



Meeting the Training and Capacity Needs of Frontline Health Workers During the COVID-19 Pandemic: Lessons Learned

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COVID-19 has brought widespread disruption to essential health care throughout the world—including sexual and reproductive health (SRH) services. During the first eight months of the pandemic, Pathfinder International teams across the globe worked rapidly to adapt service delivery, training, quality assurance, and social and behavior change (SBC) programs. The lessons learned provide insight for SRH program preparedness in the event of future emergencies and for resiliency of global health supply chains and collaboration systems. This brief is part of a series on Pathfinder International’s COVID-19 response strategies, impact, and lessons learned.

The Pathfinder Approach

Pathfinder has worked with governments, communities, and other partners to maintain access to critical SRH information and care. During the COVID-19 pandemic, Pathfinder and its partners have deployed innovations and adaptations to train facility- and community-based health care workers on the most up-to-date guidelines and skills for working safely and effectively in a pandemic. Pathfinder’s COVID-19 learnings and successes denote opportunities for lasting positive change. Each of the following approaches has proven critical to mitigating the negative secondary impacts of COVID-19 on the delivery of SRH training to health workers:

- **Modify face-to-face activities to adhere to COVID-19 prevention protocols.** Skills-based training is often most effective when done face-to-face, onsite. Limiting the number of participants and meeting in large spaces can help attendees adhere to physical distancing recommendations. Consistent and correct use of masks, handwashing, and sanitizer also help ensure that face-to-face trainings are conducted as safely as possible.
- **Adapt capacity strengthening to virtual or hybrid models.** Virtual learning can eliminate risk of COVID-19 transmission and provide high-frequency, low-dose knowledge and tools and generate timely dialogue. Even beyond the pandemic, governments and organizations should do the following:
 - Invest in digital infrastructure, tools, and services, as well as developing digital literacy and trust.
 - Employ proven strategies to optimize engagement in virtual learning.
 - Explore hybrid learning models to employ a mix of digital knowledge-based and in-person skills-based trainings.
 - Assess the effectiveness and acceptability of adapted virtual and hybrid trainings for different audiences.



PHOTO: RICARDO FRANCO

Bebina Cuamba leaves the Xipamanine health center after receiving care.

Background

Early in 2020, as the COVID-19 pandemic led to physical distancing and quarantine restrictions around the world, traditional modalities for training and information dissemination were ill-advised. Lack of information, rapidly changing evidence, and fear were pervasive among health sector professionals and lay persons alike. At the same time, there was an urgent imperative for health workers to continue to provide essential, lifesaving care to their communities—both for acute COVID-19 response and to maintain other essential health services. Multilateral organizations, national governments, and individual health facilities scrambled to develop COVID-19-sensitive strategies and platforms to maintain standard in-service training. They also worked to rapidly deploy training on COVID-19 prevention, containment, and treatment information as it evolved.

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Key Training Adaptations and Innovations

Modify Face-to-face Activities to Adhere to COVID-19 Prevention Protocols

Some skill-building requires hands-on demonstration and practice under supervision. Therefore, it cannot always effectively be translated to a digital format. The ability to safely continue some in-person learning during the pandemic has proven highly beneficial. In countries where in-person events have been allowed during the pandemic, programs modified face-to-face trainings and activities to adhere to COVID-19 prevention protocols. Some programs shifted from workshop style trainings to onsite training at health workers’ own facilities, reducing the need for travel. Onsite training also enabled a greater number of providers to participate without compromising staffing levels at their facility. Additional modifications included reducing the number of participants—for example, 10 people maximum—to facilitate physical distancing. In-person trainings and events were held in large spaces, and participants were required to use on-site handwashing facilities, hand sanitizer, and masks. Some programs plan to continue these approaches beyond the pandemic; however, understanding the relative costs of this evolved approach will be key to determining long-term sustainability.

