MAKING CAPACITY BUILDING INNOVATIONS FOR HEALTH WORKERS STICK: LESSONS FROM COVID-19 VACCINE INTRODUCTION

Webinar Transcript

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Hi, everyone. Welcome. We're just going to wait another minute or so, and let people join. But for those of you who have joined us, please, we'd love to hear who you are. So please write your name and where you're joining us from in the Chat box. Thank you. We'll get started in just another minute.

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Hi, everyone. Thanks for joining us. We're going to start in just one more minute. We're going to let a few more people join, so please, as you join, let us know who you are and where you're joining us from. And we'll start just in one more minute.

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Okay. I think we're going to go ahead and get started. So hello, welcome, and we're so glad that you can join us today. My name is Lisa Oot, and I work as a Senior Technical Officer for the MOMENTUM Routing Immunization Transformation and Equity project. And I'm very pleased to introduce today's webinar, which is, "Can we make for health worker capacity building stick? Lessons from COVID-19 vaccine introduction." I will be presenting today's session with my esteemed colleague, Denise Traicoff, who has served as a Lead Consultant for this work. I will be facilitating the first half of today's session, and then I will hand over to Denise, who will do the second part. Both Denise and I will be reviewing and responding to questions in the Q and A box, and also at the end of the presentation.

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I'd also just like to spend a quick moment to describe the work that we're doing on MOMENTUM Routine Immunization Transformation and Equity more broadly. We are a USAID-funded project that works towards a world in which all people eligible for immunization, and particularly underserved, marginalized and vulnerable populations, are regularly reached with high-quality vaccination services to protect their children and themselves against vaccine-preventable diseases. So before we begin, I'll just do some quick housekeeping to make sure everyone understands the Zoom environment for today's webinar. So we are offering simultaneous translation services in French for this webinar. You can access the French speaking channel by clicking on the Interpretation icon on the bottom of the Zoom screen to choose your language. You can listen to today's webinar in either English or French, so do that now if you'd like to hear it in French. Please make sure to use the Q and A button located at the bottom bar of your Zoom window to ask questions during the presentation, or for any technical help you may need. You may use the Chat

feature to introduce yourself, and thank you to those who have, and also to share thoughts during the presentation. But do not use the Chat to ask questions. The questions, you will be asking using the Q and A button, and they're only visible to you, our presenters, and technical support. If you are having technical difficulties, our technical support team will respond to your questions privately. We will collect your questions for our speakers, and will save them for a discussion period. Also, please note that this webinar is being recorded, and following today's event, you will receive an email with a link for the recording. Also, if there are questions that we don't get to answer today, we will forward them to the presenters, and share responses by email to all participants who registered.

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Okay, we're ready to begin. As the world worked rapidly to introduce in scale COVID-19 vaccination, we saw an abundance of resourcing for rapid capacity building, which presented an opportunity to explore capacity building innovation and potential application for routine immunization. This led to a desire to understand across our projects what innovations were being implemented to introduce COVID-19 vaccination, and if and how they could be applied for routine immunization and life course vaccination. Today we will share with you what we learned about how health worker capacity building innovations were implemented, and how we think they can be reflected and used to strengthen capacity building for routine immunization. We also want to use this opportunity to hear from you all, and to learn from your experiences, and the innovations that you have used as well.

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We have two objectives for today's presentation. The first is to share findings from the landscape analysis which was conducted in 2022 on emerging practices for capacity building associated with COVID-19 vaccine introduction. The second objective is to brainstorm obstacles around sustaining effective innovations for health worker capacity building in immunization. I will spend the next few minutes providing a brief background on this work, and I will walk us through Phases 1 and 2 of the analysis. As I mentioned in the beginning, I'm then going to turn the presentation over to my colleague, Denise, who will present on Phase 3 of the project and take us through the recommendation sections. We have interspersed different polls and activities into this presentation as, again, we want to hear from you all, so please, please, do make sure that you have comments and questions, and put them into the Q and A box.

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So with this activity, we have two main research questions. First, how has health worker capacity building for COVID-19 immunization been delivered in selected countries since the beginning of the pandemic, and what factors have influenced its implementation? And then two, what factors affect the potential applicability of these new or modified methods for routine immunization over the longer term? For this activity, we were interested in gathering information both on formal training and also non-training interventions. I'll also say that we recognize that other process improvements, such as automations of microplanning, improved worker performance are also important, but we focused our research on a stricter definition of capacity building, one that is focused specifically on health worker learning, and not on processes that may have improved performance. I'll also note that our research questions do not address if training or capacity building innovations actually led to improvement in skills or outcomes, as this was beyond the scope of this specific analysis. And you'll see that we've noted this as a limitation.

