replication training. TTT faculty screened candidates to ensure they met the selection criteria described above and were committed to training others in their community. Successful applicants received a small stipend to support replication training costs and some scholarship funds were provided to participants who demonstrated a financial need to attend the TTT workshop.

TTT workshops

Six TTT workshops, entitled Building Blocks for Peer Success, were conducted across the country, with a special focus on the southern United States, where our needs assessment identified a high level of both interest and need for peer training programs and a high incidence of newly reported HIV cases. Prior to the workshop trainers participated in conference calls to review the training toolkit. The trainers also discussed preassigned training modules that participants would facilitate in the workshop "teach-back" sessions. Each TTT workshop lasted 3–4 days and included sessions on planning a training, recruiting participants, facilitation skills, and training evaluation. Faculty modeled different training styles by facilitating specific training modules, providing exposure to a wide range of styles and skills. The TTT included teach-back sessions facilitated by the training participants who received feedback from faculty and other participants. Finally participants learned how to use the toolkit to develop their own training agenda and identify modules for replication training sessions.

Evaluation

A mixed methods evaluation was designed to answer three questions: (1) What training materials were most useful to trainers? (2) Was this model successful in expanding local capacity to train people living with HIV as peer educators/advocates? and (3) What aspects of the model were most useful to participants in designing and implementing local training sessions? Three instruments were used to collect this information: an anonymous evaluation completed by participants at the conclusion of each training workshop assessed the value of each training session and whether or not the materials would help them implement a follow-up training; a training replication report completed by participants at the conclusion of their local training sessions provided aggregate demographic information on characteristics of peers trained locally, the content and duration of the training, and barriers or challenges encountered in implementing the training; and a semistructured debriefing interview guide that was conducted 6–12 months after the first replication training to provide feedback on the strengths and weaknesses of the program. Simple descriptive statistics were used to analyze quantitative data from the replication reports (SPSS version 16.0, SPSS, Chicago, IL). Qualitative data from the debriefing interviews was read and analyzed for themes by three authors using the coding techniques of grounded theory, coding each theme that emerged and then grouping the themes into common categories.[22,23] The study protocol was submitted to the Boston University Institutional Review Board and was determined to be exempt.

Results

TTT workshops

Six master trainers collaborated to organize and conduct six TTT workshops in Tennessee, California, Missouri, New York, Connecticut, and Florida between May 2009 and March 2010. Ninety-one trainers attended one of the six workshops. Sixty percent of the participants were female, 43% were black, 34% white, and 21% Hispanic (Table 1). The large majority of workshop participants came from community-based organizations (42%) or AIDS service organizations (35%), while 12% and 5% came from health clinics and hospitals, respectively. Over half (53%) of the participants were already working as peer trainers and 24% were peers themselves. Other occupations represented among the participants included peer supervisors (36%), program managers (24%), and other trainers (33%). The workshops lasted 3.5–4 days each.

Local training sessions

A large majority (96%) of the workshop participants returned to their communities and conducted a total of 26 local training sessions for another 272 peers between July 2009 and July 2010 (Table 2). Eighty-eight trainers were involved in the local training sessions, including most of the original workshop participants and some of their local colleagues. The duration of the local workshops varied widely, with the shortest lasting only a few hours and the longest lasting 9 days. The mean duration was 3.4 days, and the majority of training sessions (69%) lasted 3–5 days (data not shown). The majority of peers who attended the training were female (56%) and black (56%), with 16% Hispanic, 26% white, and 1% other race/ethnicity. Half of the peers who attended the local workshops were

Table 1. Characteristics of Train the Trainer Workshop Participants

	n	%
Total trainers	91	100
Race/ethnicity		
Male	36	40
Female	55	60
Black/African American	39	43
White	31	34
Hispanic	19	21
Other	2	2
Occupation[a]		
Trainer of peers	48	53
Peer supervisor	33	36
Manager	22	24
Other trainer	30	33
Peer	22	24
Other	23	25
Trainer organization		
CBO or social service agency	38	42
AIDS Service organization	32	35
Health clinic	11	12
Hospital	5	5
Other	9	10

[a]Participants could list more than one occupation.

Table 2. Summary of Peer Training Replication Workshops

	n	*Mean*
Number of training workshops	26	
Duration of workshops		3.4 days
Total peers trained	272	10.46
Peer demographics	*n*	%
Gender		
Male	111	43%
Female	135	56%
Transgender	3	1%
Race/ethnicity		
Black	151	56%
White	72	26%
Hispanic	44	16%
Other race/ethnicity	4	1%
Number currently working or volunteering as peers	136	50%

already working as peers in their communities and the other half were hoping to become peer educators.

