

## WISH COVID-19 Learning Brief #1:

# Remote training for contraceptive service delivery

September 2020

*Restrictions and lockdowns imposed in response to the COVID-19 pandemic have significantly affected organisations' ability to conduct training and quality assurance work, which is essential for high-quality sexual and reproductive health (SRH) service delivery under the Foreign, Commonwealth and Development Office (FCDO) Women's Integrated Sexual Health (WISH) programme. In response, WISH implementing partners and the wider SRH community are having to adopt remote and adapted training and assessment methods in order to continue delivering SRH services to women and girls during this period. This Learning Brief summarises learning on approaches to remote training to train health workers in developing countries. Written by WISH4Results, the Third Party Monitoring team for the FCDO Women's Integrated Sexual Health (WISH) Programme, the publication includes the experience of WISH partners in adapting their training models in response to COVID-19.*

## Key learnings

1. Knowledge-based trainings translate more easily to online delivery using existing resources and learning platforms.
2. Competency/skills-based training and assessments are harder to replicate remotely, given the importance of in-person evaluation of practical skills (for example, for procedures such as implant and intrauterine device (IUD) insertion and removal, and surgical abortion), support and practice on clients. In the short-term, video technology can be helpful but should be prioritised for situations where training needs are less acute – e.g., health workers have prior experience of the procedure – and where training is essential to the continuation of services.
3. To maximise the effectiveness of virtual classes and sessions, be sensitive to connectivity levels and consider the impact of group size and moderation.
4. COVID-19 has disrupted the training status quo, providing SRH programmers with an opportunity to experiment with new approaches and do things differently. SRH professionals should integrate new experiences and learnings from this period into longer-term training planning.

## A greater role for remote training

The COVID-19 pandemic has drastically affected the capacity of organisations to train health providers, jeopardising their ability to maintain SRH services for women and girls. Due to risk of infection, movement restrictions and the diversion of medical personnel and resources away from essential services, traditional in-person trainings and assessments are no longer feasible. In response, a training 'revolution' has taken place as organisations adapt to find ways of maintaining health workers' skills and knowledge from afar. The work has centred on two broad categories of training:

- Knowledge-based training, improving trainees' familiarity with theoretical concepts and information, is relatively easier to translate to remote ways of working by harnessing digital platforms.
- Competency or skills-based training tests how healthcare workers apply this knowledge to real-life situations, and is more dependent on in-person assessment and regular, observed patient contact to deem providers able to practice. More innovative adaptations are required for its continuation.

The disruption of pre-COVID-19 training models has shown the advantages of remote training by removing travel requirements and some of the costs associated with in-person training, while providing an opportunity to streamline training and more easily bringing together trainees from different geographies in single sessions. This brief captures some of the emerging evidence from the SRH sector on what can be easily and rapidly be adapted and where the challenges lie.

## **Categorising remote training adaptations**

Adaptations to training for remote contexts are broadly clustered around the two broad categories of trainings.

### **Knowledge-based training**

Knowledge-based trainings – such as on contraceptive counselling skills or the clinical theory, for instance – are more easily and rapidly translated to remote contexts, being more theoretical and often more didactic (see Box 1). They lend themselves to situations where service gaps need to be filled rapidly, or where 'refresher' trainings are needed as identified by trainees' previous assessments. Training on discrete topics which are largely knowledge-based, such as contraceptive counselling, can be quickly mobilised remotely.

The UK's Faculty of Sexual and Reproductive Healthcare (FSRH) provides contraceptive 'essentials' courses, including a Contraceptive Counselling free online course in English, which takes two hours. Staff pre-identified as having requisite experience could benefit from these remote training resources to gain essential knowledge, to be expanded on by virtual sessions with trainers or 1-1 training in facilities.

#### **Box 1: Considerations for remote knowledge-based trainings**

Remote knowledge-based trainings can be broken into different components, with pre-reading and specified videos or animations to study in advance.

- Following self-directed study, lectures, overviews and demonstrations using Zoom, Skype and other video call platforms can enhance knowledge uptake through virtual face-to-face training.
- Class size should be restricted to fewer participants than would typically attend in person in order to control chat flow, allow for connectivity issues and delays, to organise breakout groups and respond to questions. Ideally a separate administrator supports the trainer to manage the call and note questions.

### **Competency/skills-based training and assessment**

Competency- and skills-based training, which typically rely on hands-on and face-to-face methodologies, present more practical challenges in the context of COVID-19. SRH training

has had to adapt to reduce the instances in which face-to-face contact takes place, as well as the number of people in a health training setting.

A preliminary adaptation has been developed in response to COVID-19 by Marie Stopes International (MSI). Given the restricted context, MSI have used competency assessment data and training records to prioritise providers with critical learning needs. This approach is also used by International Planned Parenthood Federation (IPPF) Pakistan. Once key staff with performance gaps requiring refresher training are pre-identified (and additional training for those with less acute training needs is postponed) and infection prevention and control (IPC) measures are in place, limited training can, in theory, take place.

