Introducing Cultural Competence Training in Bolivia as a Model for Other Developing Countries

September 2008

USAID
FROM THE AMERICAN PEOPLE

the ACQUIRE project

ACQUIRE Report

Introducing Cultural Competence Training in Bolivia as a Model for Other Developing Countries

September 2008

Gail Price-Wise

USAID
FROM THE AMERICAN PEOPLE

the ACQUIRE project

The ACQUIRE Project
c/o EngenderHealth
440 Ninth Avenue
New York, NY 10001 U.S.A.
Telephone: 212-561-8000
Fax: 212-561-8067
e-mail: info@acquireproject.org
www.acquireproject.org

This publication was made possible by the generous support of the American people through the Office of Population and Reproductive Health, U.S. Agency for International Development (USAID), under the terms of cooperative agreement GPO-A-00-03-00006-00. The opinions expressed herein are those of the publisher and do not necessarily reflect the views of USAID or of the United States government.

The ACQUIRE Project (Access, Quality, and Use in Reproductive Health) is a collaborative project funded by USAID and managed by EngenderHealth, in partnership with the Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Inc., Meridian Group International, Inc., and the Society for Women and AIDS in Africa (SWAA). The ACQUIRE Project's mandate is to advance and support reproductive health and family planning services, with a focus on facility-based and clinical care.

Printed on recycled paper in the United States of America.

Suggested citation: Price-Wise, G., 2008. *Introducing cultural competence training in Bolivia as a model for other developing countries.* New York: EngenderHealth/The ACQUIRE Project.

Contents

Acknowledgments v
Executive Summary ix

Introduction 1
- Background 1
- Cultural Competence as Used in the Curriculum 2
- Development of the Curriculum 3
- Development of the Training Materials 5
- Delivery of the Course 6

Project Evaluation 7
- Provider Pretests and Posttests 7
- Client Exit Surveys 8
- Key Findings 10

Tips for Creating a Curriculum in Cultural Competence 15
Replication and Scale-Up 17
- Recommendations for Improving the Curriculum 17
- Steps and Recommendations for Creating New Dialogues and/or Photonovelas 18
- Recommendations for Delivering the Course 19

Appendixes

Appendix 1: Data Collection Instruments 21
- 1.1: Provider Interview Questions 21
- 1.2: Client Focus Group Guide and Interview Guide 25
- 1.3: Electronic Products Survey 30
- 1.4: Provider Pretest/Posttest 35

Appendix 2: Informed Consent Statements 39
- 2.1: Informed Consent for Provider Interviews 39
- 2.2: Informed Consent for Focus Group Discussions 41
- 2.3: Informed Consent for Client Interviews 43
- 2.4: Informed Consent for Photo Documentation and Storytelling 44

Appendix 3: Evaluation Instruments and Results 45
- 3.1: Client Exit Interview Instructions 45
- 3.2: Client Exit Survey 47
- 3.3: CIES Client Exit Interview Results 50
- 3.4: APROSAR Client Exit Interview Results 53
- 3.5: Provider Pretest/Posttest, with Results and Analysis 57
- 3.6: Participant Course Evaluation 64

Tables

Table 1. Number of course participants, by how useful they found various aspects of the course content (N=20) 11
Table A-1. Results of t-test 57

Figures

Figure 1. Pretest and posttest scores, by participant 8
Figure A-1. Pretest and posttest scores, by participant 57

Acknowledgments

This report was written by Gail Price-Wise for the ACQUIRE Project; she also provided overall leadership in developing the content for the training, defining the project's approach to cultural competence, writing the curriculum, and designing the formative research and evaluation. Erika Cabrera provided technical and administrative support to the project and led the data collection for the formative research and the evaluation. Caroline de Hilari and Ineke Dibbits offered intelligent insights into Andean culture that enriched the curriculum. Susana Galdos served as the course facilitator and as an expert reviewer of the curriculum, drawing upon her experience as founder of ReproSalud del Movimiento Manuela Ramos in Perú. Inés Escandón provided technical support in developing the evaluation plan and in designing the instruments for the formative research. Fiona Nauseda, a specialist in e-learning, led the team that designed, developed, and produced the CD-ROM, and she participated in designing the face-to-face training. Alex Bermudez was the technical leader in the design and development of the multimedia CD-ROM. Joe Meiring was responsible for graphic design and other technical aspects of the CD-ROM.

Erin Mielke and Lynn Johnson from EngenderHealth had management responsibility for the project, along with Marjut Korkiamaki from Management Sciences for Health. Together, they ensured that all of the team members had clear roles and responsibilities and that all resources were used efficiently and effectively to achieve successful results, while adhering to all policies and regulations of the U.S. Agency for International Development (USAID).

Amy Damsker assisted in analyzing the evaluation data and provided excellent administrative support. Amanda Chan provided invaluable administrative support. Mansour Farahani, Project Manager at Harvard University School of Public Health, graciously donated his time to analyze the data from the provider pretests and posttests.

All involved with the project wish to thank Carolyn Curtis and Rocío Lara Palma at USAID for their support.

This report was edited by Christopher Caines and was formatted by Elkin Konuk; Michael Klitsch provided overall publishing oversight.

Executive Summary

In 2007, the U.S. Agency for International Development funded two organizations, EngenderHealth and Management Sciences for Health, to develop and deliver a pilot training program in cultural competence for health providers in Bolivia. Cultural groups in Bolivia are defined by ethnicity, urban versus rural residence, socioeconomic class, and the degree to which indigenous and mestizo groups have adopted European customs. The tension between the cultural groups affects the relationship between providers and clients. When clients feel disrespected or misunderstood, they do not come for services, they do not follow medical advice, and they may choose traditional healers and ineffective remedies over modern medical providers. The result is higher morbidity and mortality rates and more unwanted pregnancies.

