LEARNING UNCUT EPISODE 41:
TAKING LEARING GLOBAL: NIKITAH HABRAKEN AND JANE EARLE

Karen Moloney: Welcome to another episode of Learning Uncut. I'm Karen Moloney.

Michelle Ockers: And I'm Michelle Ockers.

Karen Moloney: And today we're talking to Nikitah Habrakenn from ASHM, and Jane Earle from The ID Crowd. Welcome both of you.

Jane Earle: Thank you.

Nikitah Habraken: Thank you.

Karen Moloney: So ASHM is the Australasian Society for HIV, Viral Hepatitis, and Sexual Health Medicine, and Nikitah and Jane are going to be sharing a story of translation and localization for their learning solution, which at the time of recording has been published in 14 languages across 10 different countries. So Michelle, would you like to get us started?

Michelle Ockers: Yes, thanks a lot. Nikitah, can you give us some background about ASHM, and what the organization does?

Nikitah Habraken: Sure. So ASHM has been around since about 1990, it's our 30th anniversary next week in fact. And we primarily came about as part of the HIV response in Australia. But then as time went on, moved into viral hepatitis and sexual health as well. And we primarily run medical education. So we develop and deliver medical education for the health workforce, on blood borne viruses and sexual health. And we also work in the policy and advocacy space, and also run medical conferences.

Michelle Ockers: Okay, thank you. And we're going to be talking about a new medication for hepatitis C that was introduced in 2016 today, and the education program that you wanted to talk around that. It was a game changer for the treatment of the disease. So to give us some context, how did this new medication change treatment?

Nikitah Habraken: Yeah, so these new, I guess you could call them revolutionary drugs, came out, that treat hepatitis C. And I guess what was different about them was that they have a 95% cure rate. So basically everyone is cured. The treatment is really easy, it's only eight or 12 weeks that people need to take it for, and there's virtually no side effects. And this was really different to the old medications. So prior to this, if you had hepatitis C and you underwent treatment, the treatment was really long, the side effects were horrible and the cure rate was much lower. So I guess what we saw was an opportunity to be able to treat more people. And for it to be easier for people.

Michelle Ockers: Yeah, so a radical change, all for the better. But obviously lots of people needed to be made aware of this shift. Who needed to be educated, and what were the key messages you wanted to get out to these groups?

Nikitah Habraken: Yeah, so before these new medications came out, hepatitis C was mostly treated in specialist settings, so in a tertiary hospital. And then because these new treatments were much easier, the side effect profile was way less, there came an opportunity to be able to expand hepatitis C treatment out of tertiary care and into the community setting. So into primary care, into drug and alcohol clinics. Really making it easier for the patient to access treatment. But I guess the gap that we saw was that the clinicians that are working in these services traditionally haven't had experience with hepatitis C treatment before. So we saw a need to really upskill this workforce.

Michelle Ockers: So it was predominantly the clinician workforce who were the audience for this program?

Nikitah Habraken: Yeah, so that's ASHM's main focus is clinical workforce education. For hepatitis C, I think everyone's trying to get more and more people involved. So it's not just the clinical workforce, but yes, that was definitely the focus for this. Particularly doctors working in addiction medicine settings, or other primary care providers that were working with patients who inject drugs.

Michelle Ockers: Okay. And what was some of the key messages or the key things you needed them to understand and to be doing differently?

Nikitah Habraken: We needed people to understand who to test, so who might be at risk. We needed them to understand what they needed to do to put someone on treatment, so the tests that they needed to order. We needed to teach them that hepatitis C treatment is now easy, it's accessible, that they should be treating everyone regardless of their background.

Michelle Ockers: And to roll out, or to develop and roll out the program, you collaborated with some other organizations. Can you introduce us to who the partners were on this project and what the different partners brought to the collaboration?

Nikitah Habraken: Originally we developed the program for Australia, but we always had the idea that we might take the program to other settings. So to other countries. So initially the partners were ASHM and the Kirby Institute at the University of New South Wales in Sydney. And then with the international adaptation we partnered with INHSU, who are the International Network on Hepatitis in Substance Users. And I guess those three organizations brought a really nice mix. So ASHM had the clinical expertise and experience in developing and delivering medical education. The Kirby Institute had the research background, so they brought a wealth of knowledge, both in terms of content, but also in terms of the monitoring and evaluation side of things. And then INHSU has this incredible international reach and networks, so really leveraging off that there.