Some adaptations to COVID-19-era training itself have already emerged among SRH programmers, as demonstrated in Box 2.

### Box 2: Case study of remote training adaptations: Rahnuma, Pakistan

Rahnuma, an IPPF member association, has found ways to continue training for SRH professionals on contraceptives, including hormonal implants, IUDs and self-injectable contraception (DMPA-SC) during COVID-19. Rahnuma's skills-based trainings employ a number of different approaches in line with what is feasible in different local contexts:

- 1) **In-person training** – The training cohort is scaled down from the typical 10 participants to five participants, in a large room with social distancing measures in place. Skills are observed by trainers, as trainees demonstrate, for example, implant insertions.
- 2) **Decentralised 'buddy' model** – Pre-COVID-19 trainings for medical professionals and quality assurance (QA) managers at each geographical cluster have created a pool of trainers who can now provide in-person training and mentoring to improve family planning (FP) and abortion care services. QA managers review cluster data to identify sites requiring additional support and visit them, observing IPC guidelines and using emergency medical supplies for infection control to ensure on-the-job training and mentoring to build providers' skills and confidence.
- 3) **Combination** – In-person master trainers (via phone or WhatsApp) availability is accompanied by established job aides (including existing animated videos, checklists and presentations, as well as Rahnuma's own tailored materials) for support and troubleshooting.

The concept of 'bubbles' is being explored in remote competency-based SRH training, where a small number of participants are paired with a trainer. However, paring down trainings to a lower trainer/trainee ratio requires more time and more clients available to practice on, necessitating higher training budgets. MSI are trialling an adaptation to competency assessments for long-acting and reversible contraceptives (LARCs) which may address these concerns (Box 3).

Supportive supervision, a form of performance improvement training typically involving supervisory visits with shadowing and/or close contact by mentoring staff have also been adapted by the PATH and Jon Snow, Inc. Subcutaneous DMPA (DPMA-SC) Access Collaborative programme and the Ministry of Health in Madagascar. Virtual supervision now takes place over the phone, as management teams simulate a mock self-injection visit with a client over a call with trainees. Trainees, following a document with steps and a basic script,

role play the procedure over the phone with their mentor. The Access Collaborative is now exploring the introduction of similar remote supervision approaches in other countries.

### **Box 3: Case study of remote competency assessment adaptations: Marie Stopes International, Malawi & Ghana**

MSI are trialling remote competency assessments for contraceptive methods\* in Malawi and Ghana. The remote competency assessment process currently involves the following steps:

- 1) The provider being assessed ensures consent from the client for audio or video stream or recordings, capturing the image of the anonymised client case record on camera which is then sent to the assessor. The provider ensures that the client's identity is not revealed throughout the process.
- 2) Start the video call or clip recording and go through the procedure. The assessor on the other end of the call marks each step (e.g. sounding the uterus, client interactions, measurements, insertion) as it is captured.
- 3) Hold follow-up conversation with the healthcare worker, sharing scores and overall rating with detail of steps requiring attention and further practice.

*\*Safeguards are in place for services requiring higher clinical competence such as IUD insertion, with restrictions on who is eligible for remote competency assessment. Only providers assessed as competent who have provided the service regularly since their last assessment are eligible.*

## **Limitations of remote training**

### **1. Barriers presented by COVID-19**

Despite adaptations, COVID-19 continues to affect the feasibility of trainings in terms of trainer availability and curfews restricting access to sites. Slowdowns in government approvals for training funds and reduced budgets have also affected trainings of public sector health workers. In any case, in-person/skills-based trainings not essential for service continuation should be postponed. Competency trainings should only go ahead where there is a critical need for SRH professionals to develop skills and where trainings can be adapted in line with what is feasible and safe in that particular context.

### **2. Assessing offline learning from a distance**

For programmes where donor reporting on training outcomes is required, assessing trainees' absorption of self-directed learning materials such as video clips is not always easily captured. IPPF have found that the accuracy of self-reporting is variable, with difficulties understanding what trainees have gained from the videos or how this could be improved. For trainings which rely heavily on trainees' interactions with offline resources, opportunities to discuss self-directed learning and identify gaps should be built in.

### **3. Replicating tactile elements of procedures**

Without advanced technology such as virtual reality, tactile gloves or other advanced resources, certain elements of SRH procedures cannot be replicated in remote training contexts where clients are not involved. Model arms for implant skills development may be used, but the sensations of depth and pressure which are critical for SRH professionals to gauge during IUD insertion procedures are impossible to capture over screens or in theoretical explanations. When assessing which trainings are critical and feasible to hold, the shortcomings of remote approaches in this regard should be taken into account.

## Suggestions for adapting SRH training to the COVID-19 context

This section highlights considerations programmers may wish to think about when adapting SRH trainings to the context of COVID-19.