Twenty reproductive health providers participated in a two-day training program. The program combined face-to-face activities with the use of a CD-ROM. Providers learned how ethnicity, the social hierarchy, and culture can impede communication and lead to low utilization of reproductive health services. Many concepts in the course can be applied to providers from any cultural group working with clients from any other cultural group. That said, the real strength of the program lies in how specific problems between this targeted group of providers and clients were integrated into the curriculum. To identify problem areas, focus groups and interviews were conducted at the beginning of the project. Client focus groups were conducted in Spanish and Aymara. Skilled facilitators engaged clients in discussing what they like and dislike about the services they receive. Providers were interviewed about what they thought about their clients. Lay health promoters discussed their interactions with doctors and community members. Issues raised were woven into the curriculum with dialogues demonstrating appropriate and inappropriate provider-client interaction. Quoted remarks from clients and health promoters describing upsetting interactions with doctors and nurses were included. Such quotes are very useful because providers rarely treat people disrespectfully *on purpose;* rather, providers do not know which comments may be seen as hurtful.

The curriculum is based on a model that divides cultural competence into three areas: internal cultural competence; communicative cultural competence; and knowledge-specific cultural competence. *Internal cultural competence* allows the provider to recognize and *manage* prejudices so as to act independently of them; it requires an internal dialogue. *Communicative cultural competence* has as its goal that the client should understand what the provider asks and recommends, feel at ease in speaking openly about her medical history, and be willing to voice concerns about recommended treatments or contraceptives. The provider will help the client speak about conflicts between traditional beliefs and modern medicine to negotiate an appropriate compromise. Internal and expressive cultural competence do not require knowledge of a particular culture. This is important to convey, because people who are new to cultural competence often focus exclusively on understanding local health beliefs and customs. Only the third category, *knowledge-based cultural competence*, relates to having specific information about the beliefs and practices of the cultural group with which the provider is working.

The program was evaluated through provider pretests and posttests and client exit surveys. A comparison of pretest to posttest data indicated a statistically significant positive change in providers' knowledge of many of the issues addressed in the curriculum (t value of –5.3 with a p value of <0.0000. On average, respondents' correct responses improved from eight of out of 16 to

10 out of 16). Although this change suggests that the difference may be due to the intervention and not chance, the small sample size (n=19 for pre and post) and the existence of minor problems in administering the questionnaire are important considerations when reviewing these results.

These results are presented in this report together with a discussion of challenges posed by the methodology for conducting the client exit surveys and recommendations for improvement. Recommendations for adapting the program for different populations are also presented.

The course can be found online at www.msh.org/culturalcompetence. However, local experts in cultural competency and some of the training participants have noted that the writing style in the course is too formal. This may be corrected, depending upon the availability of additional resources in the future.

Introduction

Background

Cultural competence as a field of study is maturing in the United States, particularly in health care. Many providers recognize that culture can profoundly affect the client-provider encounter and can alter the course of prevention and treatment. In the United States, a growing number of training programs, conferences, research studies, and other resources are strengthening the field of cultural competency.

In contrast, in developing countries, there is little awareness that cultural differences between client and provider can be an impediment to good health care. Perhaps because of the undersupply of skilled manpower, drugs, and health facilities, among others, the impact of culture on health has been largely ignored. Racial and ethnic health disparities are usually attributed to poverty and insufficient health resources, without consideration of how clients *feel* about their providers, of whether clients perceive that they are the subject of racial or ethnic prejudice, or of whether they understand and trust their providers. Some programs attempt to provide services in a culturally appropriate manner. However, these typically focus exclusively on tolerating specific practices, such as allowing the client and family to take possession of the placenta after childbirth.

Providers throughout the world often may not recognize how their own prejudices and stereotypes affect client care. This is particularly true in developing countries, where the social hierarchy has remained largely unchallenged since the colonial period. Many providers belong to a higher socioeconomic class than their clients, and in many countries they may be of a different ethnic background. Most have an honest desire to improve the health of the less fortunate; however, they do so in the context of social inequality. Providers rarely treat their clients disrespectfully *on purpose*. Many have been trained in a system in which it is natural to treat clients in a condescending manner. Providers may be unaware that clients are fearful and mistrustful, or they may not see how fear and mistrust affect client care. Even when modern health care is accessible, clients may opt against taking advantage of it. Instead, they may choose traditional healers over modern medicine, go without services, fail to take prescribed drugs, or refuse modern contraceptives. This happens for several reasons: 1) clients may not like or trust modern medical providers; 2) clients may act according to their beliefs and cultural practices; 3) clients may have no way to reconcile conflicts between traditional health beliefs and modern medicine *because* they are unable to speak openly with modern medical providers. The results are higher morbidity and mortality rates and more unwanted pregnancies.