Michelle Ockers: So Jane, I would like to ask you a question. You work for The ID Crowd, and ASHM engaged The ID Crowd in the first instance to help develop a solution. When they came to you and asked you to work on this project, what was it they asked you for? What sort of brief did they give you?

Jane Earle: Yeah, Emma Day from ASHM came to us and she just had a great big body of content from an existing course. And as Nikitah said, the way things were treated in the past was quite different to the new model of treatment. So she had a great big slide deck and she said to us, "The world's changed. We need another training course. We need this updated, but this is all wrong." So we didn't have a clear sense of what the solution would be, we knew it had to be online learning because they had a blended program that they wanted to keep on with, and that's a face-to-face piece that follows an online program. But it was really up to us to come up with whatever the solution was that worked for them, and to work with the changing landscape of the content they had.

Karen Moloney: Just thinking about the audience that you were designing for, so we've already mentioned that they were the clinical workforce Thinking about from your design standpoint, there were a number of challenges there, weren't there, around the audience in terms of this was not being delivered within an organization. So can you just talk to me a little bit about the audience and the sort of things you have to think about when designing for them?

Jane Earle: Yeah, that's right. It's a really broad audience because as Nikitah said, it's health workers in the drug and alcohol space. So often that's doctors, but there could be other specialists and other clinicians in that space. They come to the course voluntarily. It's available freely for them on the ASHM website, so they can take it at any time. And different levels of education in that group, so people have different levels of familiarity.

Jane Earle: As Nikitah said, once upon a time this sort of treatment was only available to patients through doctors with specialist skills, and now it was being made open to everybody. So a real variation in the base knowledge that we could predict from the audience, and just the reasons they would come to the course. So pretty interesting.

Karen Moloney: Very interesting.

Karen Moloney: I think before we dive into some of the other details about this it's probably good to get an idea of what the program itself looked like. So if I'm a clinical professional that's coming into this online learning, what does that program look like for me?

Jane Earle: Yeah, so when a professional comes in and the learner comes in, they see a 60 minute online learning module, that they take from the ASHM LMS. And after that there's a one day face-to-face course that they do, and that's offered in all the different variations. The 60 minute module is a fairly intensive one, it's a bit

of a different approach because rather than sort of a telling, in medical education there's often a lot of telling and lots for them to read.

Karen Moloney: I can imagine. Lots of content to get across, right?

Jane Earle: Lots of content. And so we sort of flipped this on their head and knowing that our learners were good readers, we actually took a case study based approach all the way through this module. So we put a lot of the teaching materials into supporting documents or into feedback. So rather than sort of making them read, click next, read, click next, and then do an activity, the whole thing is activities. So they go out and they read the teaching information effectively in supporting PDFs, which we wrote these from scratch, but then we also had a lot of other resources that we've used to support the learning. So it might be a summary of intro to hepatitis C, or it could be something like a decision making tool. And then we also put a lot of information in teaching and feedback.

Jane Earle: That gave the learners and opportunity to just try it first. So if they're confident about their own ability and their knowledge, they can sort of dive in. And hopefully they make mistakes, and people learn a lot from making mistakes.

Karen Moloney: They do.

Jane Earle: If they choose not to do their research, that's fine. It either validates what they know or it helps them learn from their own self confidence. Yeah. And then the feedback is there to the questions that either reinforces or corrects.

Karen Moloney: Because the thing about their experience, I mean some of those people will have been working with hep-C and already giving out prescribed medications. Is that right, Nikitah? And then there are some people that because of the nature of the medication, this would have been their first kind of brush with that subject matter.

Nikitah Habraken: Yeah, exactly.

Karen Moloney: Okay.

Jane Earle: And we needed to respect that knowledge, that the ones who already had it brought with them. But there's basic biology and so on that they need to understand about how the disease actually works, as well as understanding how to apply the new medications. So it's very much an application based course, it's applied learning at every stage.

Karen Moloney: Yeah, very big challenge. Very big wide audience. But in terms of the creation of the program, I might ask this to both of you. There are lots of moving parts to this program, and also lots of people involved. So Jane, from your side, what sort of people did you have involved in the development of the program?