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I'll now provide a brief overview of the analysis timeline, and then we'll dive further into each phase in the subsequent slides. The research was conducted in three phases; first an online survey with program staff, which was followed by key informant interviews with six of our online survey respondents. We then used this information from

Phase 1 and 2 to design a survey that was sent out globally. So I'm now going to dive into, yes, the methods for Phase 1 and Phase 2. So prior to the start of our work, we coordinated with the World Health Organization and other partners to understand what information and research had already been completed, and how this work could be complementary and improve understanding around health worker capacity building. We developed the online questionnaire, using questions from a strategic framework we had developed. We asked questions regarding training and non-training interventions, including questions about new methods that were used. Although we use the term "innovation" throughout this presentation, I will note that in the survey, we did try to avoid the use of the term "innovation," because we felt that it could cause some confusion, as we recognize that innovations aren't necessarily new to capacity building. Some innovations may be used already in several countries, and others may be new to a particular audience or a country, so we just wanted to be mindful of that. For the online survey, we used Google Forms, and this was done in both English and French. We pilot-tested each of these, and then they were sent to our project country teams, those who had supported COVID-19 vax introduction, and-or the rollout. The surveys went out between May and June of 2022, and country programs where staff did not support the rollout were not included in this original survey. We received 10 responses from our country programs, which we recognize is not a huge number, but it was enough to be able to see trends, and then to identify questions which needed to be improved as we redesigned the questionnaire for the global survey. To supplement the online survey, we also conducted key informant interviews with our in-country program staff, and this is from six countries that are highlighted on the right. We did one KII per country, except in India, we did two, and these were conducted from June to August in 2022, and they really allowed us to have an opportunity to dive deeper into questions and add additional information on questions that were kind of superficial or answered only partially through the online survey. Again, we used these to then design the global survey, which was sent out to the global community.

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All right, so diving into the learning from these six country programs: We learned of several training innovations in Phase 1. We heard from our six countries about the use of the ECHOplatform. We heard about the use of live virtual sessions, videos and also distance learning for service providers. So we learned of a really what we found as an innovative idea about training by peers in the share, which consisted of teams traveling regionally to visit health centers and provide training. And to us, this is notable, as it was a variation on the standard training of trainers, or TOTs, as we heard how the strategy really empowers lower levels of the health system, and allows both for local context and peer networking through this strategy. We also learned about non-training interventions and innovations. We heard about the use of group chat via social media. We heard about supervision and coaching; this included remote supervision. And we heard about the introduction of a national helpline, and also the frequent use of job aids. To highlight, in Kenya, training was conducted via one-hour weekly sessions that participants attended with their supervisors. Training was supplemented by virtual and in-person supervision. It was a two-way experience, and supervisors received real-time updates about field activities. We love this example, as it demonstrates the relationship between training and non-training interventions for capacity building, providing continuity among several practices, and recognizing that connection between training experience and post-training application.

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So what did we find? How well did these innovations in capacity building work in the countries
in which we surveyed? So we learned that distance-based training methods were generally more successful at national and provincial levels than they were at lower levels. We also learned that for most, COVID-19 vaccine introduction and rollout was the first opportunity to explore learning, online learning, as a national initiative. When we asked about the reach of trainings that were implemented, most countries reported that almost all workers who

needed training were reached. We also found that evaluation methods were mostly focused on participant satisfaction, rather than knowledge or behavior change. And we found that supervision observation of task performance was described as the most accurate evaluation method, and provided opportunity for just-in-time learning. Non-training interventions were deemed to be more successful than training interventions. For example, India introduced a COVID national – a COVID-19 helpline for health workers which has been scaled and sustained. So we recognized how important contextual factors are, and to contributing to the success, and really the sustainability also of new interventions. So in looking at the analysis, we found that contextual factors fell around three main categories; the first category was learning and work environment. And we found that in addition to the availability of technology, learning and work environment were extremely important; specifically, having clear expectations of work responsibilities. This reinforces what is seen in the literature, and it's known to have one of the greatest impacts on health worker performance. The second area is the managerial support. A good example that we saw was from Niger, where the Ministry sent a letter stressing the importance of the COVID vaccine introduction, and encouraged workers to be trained. This ensured that all of the regions heard a consistent message on its importance, and we felt this could be a really great motivator for people. Lastly, we also learned through these sessions how critical available resources are. This also included partnering with other areas of the health system, moving away from vertical planning, which is a great strategy when testing new methods.