In 2007, the U.S. Agency for International Development (USAID) funded two organizations, EngenderHealth and Management Sciences for Health, to develop and deliver a pilot training program in cultural competence for health providers in Oruro, Bolivia. Bolivia was selected because of its cultural diversity. Bolivia has 36 distinct cultural groups and nearly 40 different languages. Bolivia's ethnic distribution is estimated to be 56–70% indigenous people and 30–42% *mestizo*. The largest of the approximately three dozen indigenous Amerindian groups are the Aymara, Quechua, and Guaraní (comprising the Chiriguano and Guarayo).[1] White Bolivians (of European descent) constitute 15% of the population.[2] Cultural groups in Bolivia are defined only in part as

[1] Gamarra, E. A. 2007. Bolivia on the brink. *Council Special Report No. 24.* New York: Council on Foreign Relations.
[2] https://www.cia.gov/library/publications/the-world-factbook/geos/bl.html, retrieved 8/12/2008; http://www.state.gov/r/pa/ei/bgn/35751.htm, retrieved 8/12/08.

being of European, indigenous, or mixed descent. Other factors include the degree to which mestizo and indigenous people have adopted European customs, whether populations are rural or urban, and their level of income and education.

The main purpose of the pilot program was to adapt and test materials initially developed for U.S. domestic use. The curriculum addressed the issues of trust and communication in the context of ethnic differences—currently a hot issue in Bolivia and a determining factor in recent sociopolitical conflicts. Many reproductive health and family planning programs have been attempting to address the client-provider interaction as a key component of quality of care, yet there were no materials to assist in systematically addressing culture as a factor in client-provider interactions.

Twenty providers participated in a two-day training program called Competencia Intercultural para la Atención de Salud Sexual y Reproductiva [Cultural Competence for Sexual and Reproductive Health Services]. The training program took place in Oruro at the end of October 2007. Situated in the Bolivian *altiplano* (high plains), the department of Oruro has about 400,000 inhabitants. The most widely spoken languages are Spanish, Aymará, and Quechua. The providers came from two nongovernmental health organizations, Asociación de Promotores de Salud de Área Rural (APROSAR) and Centro de Investigación, Educación y Servicios (CIES). The program combined face-to-face activities with the use of a CD-ROM. At the direction of the course facilitator, participants viewed educational materials and discussion questions on their computers during the workshop and then discussed the material with the other participants. Providers were educated in how ethnicity, the social hierarchy, and culture can create mistrust, impede communication, and lead to low use of reproductive health services.

The basic concepts in the training program were derived from curricula targeted at a U.S. audience presented on the web site The Provider's Guide to Quality and Culture (http://erc.msh.org/qualityandculture). The Provider's Guide web site originated in 2000, with several modifications and additions over several years. The most recent data indicate that the Provider's Guide web site received 7,129 visits in June 2005, compared with 6,537 in June 2004 and 2,322 visits in June 2003. (More recent data are not available because grant funding to continue monitoring the web site is no longer available.)

Cultural Competence as Used in the Curriculum

The curriculum is based on a model (developed by the author of this report) that divides cultural competence into three areas: internal cultural competence; communicative cultural competence; and knowledge-specific cultural competence.

- *Internal cultural competence* allows the provider to *recognize* and *manage* prejudices so as to act independently of them. It requires an internal dialogue: *I'm uncomfortable with that person's ethnic background, but my job is to treat her respectfully and to improve her health.*
- *Communicative cultural competence* has as its goal that the recipient of the communication should feel respected. She should understand the questions the provider asks and what the provider recommends. She should feel at ease in speaking openly about her medical history and should feel able to voice any concerns she may have about a recommended medical treatment or family planning method. A provider with communicative cultural competence will help his or her client to speak openly about conflicts between traditional health beliefs and modern medicine so that client and provider can negotiate an appropriate compromise.

  Internal and communicative cultural competence do not require any special knowledge of the particular culture one is dealing with. Without knowing anything about the other person's

culture, a provider can be culturally competent by asking open questions, by managing his or her prejudices, by showing respect, and by speaking in a way that does not presume that the other person shares the provider's own values or experiences.

- *Knowledge-based cultural competence* requires specific information about the beliefs and practices of the cultural group with which the provider is working.

Competencia Intercultural para la Atención de Salud Sexual y Reproductiva includes information and exercises based on all three types of cultural competence.

Development of the Curriculum

The curriculum is based on the premise that all human beings harbor prejudices about one another based on a host of characteristics, including skin color, dress, and language. The project in Bolivia developed exercises to encourage providers to examine their prejudices honestly by asking questions about their experiences with member of cultural groups different from their own and the stereotypes they have come to accept as true. Whereas the original curriculum used in the United States instructs providers to prevent their prejudices from infringing upon their interaction with clients, the curriculum developed for Bolivian providers went a step further: It used dialogues to *demonstrate* how the provider can manage his or her thoughts so that his or her words and actions will be appropriate.

The curricula used for U.S. and Bolivian providers similarly emphasize how to communicate across cultures. The U.S. curriculum focuses on specific aspects of the medical encounter (such as techniques for procuring a complete and accurate medical history) and on methods to increase clients' compliance with medical advice. The curriculum for the Bolivia project adapted that material for a reproductive health setting, focusing on the pelvic examination, family planning, and perinatal care.

Many of the basic concepts presented in the course can be applied to providers of any cultural group working with clients of another cultural group. That said, the real strength of the Bolivia program lay in how specific problems between this targeted group of providers and their clients were identified and integrated into the curriculum.

To identify problem areas, a series of provider and client focus groups and interviews were conducted at the beginning of the project. Client focus groups and interviews were conducted in Spanish and Aymara. The focus groups were led in informal discussions by skilled facilitators who were able to engage clients in addressing what they like and dislike about the services they receive. Providers were interviewed individually about what they thought and felt about their clients. Lay health promoters (*promotores*) took part in the focus groups. This process allowed the project team to identify problems that should be included in the curriculum. This kind of comment and the feelings of the clients were woven into the curriculum. The focus group and interview questions are included as appendixes to this report.