Jane Earle: Yeah, it is a huge project management challenge. So we have a project manager on our side, who's helped coordinate, particularly the localization of all the different variants of this course. And then we've got our ID Crowd team. So we've got our instructional designers, our visual designers, developers and QA. And we've also worked with a voiceover partner to help source voiceover... There's an animation in there, so that had to be localized every time we changed the language. We needed new audio partners for each different language group.

Karen Moloney: Okay. So I'd imagine from your side, so we've got our Australian version in English, but then when you are creating versions for the different countries, it's not just about the text and the narration. What other considerations were there in terms of that localization?

Jane Earle: Yeah, there's a lot of work to be done to make sure that the medical approach is the same in each country as well, and that's where the ASHM team really took over. And they coordinated translation and the medical review of the course in each language.

Karen Moloney: Okay. So Nikitah, There are cultural implications as well, sometimes in different countries about what you can and can't talk about, and how you present the information. So who did you involve in that and how did you find those people?

Nikitah Habraken: I think something that was important for us from the get go was that these weren't just straight translation pieces, that we really did adapt to the content so that it was suitable for the audience in that country. The way that we did that was we engaged a group of maybe eight to 10 multi-disciplinary experts in the field of hepatitis C. So that's ranging from specialist doctors who have a really strong clinical skills, to researchers, to the target audience. So having general practitioners and addiction doctors involved, but then also having the affected community involved from the beginning as well. So the people that these doctors would potentially be treating.

Karen Moloney: So you're looking at not just the content you're wanting to push on who you're educating, but also the people that are going to be receiving that treatment, and those interactions from those people on the other end?

Nikitah Habraken: Yeah.

Karen Moloney: Okay. So I know, Nikitah, one of the biggest challenges on this project, and I know there were many, we won't go through. But the solution that you educating people on was still quite new at the time. So what impact did this have on the solution you were developing, and how did you deal with that?

Nikitah Habraken: Something that was sort of ever changing and something that was different across all of the countries that we were working in were the guidelines. So the treatment guidelines and the treatments themselves. So the medications themselves were sort of in the beginning ever evolving. So we had to adapt to

that. So for example, the doctors who are able to prescribe in one country might not have been able to prescribe in another country, or the people who are able to be to access treatment in one country might've been different to another country. And then that was also changing very quickly. So as new drugs would come on board, so new companies would bring on new versions of the different therapies, that would change. And so the options that were available to treat patients in the various countries would change. And so we then needed to update our content to reflect that.

Karen Moloney: So the partnership between ASHM and ID Crowd would have been completely integral to the way that this project all rolled out.

Jane Earle: Yeah, it definitely was. It was as Nikitah said, there were just so many changes that managing multiple rounds of review and maintenance in the early stages was really tricky. And we were able to work together and come up with a bit of a process. So there's a fair bit that ASHM does on their side to get things working, and then it comes across to us. And we've got a fairly clockwork like process now, to make sure that when we get changes we know that it's all well-reviewed, and you've got translators who have been through it and so on. So it's working pretty nicely now.

Karen Moloney: Because I know that one of the changes that you made was around the storyboards in the early stages.

Jane Earle: So the storyboards we found, I think particularly this is one that you've had to handle, Nikitah with the storyboards, but we've had to have a really consistent template because we've got the content changing for the localization, and then we've got our developers needing to implement changes in a language that they don't read. And then we need to do QAs and so on. So Nikitah has a really good process on their side that they use to involve the translators and the subject matter experts.

Nikitah Habraken: What we were finding was when we were sending our clinical expert steering committee these big long story boards, which were in Word documents, full of words and full of instructions for developers, it didn't really make sense to them. We were finding that they were missing things because they're just being asked to read this huge big lump of text, and they can't really visualize how that's going to look on the screen. So what we did when we started reviewing things to make, for example, updates to the content when new treatments came on, we scrapped sending the storyboards out to our committees, and asked them to just do the online modules and then take screenshots of where things needed to be changed, and indicate that that way, if that makes sense.

Nikitah Habraken: So we were finding that that meant that they were actually doing the modules, so they were actually going in so that they could see what things were looking like. And we were finding then that less things were missed.