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We are now going to pause and ask about, one, to remind you all to put your Q and A in the Q and A box, and to see if there's any questions that we want to answer right now before we move on to the presentation. Okay, it doesn't seem like we have any burning questions right now, so please, as we're going through, add your questions, and we'll be looking to respond to those in the next few minutes. Okay, we did have one question, sorry, let me answer this live. Thank you, guys. We received a question that asked, can you provide more detail about the non-training aspects? So we defined non-training as anything, any capacity building activities that really fell outside of formal training, so supportive supervision, coaching methods. We saw that people were doing this both virtually, and the example from Kenya where there were joint – that there was initial training, and then this was followed by non-training intervention. So follow-up coaching and mentoring – those types of interventions. So what we were defining is non-training interventions. And then one more quick question asked from Luke – how was the interview distribution done that resulted in 10 responses from 10 countries? So the project has a number. We support country programs and selected only the 10 countries where COVID, where our staff had been supporting COVID vaccine introduction or rollout. And then from those country responses, we asked our staff if they would be willing to do follow-up interviews, and we had six people who we were able to interview and follow up with. Okay, I'm going to keep going. So please do keep adding questions into the Chat.

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But now, I hope everyone's ready – we have a poll question for you all. So please take a few seconds, 30 seconds, to think about what factors do you think best contribute to successful outcomes? So on this list, select the top three factors that you think would lead to successful innovation. So I'll read them out: Dependable technology, financial support for supervisors, managerial support, motivated workforce, quality supervisors, capable training, resources, such as training materials and job aids, and technical equipment. So your three top factors that would lead to successful innovations. We'll give another 15 seconds, and then we'll ask if Sakina can flash the poll results. Okay, so we had a good range of mix that I'm seeing, a few coming out quite prominently. So quality supervisors was first, a motivated workforce second, and then resources – so training materials and job aids, as well, with those three were the top three that you felt would really contribute to innovations. Okay, great. And we can see that there actually was

quite a bit of recognition of really, possibly needing many of these, all of these, to be able to do that well. All right, thank you. So I'm now going to pass the microphone over to my colleague, Denise, who is going to go through the rest of the presentation. So over to you, Denise.

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Thank you, Lisa. So hello, everybody. I will, for my part related to Phase 3, I will briefly review our methods for Phase 3, and then I will share the results and discuss the implications off our findings. So please continue to ask questions in the Q and A. So for our methods, we fine-tuned questions based on our findings from the earlier phases that Lisa just described. We also reviewed the reports related to capacity building from WHO in Jhpiego, and we again used Google Forms for French and English versions of a survey. We pilot-tested in both languages, and disseminated the survey link via email and websites that are popular among immunization practitioners. We had a two-week window for the survey to collect responses, from October 18th to the 31st, but we actually kept it open until November 7th, and we sent multiple reminders. To encourage participation, we offered a raffle for participating, so there was a drawing where a respondent would win a free one-hour consultation with a capacity building expert. And someone in Ethiopia was the one who won that drawing. Okay, so let me go through a little bit -- okay, now I'll go through the profile of the respondents. We analyzed the data with Google Forms and Excel pivot tables. We did qualitative analysis using keyword coding that was done by two team members. We had 100 respondents, which was sort of convenient; 71 English language, and 29 French language respondents. There were 31 females and 69 males, and you can see the breakdown by language in the graph on the right. Of the education level, the most frequently recorded was 59, who reported having a master's degree. And the median experience in immunization was 6 to 10 years. Eighty respondents reported being supervisors, and the provincial level was the most highly represented among the administrative levels that went from local to global. So related to the location of our respondents, the respondents represented 35 countries. Nigeria had the greatest number of English language responses, and the Democratic Republic of Congo had the greatest number of French language responses. And notice the geographic representation, we had no responses from the Western Hemisphere, for example, so that is one of our limitations. So those of you who develop training know that before you design a training, you should do a training needs assessment.