Participants of the client focus groups and interviews were asked to draw from all of their experiences with health providers, not only providers from CIES and APROSAR. This is important to note because the negative comments may not refer to CIES or APROSAR. The intent was to identify impressions of health providers in general, so that specific concerns could be incorporated into the curriculum.

Major themes identified included the following:

- Women who wear traditional dress, called *señoras de pollera*, are subject to prejudice and stereotyping by providers.
- There are also great cultural differences between people from rural and urban areas. This is particularly significant because most providers come from urban areas.
- Even when both providers and clients share the same indigenous ethnolinguistic background (Quechua or Aymara, for example), providers may nonetheless harbor prejudices against women who wear traditional dress and/or come from rural areas.
- Women in rural areas, particularly the *señoras de pollera*, are completely unaccustomed to being undressed around anyone except their husbands. They are extremely embarrassed during a pelvic examination, and some fear that a male doctor may become sexually excited during the exam.
- Rural men often feel jealous when their wives are examined by male doctors.
- Providers reported that many clients are "closed" and uncommunicative. No provider reported that this was due to his or her inability to put the client at ease.
- Many participants reported having had at least one encounter with a doctor or nurse that was upsetting in that they felt disrespected or hurried out of the examination room. Some reported that the doctors became impatient with their questions and simply wanted the patient to follow orders. Several patients stated that they were hesitant to seek medical attention because of such bad experiences.
- Several patients reported that people with money are treated more respectfully than are the poor; *señoras de pollera* are treated disrespectfully, however, even when they have money.
- One focus group comprised *promotores*—members of a rural community who are trained to provide health education to their neighbors and to serve as liaisons to the local clinic. Many *promotores* said they were afraid to speak to doctors, even about issues that could improve patient care.
- Both the clients and the health promoters spoke about traditional health beliefs. One example is *lari lari*, a mythical cat without ears that captures the breath of an infant. This causes the child to make a mewing sound when breathing and causes the child's skin to turn a purplish blue.
- Several clients mentioned that providers make casual comments that are condescending. For example, some providers reportedly react with surprise and disapproval when they discover that their clients have had consecutive pregnancies very close together, saying, for example, "*Señora*, you're pregnant again? Don't you know it's bad for you to have another pregnancy so soon?"
- Clients believe that a "good doctor" is one who not only knows how to heal, but who also treats them as a friend.

These themes were incorporated into the curriculum. A series of dialogues was written demonstrating inappropriate communication between provider and client and showing how the interaction could be improved through a more culturally competent approach. In most cases, the "bad" dialogue was presented, followed by a question that asks the user to reflect upon how the dialogue might affect the health outcome. Many of the dialogues clearly demonstrate how a simple conversation can cause a client to omit an important part of the medical history, refrain from asking how a contraceptive method is used correctly, or simply decide not to return for follow-up care. The discussion question is followed by the "culturally competent" dialogue in which the provider speaks more appropriately, leading to a more productive medical encounter. Some of the dialogues show what the provider and client are thinking during the encounter and how this differs from what is actually said.

Following an introductory module, all of the material was organized into four modules:

1. *Managing Your Prejudices* trains providers to recognize their prejudices, to explore how they have developed those prejudices, to learn to question their automatic responses, and to treat clients with respect, independent of their prejudicial thoughts.
2. *Who Is a Good Health Provider?* addresses who clients perceive as a good provider and how this notion affects clients' participation in prevention, diagnosis, and treatment.
3. *Cultural Competence in Sexual and Reproductive Health Services* addresses a range of reproductive health services, including the gynecologic examination, family planning, antenatal care, pregnancy care, home births, and postnatal care. The module is based on the concerns and preferences expressed by the clients in the focus groups.
4. *Working with the Community* covers how health-related behavior is sometimes more easily changed by working with a community as a whole rather than trying to get individuals to act differently from their neighbors. The module addresses the use of lay health promoters as an important liaison with the community and provides guidance for talking with clients about traditional healers so they do not feel they have to choose between traditional healers and medical providers.

Local experts in cultural competency and some of the training participants noted that the writing style in the course is too formal. This may be corrected, depending upon the availability of additional resources in the future.

Development of the Training Materials[3]

The product design and delivery team conducted an assessment of the target audience's learning styles and access to technology to determine which blended learning model and platform would be used for the project. The team distributed surveys and conducted interviews with 28 members of the target audience to learn about the level of computer literacy among training participants. The assessment findings were used to develop a CD-ROM and accompanying participant print workbook.

The CD-ROM is designed as a self-instructional learning program that can be used either as a stand-alone product or as part of a face-to-face cultural competence training. The CD-ROM contains five modules that, with the exception of the introductory module, are presented in a nonlinear fashion. Each of the modules uses a standard navigation system that begins with a learning objectives page.

The CD-ROM includes *photonovelas* (i.e., combinations of photographs and dialogues related to the module content) that demonstrate both positive and negative interactions between patients and providers. All of the photonovelas were built using Macromedia Flash Professional, Version 8.0. The photonovelas consist of cut-out photographs of an assortment of patients or providers on opposite sides of the screen, with an assortment of dialogue-box treatments indicating speech or thoughts. Users are able to navigate forward or backward through each photonovela at their own pace.