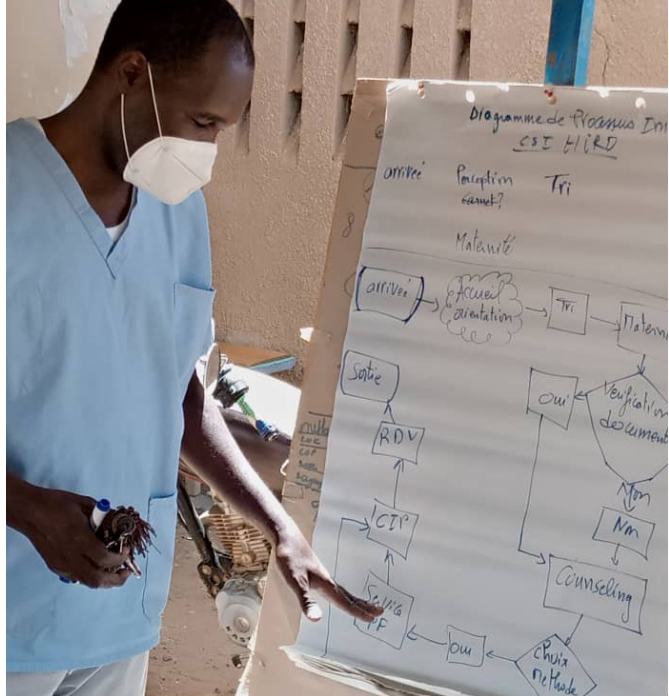


PHOTO: Ada Zourkaleini

The Advance Family Planning project in Nigeria adapted a three-day face-to-face media advocacy training that usually included field trips to facilities to a virtual training delivered via Zoom and WhatsApp. Recognizing the impracticality of three full days of virtual training, the program instead held two-hour training sessions three days a week for five weeks, replacing in-person field trips with phone or Zoom interviews. Given the demanding schedules of the participants, it was challenging to ensure their attendance and attention for the full training period. Some did not turn in their required deliverables at the end of the training. While some participants felt that the virtual model had as much value as an in-person training, program staff noted that the field trips and interviews were more powerful when done in person.

Adapt Capacity Strengthening to Virtual or Hybrid Models

In contexts where in-person training modifications were not feasible or sufficient, training pivoted to virtual or hybrid models. Virtual trainings have been able to reach a diverse health workforce, including family planning clinicians from medical doctors to community midwives, hotline agents, CHWs and their supervisors, community-based distributors, and government stakeholders. While new content had to be developed to convey COVID-19-specific guidelines and information, virtual training has helped programs to meet health workers’ immediate information needs by sharing new knowledge for safely adapting services to the COVID-19 context and providing refresher training. For example, at the start of the pandemic, programs quickly implemented IPC refresher trainings and updates on water, sanitation, and hygiene (WASH) practices and COVID-specific IPC

For community health workers (CHWs), modified in-person trainings helped support task-sharing, a critical approach to ensuring continuity of essential services during the pandemic. For example, to mitigate declining service uptake in Pakistan, the Naya Qadam project developed a pool of master trainers. These master trainers provided cascade training to lady health workers on implementing the World Health Organization IPC guidelines to prevent COVID-19 transmission.





Some programs experimented with hybrid learning models that combined virtual knowledge-based sessions with limited face-to-face skill-based sessions. For example, the Pathfinder Tanzania team was in the middle of a training when the country announced a ban on social gatherings. Though participants had already traveled to attend the learning event, COVID-19-prevention measures were instituted immediately, and the training was shortened. The training team moved quickly to adapt the training to be done virtually. The team mapped facilities that could support virtual training and included them in a virtual three-day training on COVID-19 prevention. Where in-person training was still necessary, the team procured the proper PPE and WASH supplies, limited participation to five or fewer attendees, and shifted to on-the-job training at participants' own facilities rather than regional convenings.

strategies. Virtual training and remote provision of guidance and job aids have also helped frontline health workers to provide gender-sensitive support and referrals to survivors of gender-based violence, the incidence of which has risen during the pandemic.