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For COVID-19 vaccine introduction, the training needs assessment was basically done at the global level by WHO and others who monitor the development of various antigens, and identified the impact on current practices. This is important to understand the training need, because it can determine what delivery method is the most effective. So one of the questions that we asked was to the respondents, asking them their own expectations of what they thought they would need to learn about the COVID-19 vaccine. The choices that we provided parallel the major training categories of knowledge, skill and attitude, and respondents could check as many as applied. Eighty-two percent expected to need information, such as guidelines and protocols. This is notable, as it implies that guidelines, job aids, videos or lectures with Q and A could be appropriate training delivery methods. The second highest expected training need, 60 percent, was that the respondent knew of colleagues or community members who had concerns about COVID-19 disease or the vaccine, and I wanted to be able to converse with them in a constructive way. This is also a knowledge need, but it also could require skill building. So I want to say our N was small, of 100, but still, we noticed no notable differences between French and English responses, so our findings combine both surveys. So we then asked the respondents, what methods they used for learning about the COVID-19 vaccine, and they could check as many as applied. You'll see that 77 percent said that virtual, using live webinars with participant interaction was one of the methods that they used for learning about COVID-19 vaccine. Sixty-one percent had live webinars in lecture form. And then notice that one third had some type of in-person training. So we asked if any of the methods that

were a new way for them to learn, and 69 percent said yes. If they said yes, they were asked to provide a brief description about what was new, and you'll see there a couple of the descriptions that we received. So this is a Word Cloud summary of the keyword analysis of their responses. Virtual was the greatest keyword that we identified. Fifty-eight percent of the people who said that they learned something knew stated that it had something to do with virtual learning. But do notice that virtual, actually that could mean anything, and some people answered webinars, which is a type of virtual learning, so there is probably some overlap there. We also asked about responsibility for training others. If they said yes, which 74 percent did, 74 percent said they were responsible for training others, we asked them was there any new method related to how they taught, and their perception of its success. We hoped that those respondents would share additional perspectives. So just over 80 percent reported being involved in a TOT, either as a learner or as a trainer. So you'll see that cascade training continues to be popular, even amidst the COVID-19 pandemic limitations. For the trainers, the most common innovation related to training that they reported was that they trained some levels virtually and some in person, and similar to what Lisa said earlier, mostly it was that they would train the higher levels, national or provincial virtually, and then lower levels in person.

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So the survey continued with similar questions related to non-training interventions, which we provided the definition of that Lisa described a minute ago – that would be supportive supervision, job aids or guidelines, and coaching or mentoring. So here is a summary of capacity building innovations, what was new. They are grouped by training, non-training and monitoring and evaluation methods. And then they're just listed in alphabetical order. For training, blended delivery methods could be a variety of distance-based methods, such as webinars and videos, or blending distance-based method with in-person training, or both. For non-training innovations, over half reported some type of new method, and most noted were innovations related to supportive supervision, which was noted by 47 percent of the innovators.

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So for this slide, allow me to direct your attention to the table on the left side of the slide. The gray and white bars, or rows, are the results related to satisfaction with training. So note our N is 100 – these are all the people which responded, not just those that said something was new. So these questions – so 57 percent reported that they would happily use the method again, of all the methods that they used to learn about COVID, 57 percent said they would happily use that method again. A sizeable minority, 38 percent, reported that some methods worked well, and they may consider continuing the approach. And there were several other choices on the scale,
but these were the two answers that we used as the definition of a successful training when we were interpreting the data. Now the blue and green bars are related to satisfaction with on-the-job support. So respondents also appear satisfied with their ability to obtain help when needed, with 57 percent reporting that that's the case. The graph on the right is the self-reported confidence to do their job after they were trained. And you see at 70 percent, at every administrative level, 70 percent reported feeling fully confident to do their work. Analyzing the self-reported confidence with the perceived training needs indicates that most respondents felt capable of doing their job, and needed only information guidelines, either to inform their work or to advise others. And remember that the median experience in immunization was 6 to 10 years, so this could be really a realistic situation on the ground. If someone reported a new method of training or non-training capacity building, we asked them if the method had been sustained. For the non-training innovations, we learned of 17 successful innovations, meaning that they exceeded or mostly met expectations. Of those 17 successful innovations, five reported that all new approaches have been incorporated into standard operating procedures. So here are the five successful innovations that were sustained, which occurred in four countries; Bangladesh, Burkina Faso, Kenya and Zambia. So any of you on this webinar from

those countries, you can give yourself a round of applause. For those who reported successful training or non-training interventions, we want you to know their perspective on the reasons for success. We fine-tuned the way we asked this question after Phase 1 and 2, and in Phase 3, we were better able to rank the five contextual factors for success. And you can think about what I'm describing here, compared to your answers of the poll that Lisa just provided to you that you responded to.