Delivery of the Course

Twenty providers participated in a two-day training program. The providers came from two nongovernmental health organizations, APROSAR and CIES. The program combined face-to-face activities with the use of a CD-ROM. At the direction of the course facilitator, participants read

[3] Fiona Nauseda, of Management Sciences for Health, developed the training materials.

educational materials, the dialogues, and discussion questions on their computers and engaged in facilitated conversations. Participants included six nurses, four auxiliary nurses, four physicians, two teaching professionals, a psychologist, a lab technician, a dentist, and an administrative assistant.

Project Evaluation

Provider Pretests and Posttests

Cultural competence as a field of study is maturing in the United States, particularly in health care. Many providers recognize that culture can profoundly affect the client-provider encounter and can alter the course of prevention and treatment. In the United States, a growing number of training programs, conferences, research studies, and other resources are strengthening the field of cultural competency.

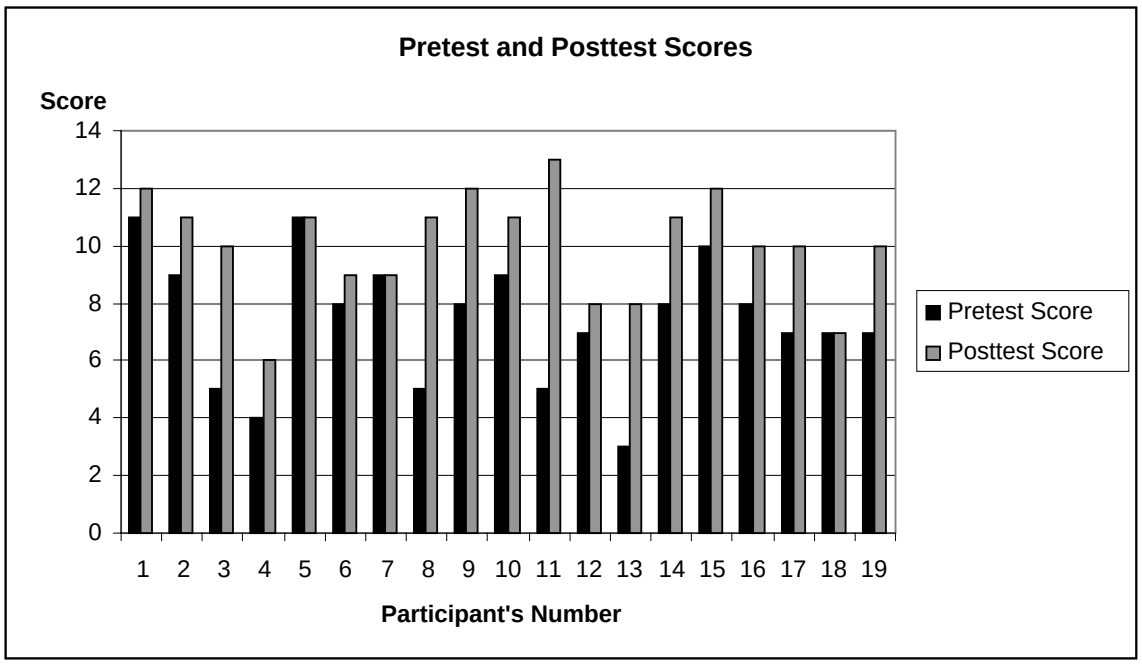
All providers participating in the training completed an identical self-administered written pretest and posttest to determine changes in their knowledge and attitudes as a result of the training. The test was given to the providers immediately before the training program and immediately upon completion of the face-to-face and electronic components of the training program. The pretest and posttest were anonymous.

The course had 20 participants. Unfortunately, the pretest of the last participant, who entered the course late, was lost. Therefore only 19 matched pretests and posttests were included in the analysis. The test consisted of 16 multiple-choice questions. The exact same test was applied on the morning of the first day and at midday of the second day, after 12 hours of course participation. No explanations regarding the test were given during the course. Participants were told not to communicate during the test, and they were observed to ensure that no communication occurred.

For three of the questions (2, 10, and 16), there were more correct answers in the pretest than in the posttest. To correct this, more content should be added to the course to strengthen the topics covered by Question 2 (a true-false statement reading: "A really conscientious health provider can eliminate his or her own prejudices or negative assumptions about certain types of patients") and Question 10 (a true-false statement reading: "Providers should suggest that their clients deliver their babies in the squatting position [*en cuclillas*], since this is most natural for rural Aymara and Quechua women"**)**. Question 16 was designed to test whether the participant recognized unfounded stereotypes of women who wear traditional dresses. The question was ambiguous because, while the expression *señora de pollera* refers to women who wear traditional dress, such women may not always wear them and may change to modern dress occasionally. Providers were apparently confused by the question, and the number of correct answers deteriorated from 10 in the pretest to five in the posttest. This question was determined to be invalid and was eliminated from the data set.

Figure 1 shows that the posttest scores are higher than the pretest scores for most of the participants. The pretest yielded a mean of eight correct answers out of 16 possible ones. The posttest yielded a mean of 10 correct answers. Mean improvement was 2.4 correct answers (median 2, mode 1, range -1 to 8) Two participants had the same or similar scores for both tests.

Figure 1. Pretest and posttest scores, by participant



To determine whether the difference in scores between the pretest and posttest was statistically significant, we used a paired t-test. Detailed results of the t-test are presented in Appendix 3.5, Table A-1.