The most common topics for the training sessions were well divided among the three core competencies, HIV/AIDS, Peer roles, and communication. Peer Roles and Responsibilities were covered in 85% of the workshops, followed closely by Overall Communication Skills (77%), and the HIV Life Cycle (73%; Table 3). Other topics covered in at least 50% of the local training sessions included the HIV/AIDS core competencies of HIV Medications and Adherence and HIV Transmission and Risk Reduction; the peer role competencies of Discussing Disclosure with Clients and Boundaries and Self Care; and the communication competencies of Asking Open Ended Questions and Listening Skills.

Factors that gacilitated teplication training sessions

TTT workshop surveys were completed by 85 training participants. Another 40 trainers participated in the semi-structured debriefing interviews after they completed their local replication training sessions. Several important themes emerged about aspects of the training that helped facilitate the replication process.

Table 3. Training Modules Used in Replication Trainings

Modules	*Frequency*	%
Peer roles and responsibilities	22	84.6
Overall communication skills	20	76.9
HIV life cycle	19	73.1
HIV medications and adherence	18	69.2
Boundaries and self-care	18	69.2
Asking open-ended questions	17	65.4
Listening skills	16	61.5
HIV transmission and risk reduction	13	50.0
Discussing disclosure with clients	13	50.0
Workplace ethics/code of conduct	12	46.2
Behavior change/stages of change	11	42.3
Interacting in a nonjudgmental manner	8	30.8
Communicating health information	8	30.8
Working as part of a clinical team	8	30.8
Navigating the health care system	8	30.8
Cultural awareness	7	26.9
Return to work	6	23.1

The teach-back and feedback model. Participants reported that the teach-back sessions gave them an important opportunity to practice training skills and receive feedback that helped them prepare for local training sessions, "One of the most useful things was the teach backs. It was challenging, but it was one of the most significant parts…." Typically, teach-back sessions involve observing an experienced trainer first, with the new trainer then replicating the session. This often results in participants parroting the observed trainer. Our teach-backs were assigned in advance as homework and participants were given additional time to prepare during the workshop itself, with faculty available to assist. Using this model, participants had more freedom to make the modules their own and execute them using their own words and style.

Faculty modeling. Another facilitating theme that emerged was the diversity of the training faculty and their facilitation styles. Throughout the TTT, different faculty facilitated training modules selected for the variation in topics, training methods and facilitation techniques. Participants routinely reported that they wished more time could have been spent observing these skilled trainers and learning from their different styles and that it was helpful to be exposed to multiple facilitation styles. People also commented that it was useful to observe how trainers wove their own experiences into the training rather than using a script from which they could not deviate.

Faculty assistance and support. Most of the trainers mentioned that the ability to get technical assistance and support from the TTT faculty was a major factor in successful replication. Training faculty was available for telephone consultation to help plan training agendas and select the training modules. Faculty also traveled to local sites to help with training preparations, and in some cases cofacilitated the training. Local trainers were highly appreciative of the experience that the training faculty brought to help with problem-solving and mid-course corrections during the training itself. "B was able to help address some issues that came up in the training and provide a second opinion."

Financial support. Most of the local trainers received a small amount of financial support to conduct their local training sessions, from $2,000 to $4,000. These funds did not reimburse the trainers for their time, but could be used to pay for meeting space, food and drink, transportation or materials. Many of the trainers talked about how important it was to have these funds available, "A budget for food and supplies is a must to be able to provide this training." In one instance where funds were not available, trainers reported that they had to pay for food and supplies themselves.

Variation in prior training experience prompted different responses

Despite efforts to target participants with prior training experience, many of the participants lacked this experience.

Some had teaching experience while others were peer leaders or peer supervisors. As one participant put it "I've done public speaking all my life….but I've never had to put [a training] together and organize it and choose the topics…." Thus, the TTT not only taught people how to put together a training, it built new training capacity among some individuals who did not normally conduct training. " [This is] expanding your comfort zone because once you've done it, it's like WE DID IT!...I'm just really proud of us for taking the challenge on."

These less experienced trainers talked about how the faculty assistance, support and modeling helped them develop the confidence to conduct their local training sessions. "I was nervous and their patience helped me to become more confident." "I thought I was ready but when the opportunity came….I wasn't as sure of myself as I thought. I just didn't have enough self-confidence the first time I was asked to do it." Some trainers reported that they were not yet ready to adapt training modules or add new ones, but preferred to stick to an existing agenda and training menu, while more experienced trainers were more likely to add additional sessions, merge or shorten existing modules, or modify sessions to suit their own training styles and participant needs. Some of the trainers reported that the HIV clinical information was not at the right level for themselves or their training audiences, largely because of the complexity of the information. One new trainer said she was very eager to use some of these materials, but felt the need to become very, very familiar with the content before actually trying to teach it to others. "AFRITAB (The HIV Viral Life Cycle) is awesome, but you got to know that you know every part about it, so I'm working on that for myself first."