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So for both training and non-training interventions, design and planning of the intervention ranked as the highest success factor, but note that that is quite a broad category, and there's so much that that could mean. It is interesting that resources and donor support weren't on the top of the list, and I noticed that resources was one of the top three in the poll that Lisa just administered. We don't know whether, you know, is it possible that the COVID-19 initiative had so much funding that there were no resource – the resource limitations weren't as much of a concern. Plus, if that's the case, that would be a risk for routine immunization if you're trying to adapt what happened for COVID-19 into RI. Or maybe another reason could be that the respondents found workaround to any of the resource limitations. So that's something to think about when we consider recommendations for a way forward, and how to prioritize resources. So we're now going to take another quick pause to remind you to put your questions in the Q and A box, and I'll be glad to answer any questions that might have come up.

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We have one for you in the Q and A, Denise.

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Okay. Okay, so I see it. Did the study explore which delivery methods respondents found most effective in supporting their learning needs? So the way that we worded the – because the respondent could check all the methods that they used to learn about COVID, so it was a checklist that they could check, and then we asked them were they happy with the methods, we weren't able to disentangle which method worked better for each respondent. We just asked in general, as I said, we asked what were all the ways you learned about COVID-19 vaccine, and how happy were you with the way that you learned? Thanks for the question.

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Okay, any other questions? Sorry, anything else? Okay. All right, so if there are not any more questions, I think I'll go on to the limitations. Okay, I'll just spend a moment to point out some of the limitations, you've already heard one or two. And I want to especially note the survey design and the dissemination really introduced a selection bias toward those who had internet access and comfort using technology. There was a low response from front-line health workers at the local level, and those two issues could be connected, since we had heard multiple times of the less reliable access to technology at the local level. And another limitation I'd like to point out is that the innovation descriptions were brief. There's really not enough information to even begin to replicate what worked in Burkina Faso, for example.

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So we'll now move on to the discussion portion of the analysis. Of course we're interested in implications for the future. And as you all know, distance-based capacity building has been around for over 30 years, so there is quite a bit of literature about what works. I'll focus on what we heard from our own data collection, and we really must remember that there is no magic bullet for every performance problem. In-person training will remain to be of great

value. It should be used wisely for problem solving and peer learning, and socialization. But it is also the most expensive, and require staff to leave their workplace. Distance-based solutions specifically related to training have many advantages. It saves time for the staff and the supervisors. It can be quickly updated as needs change. It reduces time away from work, and enables learning on-the-job. And it fosters local learning and sharing, and enables supervisors to communicate more frequently with their staff. There are also challenges with distance-based solutions; there's resistance among participants, decision makers and funders, and they each have their own reasons. And frequently, the human resources policies in the work environment might not support distance-based; for example, allocating time to learn, or providing resources for learning tools. And we have all heard the risk that people like to go to training because they get a per diem, so that is something that would need to be overcome. Technology-based solutions might have inconsistent acceptability, and it's often difficult to gauge participant interest engagement and competency. But let me point out that that's also a risk with in-person training. Conversion to distance also requires scales that are rarely present in technical programs. So we want to go – our bottom-line message, really, our analysis really underscores that fostering effective innovations requires resources, technical assistance and human resources policies that support new approaches. And in particular, I really want to stress addressing HR policies that constrain the performance; delays in pay, per diems that award attendance rather than achievement, lack of career advancement – these types of policies really are obstacles to innovations in capacity building.

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So now it's time for a quiz. You should see a poll pop up on your screen. So just imagine you're in this scenario, and choose the correct answer. Realistically, what would you do? If your organization is introducing the HPV vaccine, and your supervisor asks you to start planning a cascade training, so what's the first thing you would do? Would you set the dates for the training to ensure that stakeholders, instructors and participants are available? Would you determine the knowledge and skills that are needed for different types of personnel? Would you request a meeting with your supervisor to discuss additional strategies for staff training? Or would you talk to colleagues about taking a different approach? So what's the first thing you would do? You've got one minute to answer. Okay. So 91 percent of you said that you're going to be doing a training needs assessment, and nobody is just going to just go ahead and set the dates for the training, so that's really interesting.