The difference showed a t value of –5.3 with a p value of <.0000, suggesting that the intervention had a positive effect and that the change was not random. In reviewing the results, we should bear in mind a couple of limitations:

1. This was a small sample. There were only 20 providers, and one provider entered the course late, so there were only 19 matched results.
2. The professional and educational levels of the participants were heterogeneous, with some having difficulty using the CD-ROM because of limited computer experience and some having low literacy. Many of the participants had little experience with multiple-choice questions and were not able to handle combined answers (such as "Both 'a' and 'b' are true") or negative questions (such as "Which of the following is NOT true?").

Client Exit Surveys

Client exit surveys were conducted two weeks before and two weeks after the provider training to measure changes in provider behavior *as perceived by the clients.* The surveys took the form of multiple-choice survey questions that were read aloud to the clients. (The client exit survey instrument is in Appendix 3.2. A total of 105 female reproductive health clients were interviewed at CIES and APROSAR before the provider training and a total of 100 clients after the provider training.

Client Selection Criteria

The interviewees were *supposed* to be:

1. Female reproductive health clients of any age, either married or unmarried. Reproductive health clients were defined as women who received counseling in family planning; who received an

IUD, injectable contraceptives, condoms, or any other form of contraceptive; who received antenatal or postnatal care; or who were seen for any gynecologic problem, including infection or discomfort.

2. Clients who were seen on the day of the provider training by one or more of the providers participating in the training.
3. Clients whose most recent pelvic exam was conducted during the provider training or had been conducted in the past by a provider participating in the course.

Limitations of APROSAR Data

Clients at CIES were interviewed as they were exiting the facility. Unfortunately, we identified a number of limitations in the data collection. For the pretest, some of the APROSAR clients were to be interviewed on-site at the clinic and others in a rural area (to reflect APROSAR's principal catchment area). It was later determined that 28 clients who were interviewed in the rural area of Quillacas had been seen by a provider not affiliated with APROSAR; therefore, these clients had to be eliminated from the sample. More problematic was the possibility of courtesy bias, since some clients were interviewed in their homes by a nurse who chose the clients she knew best. Consequently, the APROSAR data cannot be used to evaluate the effectiveness of the provider training.

After the provider training, one provider left APROSAR and was replaced by another. This meant that the impact of the training on the provider who left could not be measured. Further, some of the clients interviewed for the posttest were reporting on the behavior of an APROSAR provider who had not participated in the training.

Finally, those participating in the posttest were not distinguished on the basis of how long it had been since they had last obtained services at APROSAR. The opinions of those who had sought services recently, after the providers had received training, were included with those who may have last sought services before the cultural competency course took place.

Despite the limitations in using the APROSAR data for measuring quantitative change, the information documented in the posttest is very interesting in regard to clients' responses about the care they receive. Unfortunately, the data are not relevant for evaluating the training program delivered in this project. The CIES data, in contrast, are relevant because CIES followed the client selection criteria.

Other Limitations

The evaluation was designed to have a different group of clients participating in the pretraining and posttraining client exit surveys. This was done for two reasons. Given the budget and time constraints of the project, client exit surveys needed to be completed within several weeks after the training program. As a practical matter, it would have been difficult to have the same clients seen for services before the training program and then again after the program, several weeks later. Clients are not generally seen that frequently. A second issue is that presenting a given group of clients with the same questions about their providers may result in different answers merely because the clients are being interviewed at two different times.

However, having two sets of clients also poses a problem, in that the validity of the evaluation is dependent upon having comparable groups. The groups were not stratified by age, marital status, parity, or other factors that may affect their perceptions of their providers. We do know that 52% of the pretest CIES clients were married, compared with 67% of the posttest CIES clients. Four

percent of the pretest CIES clients reported that they normally wear traditional clothing, compared with 13% of the posttest clients.

Another problem is that we do not know which clients were seen by each participating provider at CIES. This means that the data could be skewed if a given provider with particularly good communication skills saw 80% of the clients interviewed for the pretest but only 40% of the clients interviewed for the posttest.

Finally, clients may not want to make negative remarks about their providers. Some interviewers may be more skilled than others at soliciting honest answers from clients. As a result of the training experience, some interviewers may have had more skill in doing this during the posttest than they were during the pretest.

Key Findings

Client Exit Surveys

Taking into consideration the problems with the client exit surveys, the CIES analysis produced several findings that *may* support the conclusion that the provider training positively affected provider behavior. These findings have not been tested for statistical significance.

- On the statement "The providers from CIES treat me with respect," 90% of clients in the pretest confirmed that this was "always" true, compared with 96% in the posttest.
- To the question "In general, how satisfied would you say you are with the service you received today?" 66% replied "completely" or "very satisfied" in the pretest, compared with 76% in the posttest.
- At CIES, 79% of pretest clients and 85% of posttest clients reported that their providers "always" or "frequently" explained things clearly.

In addition, several findings do not necessarily reflect on the effectiveness of the provider training but may be valuable for future interventions to improve the quality of care:

- In the pretest, only 60% of APROSAR clients reported that their providers "always" or "frequently" explained things clearly. There was little change at the posttest.
- When asked to respond to the statement "I trust that doctors from CIES/APROSAR care about my well-being," only 52% of CIES clients and 44% of APROSAR clients responded "always" in the pretest. There was little change at the posttest.
- To the question "My doctor makes me feel comfortable during an examination of my private parts," 66% of pretest clients at CIES answered "always" or "frequently," as compared with 69% in the posttest. At APROSAR, the numbers were 48% and 31%, respectively.
- When asked to respond to the statement "When I don't understand what my doctor says, I ask questions," the proportion of CIES clients who said "always" was 45% in the pretest and 29% in the posttest. The responses to this statement for APROSAR clients were worse (32% in the pretest and only 24% in the posttest).