Karen Moloney: That is something that's quite common with e-learning particularly, is that people can't visualize what it is you're going to give them. And us as creatives, and developers, and designers, we know what we mean, but until people can see it it's very difficult. And then people get bogged down in the detail, when that's not where we need them to be, where they can add the most value.

Nikitah Habraken: Something that was sort of challenging was across ASHM we're always constantly updating our resources. And a lot of it we're able to do in house. So we're able to do ourselves. But as soon as something isn't in English, and we don't have the language skills within our team, we're very much relying on these external people, who are very busy doctors often, who this isn't their primary job. We're kind of relying on them to do this in their own time.

Karen Moloney: So the management of that is crucial.

Jane Earle: And you guys have actively hired as well, haven't you, Nikitah? I thought that was a clever strategy. You've got language skills in house now.

Nikitah Habraken: Yeah, we do. I think when we started, and it was just Emma, and I, and a couple of others, and we don't speak any other languages. But now we're really fortunate to have quite a few members in our team who do speak fluently the languages that we're working in. And I think that's been a real game changer for us, just in terms of we can proof things ourselves. We're not having to rely on an external translation company, who might not know the content as in depth as we do. So might not be able to pick up on things. Yeah. Being able to have those language skills in house has been incredible.

Karen Moloney: Yeah. Some of those nuances could mean a completely different module, if you don't get that right. Just back to the solution. So there's an e-learning component of 60 minutes. You mentioned there’s a face-to-face component. What does that involve, and is that essential for everybody?

Nikitah Habraken: So the way that we designed the program initially was yes, so that there's an online component that is designed for people to do before they come along to the face-to-face part so that when you come to the face-to-face training, everyone's on the same page. Everyone has the same background level of knowledge on hepatitis C. So then the face-to-face part is really spent working through real life clinical case studies. So really trying to put the knowledge that people have gained in the online learning into practice. So having practice examples to go through.

Nikitah Habraken: So in saying that though, we did design the online modules to be standalone so that you didn't have to be coming along to the face-to-face workshop to be able to benefit from it. I guess the face-to-face workshop is really seen as a value add. So a place where people can come along and put the knowledge that they've learned and the skills that they've learned into practice, I guess before going out and doing that in a real world setting.

Karen Moloney: And you would generally be giving those within the same organization? They're not public workshops?

Nikitah Habraken: No. They are public workshops. So generally we would hold something in a specific geographic area, and market it to a whole bunch of drug and alcohol clinics or GP settings. So as well as being a value add in terms of working through case studies, it was also of value for people coming along to networks. They're meeting other people who are working in other settings and potentially wanting to do similar things in their practice.

Karen Moloney: Yep, and that kind of segues a little bit into the next question I have is around the delivery and the sort of the marketing of that course. Because when you're within an organization it's quite easy to get that out through all the regular channels, and there's processes for doing that sort of thing. Getting learning into the hands of the right people. But given that your audience wasn't global, open and voluntary, how did you do that?

Nikitah Habraken: I guess in Australia, ASHM have really strong networks already of GPs, of this target audience. But internationally we were really reliant on INHSU and their networks, so they have this incredible international network. We were also relying on our in-country steering committees to push out the program through their networks, but then we also worked with the in-country sort of professional medical associations and medical bodies, to try and reach people that way.

Karen Moloney: So Nikitah, we touched on some of the challenges already that you had from ASHM's side. Can you just talk to us about some of the other key challenges? Because I know you had a few.

Nikitah Habraken: Sure. So apart from the rapidly changing landscape of hepatitis C treatments, there were a few challenges that we had. One was that we didn't originally budget for the number of updates that we would need to make. So with the changing treatment landscape, we had to make update after update, and those things come at a cost. So something that we learnt very early on was that we needed to build that cost into our budgets.

Nikitah Habraken: Another thing was not having the translation skills in house, so not being able to proof things. And again, now we're really lucky in that we have people in our team that are able to do that. I think also the time that things take. So we hadn't ever ventured on a project like this, and had no idea how long things would take. So I think something that we've learned is to give ourselves more time, more time than we ever think we'll need.

Karen Moloney: I think that there's lots of moving parts, but also you're relying on people. And there were a lot of people that you were involving in that program, in terms of reviewing and getting content from, and approval from. And all that backwards and forwards does take a lot of time.