While necessary for skill advancement and maintenance, there were diverse challenges to achieving adequate digital access and literacy to support virtual training:

- Some facilities lacked equipment, a venue, or bandwidth to convene virtual training. Electrical outages also posed a challenge. Prolonged load shedding resulted in both dropped internet signals and drained batteries when devices could not be charged.
- At an individual level, a lack of access to smartphones and connectivity for health workers attempting to work from their homes was common.
- Many trainers were new to conducting virtual trainings and struggled to adapt exercises and facilitation techniques that maintained participant engagement. At the same time participants faced competing demands and distractions when trying to participate in trainings during lockdown—while at home with family demands.

Where feedback on adapted trainings was solicited, participants had mixed experiences with virtual learning. Some providers appreciated virtual trainings for their convenience during lockdown as well as periods like Ramadan when in-person training is less feasible. Early in the pandemic, providers who had not received government training on COVID-19 were feeling stressed and uncertain about how to respond when a client presented with a fever. They felt empowered by the information Pathfinder and partners provided virtually. However, other providers did not find virtual trainings effective.

Lessons and Recommendations

BUILD DIGITAL ACCESS AND LITERACY

- Understanding digital knowledge and access is critical to the effective adaptation of trainings to modified in-person events, virtual events, or hybrid models.
- Tailor virtual training to local needs. Select platforms commonly used by participants, reduce group size to make participation easier, and integrate mixed-method approaches such as combining recorded video content with live chat sessions.





PHOTO: Sharon Atieno

A Community health volunteer holds a dialogue with a small group.

- Assess digital literacy and access of participants before adapting trainings to virtual or hybrid models. Routine assessments of internet coverage and access to smartphones, feature phones, and other digital hardware and software has helped some programs tailor their learning activities to the current context and work to fill gaps in access and connectivity. These programs will continue to routinely assess coverage after the pandemic.
- Where needed, provide tailored digital capacity strengthening to both facilitators and participants before engaging in virtual or hybrid knowledge- and skills-based training.
- Enlist early adopters to virtual learning who have high digital literacy to serve as champions and to support those who are new or resistant to virtual training.
- Advocate that governments allocate resources to expand internet and digital-device access and develop contextually appropriate virtual learning platforms.

OPTIMIZE ENGAGEMENT IN VIRTUAL LEARNING

- Optimize engagement in virtual learning by keeping sessions short and using video participation (where bandwidth is available) and mixed-media approaches—for example, a combination of video, live instruction, and group chat threads.
- Group work is an effective strategy for online learning. Programs reported that participants were very active when they worked virtually in groups, collaboratively developing ideas and sharing interesting information and constructive suggestions.

EXPLORE HYBRID LEARNING MODELS

- Organizations should consider developing global solutions that can be adapted to meet the clinical skills-building needs of participants in varying country contexts.
- Even after the COVID-19 pandemic, programs should employ a mix of virtual knowledge-based training and in-person skills-based training.

ASSESS THE EFFECTIVENESS OF ADAPTED VIRTUAL AND HYBRID TRAININGS

- The effectiveness, acceptability, and efficiency of adapted trainings must be assessed for different groups. Evaluation is critical to programs' ability to improve the training experience by adjusting the duration, content, and format of the sessions.
- In some cases where trainings were quickly adapted and implemented early in the pandemic, no pre- or post-testing was done to gauge absorption or application of information. Moving forward, programs should implement pre- and post-training assessments of on-the-job performance as well as knowledge retention.
- Virtual training is often less expensive than traditional in-person training; however, more research is needed to understand how to optimize the virtual learning experience from both the trainer and the participant perspective, and how to evaluate equity in access, comparative effectiveness, and relative costs.



PHOTO: RICARDO FRANCO

Elisa Cuinica, an activista with Pathfinder's RARE project, visits Marta Joca at her home.

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