Provider Course Evaluations

In addition to the pretests and posttests, the 20 course participants were asked to complete course evaluation forms asking for their opinions about the course. The responses are summarized in Table 1.

Table 1: Number of course participants, by how useful they found various aspects of the course (N=20)

Course Content	Very useful	Useful	Somewhat useful	Not useful
Module 1: Introduction	11	9	0	0
Module 2: Managing Your Prejudices	15	3	2	0
Module 3: Who Is a Good Health Provider?	14	6	0	0
Module 4: Cultural Competence in Sexual and Reproductive Health	15	5	0	0
Module 5: Working with the Community	12	7	1	0
CD-ROM	**Very useful**	**Useful**	**Somewhat useful**	**Not useful**
Exercises	9	11	0	0
Fotonovelas	11	7	2	0
Questions for discussion	9	11	0	0
Client and provider testimonials	14	5	1	0
CD-ROM	**Yes**	**No**	**Do not know**	
Will you use the CD-ROM in the future?	20	0	0	
Could the CD-ROM be used as a training tool without the face-to face training?	10	2	8	

The responses indicate that the participants overwhelmingly found the course to be very "useful" or "useful." In reporting on the CD-ROM, the participants found the client and provider testimonials and the fotonovelas/dialogues to be most useful.

How the Participants Will Apply the Course

Course participants were asked to identify "useful things they learned in the course" and to state how they would change their interactions with clients as a result. Responses included:

Comments about Managing Your Prejudices

- "I will question or 'put into doubt' my prejudices."
- "I learned to recognize my own prejudices and the prejudices that other people have."
- "I will think about the preconceived ideas I have about the clients I provide care for."
- "I will carefully manage the opinions I have about everyone else."

Comments about Listening to Clients and Establishing Trust

- "It is to treat them [the clients] well and make them feel at home and gain their trust so they tell me their problems."
- "It is important to listen to clients; pain is not always physical and the provider plays an important role in that regard."
- "I will ask the clients more questions about their worries."

Comments about Showing Respect for Alternative Views of Health

- "I will find an optimum balance between traditional and scientific [medicine]."
- "It is important to involve the community so they don't reject the western medical system."
- "I will value the work of the *parteras* and traditional healers."

- "I will be empathetic and will respect their beliefs and customs."
- "Regarding my clients I will think and act, taking into consideration two perspectives (theirs and mine)."

General Comments about the Face-to-Face Training

- "My suggestion is to make sure everyone in the course talks."
- "I want to tell others what I learned. It's so important to have an exchange of knowledge."
- *"Buenísimo."*
- "The workshop allowed us to get closer to the day-to-day reality of the community."
- "The fotonovelas should be included in the training manual."
- "All of the material was very clear."
- "The language in the material should be better directed to the targeted course participants." [This is assumed to mean that some of the language was too theoretical or too complex.]
- "The workshop should be held in a more comfortable environment."
- "The workshop should be available to the Ministry of Health."

Comments about the CD-ROM

The workshop had two purposes: 1) to deliver and evaluate the content of the curriculum; and 2) to test the usefulness of the CD-ROM as a tool to be used *either* independently or as a part of a face-to-face workshop. The facilitators noted that having the participants read the material on the computer during the workshop was somewhat problematic, in that the participants had very different levels of education and read at different rates.

General Comments

- "The CD methodology really helped the course participant, especially the graphics."
- "The material is very good and easy to manage."
- "Working with the CD is tiresome."
- "I want to show the CD to my colleague at work."

Comments about Using the CD Again

- "I'll use the CD again, so that I can remember what was suggested."
- "I think I could use the CD for another workshop."
- "I will use the CD to replicate the workshop with work colleagues."

Comments on Quantity of Material on the CD

- "The material in the CD is somewhat repetitive."
- "The material on the CD is too long."

Comments on Using the CD without Face-to-Face Training

- "The CD should be used as part of a face-to-face training and not alone."
- "Using the CD without the face-to-face training would not be as effective because you would miss the exchange of experiences [among the participants]."
- "One would need some guidance to use the CD as a training tool, without a face-to-face workshop."
- "Whoever has a computer can take the course independently."

Suggestions for Improving the CD

In response to the three suggestions below, several photos were changed and additional "help" text was added.

- "The photos should correspond to the dialogue in the fotonovelas."
- "In the fotonovelas, the provider and client should be looking at each other."
- "Need to clarify that one should click on the arrows to continue the fotonovela."

The three suggestions below require additional writing, consensus among the team, editing, and approval. Such changes could be considered for the next iteration of the product.

- "The language used by the clients in the dialogues should be made current."
- "The exercises should have more choices."
- "The CD should be more manageable and shouldn't have so much theory."

The following suggestion would require a different type of product, one in which the users' answers are stored online or written to a CD.

- "The CD should have space in which to record responses."

The suggestion below would require substantial additional funding.

- "Explore the possibility of adding animation and sound to the CD."

Tips for Creating a Curriculum in Cultural Competence

Courses in cultural competence should educate providers about the consequences of the *lack* of cultural competence. When clients feel disrespected or misunderstood, they do not come for services, they do not follow medical advice, and they may choose traditional healers and ineffective remedies over modern medical providers. Scenarios that illustrate why clients turn away from modern medicine and how poor health outcomes may result are very effective teaching tools.