Nikitah Habraken: Yep. And we're relying on people to do work for us when this isn't really, it's not their primary job. So they're doing it outside of their work time.

Karen Moloney: Okay. And Jane, what were some of the challenges for you in The ID Crowd?

Jane Earle: Yeah. I think on two fronts. So from the content side, it's really complex content and it was really fun to engage with it. Hepatitis C is such an interesting area, and to be able to be involved in something at such an important time of change, where there's now a chance that you can actually cure this disease. There's a goal out there to eliminate hepatitis C. And I think that's really exciting. It's so great to be able to be a part of that as a learning developer. That's a really unique opportunity. Yeah.

Jane Earle: So that was really fun. But engaging with that complex content and the complex medical content. And then trying to bring all of the best of learning design to that and not be frightened of that. Sometimes I think we face complex content and really smart learners and we just back away, and give them what they've always had. So we really sort of took a risk there to turn that content into this highly scenario driven approach. That really pushed them to do a lot of decision making throughout the program and apply their skills. And I feel like that was the right call and it was a challenge to wade on into it, but worth it. And we have had great feedback from learners over time so that one was worth doing.

Jane Earle: And then from the localization perspective, I think it was great we had that knowledge early, that we may localize this because we chose to use the Adapt framework as our development tool, which meant that we could easily change languages. So we had managed that potential risk from the beginning in the development tool we chose. So I'm glad we made that choice. But then just as you say Karen, from the project management perspective, loads of moving parts, lots to think about. There were things like there's an animation in there and there's text inside that animation, so that needs to be translated.

Jane Earle: And early in the piece I think there was a special storyboard for that, but we need to send that to translators as well. So little things like that need to be picked up and managed. And then multiply that across multiple languages for different countries. It's just a lot. So we've got some pretty good strategies in our team to manage those pieces and to make sure all the pieces get fixed up, updated and put through the right QA process as well.

Michelle Ockers: Jane, you mentioned the Adapt framework, I've not heard that before. It may be new to some of the listeners as well. Would you like to talk a little bit about what that is, and what it allows you to do?

Jane Earle: Yeah, that's the development tool, it's developed by, well, a group of people. So it's out there, it's called the Adapt framework development tool. And there's two ways of using, there's an Adapt authoring tool as well as the Adapt framework. And it's basically HTML based learning, which means that it's almost instantly accessible and responsive, once you build it in its natural form. So

there's not a lot of extra to have to do before that. And the way it's built behind the scenes means that changing the content and the language of it is not as big a deal as it would be in something like Storyline, where you have to manually update every screen. I mean you do have to do that, but it's just a simpler process in the Adapt framework.

Jane Earle: So it's a great tool to use. It's a little bit more technical than something that's designed for an everyday elearning editor.

Michelle Ockers: That front-end authoring, yeah.

Jane Earle: Front-end authoring, that's right. Yeah, but it does the job and it's definitely what we needed here. And it does mean that it works really well on a mobile and it works really well if people need accessible, or need to use a screen reader?

Michelle Ockers: It sounds a tool worth using if you're going to have a lot of change and a lot of maintenance on the content. Which you clearly knew at some point you were going to need.

Karen Moloney: Nikitah, just in terms of measuring effectiveness and ROI of the program, how are you doing that, given that access is open and that there's no formal assessment or requirement for completion?

Nikitah Habraken: The way that we do it at the moment is we survey people who are coming to the workshops. So we survey them before, immediately after, and then we follow up six months later with them. And for those three different time points, what we're looking at is a change in their confidence and competence in managing and treating hepatitis C.

Karen Moloney: And I would assume in terms of the e-learning, you can track because it's going through your LMS, right? So you'd be able to track at least how many people are accessing the program?

Nikitah Habraken: Maybe a challenge that we've had is that the Australian version, so the original version of the program, of the e-learning program sits within ASHM's LMS. So we can track things like people who are accessing, where they're accessing from, where they might drop off in the program, that kind of thing. And we embed a survey where... We don't at the moment, but for lots of our other ASHM programs, we embed a survey at the beginning and at the end of the online modules, so that we can capture data at those two time points. Especially for people who are just accessing the online module and not coming to a face-to-face workshop.