### 1. How to protect health staff delivering services

[Guidelines](#) from the World Health Organisation (WHO) provide IPC advice for health workers involved in receiving, assessing and caring for patients who may be infected with COVID-19. More specific guidance has also been made available for SRH professionals by MSI. Training activities should be sensitive to the dynamics of COVID-19 outbreaks in communities, and where cases are rapidly increasing activities should be postponed. Once immediate and critical training needs have been identified, the implementation of appropriate IPC measures can enable adapted SRH trainings to continue.

Using emergency medical supplies for infection control and social distancing measures are critical to continuing adapted training, where in-person assessments are required. Different SRH procedures carry different levels of transmission risk – for example, fitting an IUD requires health workers to be further from the patient's face than they would be for, say, contraceptive implants. FSRH have highlighted the potential for riskier procedures which require more patient contact, for example contraceptive implant insertion, to be tweaked to minimise contact between patients and providers. This could include moving more than two metres away from a patient when waiting for a local anaesthetic to take effect, or not talking during the insertion, in order to reduce risk to the health provider and patient.

### 2. Integrate opportunities for engagement

Various stakeholders have identified the value of networks and fora to accompany training activities. For example, Facebook, WhatsApp and internet forums can provide spaces for trainees to ask questions post-training, provide feedback, tips and ideas, and receive peer support, which trainers can also access and input into. With remote trainings making it easier to bring together participants from different localities, these kinds of fora may present a valuable space to develop relationships and learn from one another. WhatsApp is a popular and accessible platform for many, but a deeper understanding of how it can be harnessed to support trainings has not yet been fully documented. Anecdotal evidence suggests these opportunities for engagement and follow-up questioning become more critical to support participants in the context of remote training, fostering continuity and cohesion where trainings would otherwise be in-person.

### 3. Be sensitive to connectivity

Adaptations to training approaches should take into account variable internet and phone connections and bandwidth. As COVID-19 began to affect contraceptive self-injection training for health professionals in Madagascar through PATH and John Snow, Inc.'s Subcutaneous DMPA (DMPA-SC) Access Collaborative programme, a simple technology survey was sent out to districts and facilities to build a picture of trainees' internet and smart phone capabilities, which helped to inform their training adaptations. In some localities, mobile data networks are more reliable than Wi-Fi networks, so trainings can be more reliably streamed using mobiles if data packages and credit are pre-arranged. Some offices, facilities or headquarters may have stronger internet connections, so training participants may want to consider where they could safely travel to ahead of the training, or go to in order to download course materials and save them offline. Additionally, for downloadable videos, the studio-quality of resources is likely to be less important to trainees than the quality, accessibility and relevance of the content.



## Resources for use in remote training

The following online resources and platforms can inform the development and design of remote knowledge-based training activities:

- 1) FSRH – [e-Learning for Sexual and Reproductive Healthcare](#)
- 2) FSRH – [Contraceptive Counselling Free Online Course](#)
- 3) NHS Health Education England – [e-Learning for Healthcare Platform](#)
- 4) DKT International – [WomenCare Academy](#)
- 5) Ipas – [Ipas University](#)

### Further information

#### About the WISH Programme

The WISH Programme is the UK's flagship and largest Sexual and Reproductive Health and Rights (SRHR) delivery programme, delivering up to 20% of the UK's overall commitment to improving global SRHR. WISH, implemented in two lots led by different consortia, operates in 27 countries in Asia and Africa and is expected to contribute to averting over 29,000 maternal deaths by December 2021.

The WISH4Results team, composed of staff from the e-Pact consortium – Itad and Oxford Policy Management – acts as the third-party monitor for the WISH programme, providing verification, evidence and learning for FCDO, WISH implementing partners and wider stakeholders.

#### About WISH COVID-19 Learning Briefs

COVID-19 is very likely to have severe impacts on access to sexual and reproductive health (SRH) services for all people but for women and girls especially. The WISH programme's implementing partners, WISH4Results and global health partners are collaborating to capture rapid adaptations to SRH service delivery in order to maintain vital access to rights-based, high-quality care.

This publication is one of a series of Learning Briefs produced by WISH4Results focusing on adaptations to SRH delivery driven by the COVID-19 pandemic. Content was compiled through a series of semi-structured interviews and follow-up emails with representatives from the organisations listed below. Drafting and editing was led by Pippa Page, with support from other members of the WISH4Results team. We are particularly grateful to members of the WISH COVID-19 Technical Working Group for their insights into the challenges of and need for remote training during COVID-19 and specifically to the following organisations who contributed information to this brief:

[Marie Stopes International \(MSI\)](#)

[International Planned Parenthood Federation \(IPPF\)](#)

[Faculty of Reproductive and Sexual Healthcare \(FSRH\)](#)

[MSD UK](#)

[DMPA-SC Access Collaborative \(JSI & PATH\)](#)

Please share your feedback and comments on the materials discussed in this brief, contribute related resources and discuss other adaptations to SRH remote training by emailing [WISH4results@itad.com](mailto:WISH4results@itad.com).