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So let's see what the correct answer is. The correct answer is, whatever you chose. And I say that because we all live in the real world and we must do the best we can within our own context. So any of one of the choices could actually realistically be what you do first. And I'm thrilled that people will try and do a training needs assessment first. So let's go through each of those answers and see how it could work to even introduce some type of innovation. If you did have to just go with what your supervisor said and schedule another cascade training, you could go ahead and get that started. But then if the content is appropriate, develop one or two ideas for introducing distance learning and advocating trying something new on a small scale. If the very first thing that you do is determine the knowledge and skills needed, that's great, because if there are needs that are mostly information sharing, or things that could benefit from follow-up support, those are both examples that hold great potential for alternatives to face-to-face training, so you could maybe supplement the cascade with job aids or some type of pre-course work. If you decide to request a meeting with your supervisor before you just jump ahead with the cascade training to discuss additional strategies, that's another great way to get started. You just come prepared with some ideas for how to start small with solutions to the expected obstacles that they might raise. And if the first thing that you do is hang up the phone and talk to your colleagues and say, "Can you believe we're going to do another cascade training? What are some different

approaches?" Have those conversations, and then schedule a meeting with your supervisor to share the most feasible ideas from your discussions.

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So I will now share our recommendations, and I would invite you to post your own recommendations in the Chat. We will be sharing the Chat after the webinar, so it's a great chance for us all to share ideas. Maybe the quiz that you just had prompted some ideas for yourselves. So we learned so very much, and many of the findings are backed up in the literature. So here are some key recommendations to foster innovation, and to make it stick, which was the title of our presentation. For all capacity building, if at all possible, conduct a needs assessment. You could also use a multi-faceted approach to capacity building, and I mentioned something that Lisa mentioned with the Kenya example, is to work on blurring the line between formal training and then non-training on-the-job support. So think of those in two parts of the same, of a whole. Find a champion -- I have found this really useful myself when I was trying to introduce innovation. If there is a decision maker who agrees with you and is open to new ideas, get them involved in your ideas, and have them help you advocate with the other decision makers. You can conserve resources by innovating small, using what you have available and then scaling up. Specifically for training, make sure you're designing based on the learning goals and the learner context and their environment, so see what you can do that's practical that will help achieve the learning goal, which you will have learned through your training needs assessment. Look for alternatives to traditional cascade training. The example that Lisa shared in Niger where it was actually teams that shared with each other in the local area within that district, is a great way to have an alternative to a traditional cascade. And remember that in-person training will remain of great value, as I mentioned earlier, using it wisely for workshops, case studies and problem solving to get the most benefit of it. For non-training interventions, consider a blend of distance-based and on-site supportive supervisor, and empower local staff to analyze and address performance problems. This could include teaching local staff how to use a couple of tools, like a cause and effect diagram or a flow chart to analyze their own performance problems, and develop solutions. Observing workers and providing feedback is a powerful form of capacity building. Now I'll turn it back over to Lisa to close us out.

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Great, thank you. So I did want to just pause and see if there's any last questions or any recommendations that anyone has, before we move into the evaluation part. Happy to take any further questions or hear your recommendations and hear from your experience. And as you're thinking, I'll just say, again, thank you so much for your time and participation today. On behalf of the team, I really want to thank the MOMENTUM Routine Immunization Transformation and Equity country staff who really supported each phase of this analysis, and really to the hundred busy immunization professionals who responded to our survey. Please use this QR code to complete an evaluation. And on our next page we'll have a link to the evaluation, and also to our program report. And so we encourage everyone to read through this and use it as a resource as you're moving forward with the design of your own capacity building interventions. So just wanted to say, it looks like we don't have additional questions or comments in the Chat right now, but again, so just to say a huge thank you to everyone. We really appreciate your time today, and we will be sending out responses to the questions and answers in the chat over the next few days, and then we will also be sharing again our report, so that everyone has easy access to it.

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Okay. Oh, it looks like there was a question. How many African countries were involved in interview according to the – so of the key informant interviews, we did just six, so I believe it was four. Was it specific to the key informant interviews, or number of Africans out of the 100 who responded to the survey? We can go back to that distribution

map if that's helpful. Sakina? We did have a very good response from participants, yes, based in Africa, and a good mix of participants really throughout the continent. Less so in Southern Africa, but a good mix also of Francophone and Anglophone countries. And you'll notice that the map is color-coded by the number of respondents, so that can give you an idea of how many responded from each African country.

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Okay, well, I think we'll go ahead and end. It doesn't look like there are other questions. Again, we appreciate you joining us today. Please do fill out the evaluation, we'd love to hear from you. Again, sharing the report and welcome your feedback on the report as well. So thank you very much, everyone. We do appreciate you taking the time for us today.