Training peers as trainers

One other important theme emerged from the interviews suggests an area for improvement rather than something that was done well. Many of the training teams that participated in the TTT workshop felt that it was important to include a person living with HIV as part of the local training team. "…we needed some assistance….to train our peer trainer who is both new to training and….was not able to attend the Train the Trainer workshop." The Building Blocks for Peer Success toolkit and training workshops did not include materials or strategies to help trainers incorporate peers into the training process.

Discussion

The TTT had a significant impact on building local capacity to train peer educators. Some components of the TTT structure and delivery that were key to this success included faculty support and technical assistance, financial support and organizational support, similar to other experiences reported in the literature. For example, Burr et al.[15] found that ongoing faculty support was a key element of success in their TTT program to reduce perinatal HIV transmission. Other TTT evaluations have found that financial support to obtain items such as training supplies, binders, food, and transportation made an important difference for local trainers.[12] Our TTT participants also were required to obtain written organizational support for their attendance at the TTT and their replication training activities. In retrospect, this may have been one of the most important requirements of the application process, as none of the participants reported any difficulty obtaining space or organizational support for subsequent training activities, as has been reported in other training sessions.[11,17] Finally, this TTT was designed to be flexible and accessible to a range of communities in response to the varied needs and skill levels of different communities. While flexibility is not a hallmark for most TTT models, at least one other example of flexibility as a contributing factor to success was described for a TTT on chronic fatigue syndrome.[11]

Other findings from this study are different from what has been reported elsewhere. This includes the variation in skills and experience among participants in the TTT and the importance of incorporating end-users, peers themselves, into the training process. Some of the TTT participants did not have advanced professional experience or expertise in training or facilitation; therefore, we could not assume a common level of knowledge or experience. Despite asking for training experience during the application process, this expertise was difficult to assess on paper. Other TTTs may have experienced similar disparities, but this has not been described. Perhaps there is an assumption that physicians, nurses and other clinically-trained professionals, by nature of their training, are comfortable and competent trainers, which may not always be the case. This variation impacts the planning and delivery of the TTT as well as the replication training. In order to accommodate the variation in training experience, it was important that the TTT model incorporate basic facilitation training sessions and opportunities to observe and name different facilitation techniques, and that faculty be available to help coach new trainers through their first replication training sessions.

The ultimate target audience for our TTT was peers, which differed from most target audiences described in the literature who were more likely to be clinicians, planners or program directors. One of the strengths of our model was a peer review process in which peer leaders from across the country provided important feedback and input to the toolkit and the design of the training. This contributed to the success of the TTT because we were able to "field test" parts of the curriculum with peer leaders. However, even though the peer reviewers stressed the importance of naming peers as part of the training teams, we did not develop materials that explicitly addressed the development of peer educators as trainers. Several of our TTT participants requested this assistance. Not all peers are, or can become, excellent trainers, but the very nature of peer work suggests that it is important to build this capacity into peer training. While this was a limitation of our TTT, it highlights the need to develop curriculum and materials that focus on peer educators as trainers. They have an invaluable role to play as trainers and can offer a unique perspective and experience in a training setting.

Other aspects of this TTT make it unique. For example, the entire toolkit and training guide are accessible on line, allowing the content and structure to live in the virtual world and be adapted by future trainers. Online accessibility also improves the ease of completing advance homework exercises. If printed the entire toolkit would exceed 500 pages, making it expensive to print and nearly impossible to carry to meetings or training sessions. However, trainers and planners can review materials online and download those exercises or instructions that will contribute to a training session.

Finally, this TTT required a greater commitment of time and resources for the trainers and time for the participants than other TTTs reported in the literature. Most training programs are conducted over 4- to 20-h training sessions, and some are spread over days or weeks. Our TTT workshops lasted 24–32 h and required participants to complete preliminary assignments prior to attending the training. This was challenging for some participants who were also balancing their job responsibilities. Furthermore, our TTT workshops were regional, drawing participants from several states and it was not logistically possible to spread the training over several weeks. This investment of time and resources made it all the more imperative to ensure that participants were able to return to their communities and conduct replication training sessions.

As the United States implements health care reform, which should provide health care coverage for the large majority of individuals living with HIV over the next few years, we have an opportunity to place a stronger emphasis on strategies to reduce health disparities, reduce new HIV infections and improve engagement and retention in HIV care, as called for under the National HIV/AIDS Strategy. Peers and peer interventions may be effective in targeting the highest risk individuals who have not been effectively engaged in care.[24] These efforts can be strengthened by training peers to assist people living with HIV to access and navigate the health care system, and teach HIV self-care strategies. TTT programs that have a broad reach, are flexible enough to prepare trainers from a range of settings, and are easily replicable in the community, will be an important asset in these efforts.

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