Nikitah Habraken: A challenge that we face with the international versions is that they actually don't sit on a formal LMS. They're open access and they sit on the INHSU website. So we have less ability to track things in as much detail. But we've actually been working with Jane and The ID Crowd to try and implement some

kind of tracking sort of behind the scenes on those, so that we can see things like where people are accessing the modules from.

Jane Earle: How far they get through the module, that sort of thing. So just some Google Analytics to sort of progress through it and treat it almost like a website.

Nikitah Habraken: Yeah. I think that something that's been important to us from the beginning of the project is measuring the impact.

Michelle Ockers: And so we like to be practical on the podcast and help people to try new things. And the real story here is about the translation and localization was where the complexity came in. So if we have listeners who do have a situation where that's going to be needed on a project, Jane, perhaps we'll start with you. What are the tips you would give them to how to set themselves up well, right from the start for this kind of translation and localization?

Jane Earle: Yeah, I think if you know it's coming, that's probably the best thing, and that was definitely a gift we had here. I think really keep good records. We have lots of spreadsheets, so I know at one stage we had a very intensive project plan, with lots of different spreadsheets, going on to manage all the different components. So things like that help us keep track of things, especially earlier when we had multiple lots of changes on many different languages all at once. So make sure the animation is updated, and multiplied by 10, that sort of thing.

Jane Earle: It really helps if you keep it organized. We've got a really consistent file structure, things like that. They're little things, they're just good practice, but they make all the difference on a big project like this. And then thinking of storyboards and how they're structured to facilitate translation. That was something we sort of emerged with in conjunction with ASHM. So working through what they needed to be able to do and use as reviewers, and with their reviewers, and get their translators to be able to map the content into the right format. So that that was a joint effort to come up with the tools we needed there.

Michelle Ockers: And how would you summarize your key tips for people around localization and translation, Nikitah?

Nikitah Habraken: I think that my key tips would be get the right people involved from the beginning. So having representation from the right people. Testing your translators first, so before sending them all of the content, sending them a little piece that has maybe some examples from lots of different sections of what you need to get translated, and then having somebody check that translation. So having one of the medical experts on your committee check that actually this translation is saying what we want it to and is in the tone that we want it to be set in.

Nikitah Habraken: I think giving yourself more time than you think you need, and being open to feedback on things that don't work. I think we've changed lots of different

processes and lots of different pieces along the way. So I think, yeah, being open to feedback. We send lots of surveys to kind of everyone that we work with from our committees, to speakers at our workshop events, to the participants themselves. Just always seeking feedback.

Michelle Ockers: Yeah, very useful for the people working in multinational environments.

Karen Moloney: So we've got one final question that we like to ask all of our guests. I'm going to probably ask Jane first, could you share with us one resource you find valuable for your own professional development?

Jane Earle: Oh look, it's not a resource, but thinking about this, I think for me it's just having my metacognition radar on all the time, and watching how people learn things. So whether I'm watching people struggle with a ticket machine at the train station, or whether I'm watching little kids learn from cartoons. Those things are really interesting to me, watching what people struggle with, and how they learn, and what sticks for them. I think that's probably the biggest influence for me on how I learn about learning.

Jane Earle: I know it's not a resource out there or anything, but it's every day and it's just so practical, and to see what really works for people. I think that's very real.

Karen Moloney: Yep. Always be learning. And Nikitah, what about you?

Nikitah Habraken: I think for me, I use LinkedIn Learning a lot and YouTube. If ever there's something that I don't know how to do, I know that someone else out there probably didn't know how to do it as well, and has written me a tutorial that I can go and watch.

Karen Moloney: And they usually have.

Nikitah Habraken: Yes.

Karen Moloney: Fantastic. Well, thank you both so much. We'll include links to both your LinkedIn profiles, if anybody wants to get in touch with you to find out more about translation, localization and running a big global project like that. Thank you so much, both of you for sharing this very rich case study and your experience with us.

Nikitah Habraken: Thank you so much.

Jane Earle: Thanks.

Karen Moloney: And for our listeners, if you're finding Learning Uncut valuable, please take a moment to rate the podcast and leave a review comment. We really appreciate your help to ensure that as many learning professionals as possible have an opportunity to learn from the work of our guests like Nikitah and Jane. Thank you.