All courses in cultural competence should begin with an explanation of the three types of cultural competence: internal, communicative, and knowledge-specific. This is important because people who are new to cultural competence often focus exclusively on understanding local health beliefs and customs. Providers rarely recognize their prejudices regarding other cultures and how this affects their ability to interact effectively. It is essential to emphasize that the goal is not to eliminate prejudices, but to manage them so that they do not affect client care.

The course developers should use focus groups and interviews to identify the major learning objectives and to define the modules. For example, in the Bolivian focus groups, it became clear that the providers and clients had different concepts of a "good provider." The clients stated that "good doctors" treat them like a friend and show a personal interest in them. The providers did not mention their personal relationship with the clients and only considered clinical skills in defining a "good doctor." The conversations on this topic formed the basis for the module Who Is a Good Health Provider?

Focus groups and one-on-one interviews are essential for getting specific information about what providers and clients think and feel about one another with respect to their physical appearance, belief systems, words, actions, body language, dress, etc. Some clients are more forthcoming when interviewed individually. Others are more open in a group setting, particularly if at least one focus group participant is prepared to break the ice by speaking negatively about providers. This is a signal to everyone that it is safe to speak openly. The facilitator or interviewer should try to elicit details from providers and clients, asking such questions as, *Exactly what did they say or do that bothered you? What were their exact words? What gestures or facial expressions do you remember?* The facilitator or interviewer should be skilled in qualitative research techniques. He or she should ideally be of the same sex as participating clients.

Informed consent from clients and providers participating in focus groups and interviews, as well as those being photographed, should be secured.

Upon completion of the focus groups and interviews, all of the material should be reviewed and divided into major themes for the course modules. Learning objectives are then written for each module.

Information from the client focus groups and interviews should be integrated into dialogues and/or photonovelas that demonstrate effective and ineffective interactions. It is not useful to simply tell a provider to "treat the client respectfully." Providers rarely treat their clients disrespectfully *on purpose*. Providers need specific examples of the words, actions, and body language that will connote respect or disrespect to the client. For example, in a Bolivian focus group, a client reported

that her provider said "*Señora*, you're pregnant again? Don't you know it's bad for your health to have a second pregnancy so soon?" The clients interpreted this statement and the provider's facial expression as condescending, even though the provider did not intend to be offensive. It is useful to demonstrate to providers how casual comments and facial expressions can be hurtful and to suggest alternative ways of communicating. In this case, the facilitator could suggest that the provider ask more respectful questions about whether the woman has achieved her desired family size, such as, *Señora, your first child is now nine months old. How do you feel about being pregnant again?* The provider might then inform the client about the health benefits that flow from the optimal timing and spacing of pregnancies. Appropriate drawings or photographs should accompany written dialogues to create useful teaching tools.

Information from the provider focus groups and interviews should be integrated into exercises in the Managing Your Prejudices exercises. For example, in the Bolivian focus groups, doctors, *promotores*, and clients spoke about *señoras de pollera*, women who wear traditional dress. Providers' comments about these women, as well as the testimonials of the women themselves, were woven into the exercises to enable providers to recognize that their stereotypes of such women are not accurate for many *individual women* who wear traditional dress.

The course should demonstrate to the provider what the client might be *thinking* while in the waiting room, during an exam, a particular discussion, etc.

The course should teach providers that because of their higher status in the social hierarchy, clients may fear them. Fearful clients are less likely to seek medical care, ask questions when they do not understand what the provider has said, and follow medical advice.

Providers should be taught to avoid competing with traditional healers and traditional health practices. It is most effective to make comments such as *I'm not an expert in spirits or herbs. I use drugs and methods of family planning that are based in science. Please let me know what the traditional healer recommends for you so I can be sure our methods are in concert with one another.* In the Bolivian focus groups, *promotores* spoke about *lari lari*, an invisible mythical cat that causes respiratory distress in young children. Providers were taught not to negate the belief in this creature, but to ensure that the use of traditional remedies did not keep families from bringing ill children to the clinic.

Replication and Scale-Up

Almost all societies in the world are heterogenous, whether cultural identify is defined by race, ethnicity, religion, tribe, language, socioeconomic status, or some other criteria. Many cultural groups are too poor or disenfranchised to raise children to become health providers, particularly doctors. Therefore, in almost every society in the world, health providers of one culture or social status care for clients of a different culture or social status. Providers who work with clients of another culture may have difficulty establishing trust and communicating effectively. In the absence of culturally competent providers, clients may choose not to seek services, may withhold valuable information about their medical histories, and may not ask essential questions about a treatment plan or contraceptive method. The result is higher morbidity and mortality rates and more unwanted pregnancies. Training in cultural competence is an essential component of ensuring quality of care and should be introduced whenever possible.

Cultural competence programs may be *particularly* important when:

- There is a new influx of immigrant or refugee populations.
- There are cultural groups with few representative health providers.
- There are marked cultural differences among socioeconomic classes.
- There is a significant difference in social power between providers and clients.

Recommendations for Improving the Curriculum

For Future Dissemination in Bolivia

Analysis of the provider pretest and posttest findings indicates that several changes would improve the curriculum for Bolivian providers. The curriculum is effective as is, but it could be improved upon with further resources.

- To the statement "A really conscientious health provider can eliminate his or her own prejudices or negative assumptions about certain types of clients," six participants responded correctly in the pretest and only one in the posttest. Both the CD-ROM and the course should place more emphasis on the idea that prejudices *cannot* be *eliminated* but should be *managed*.
- Several providers in the course believed this statement to be true: "A culturally competent provider recognizes that prejudices are always based on false information and lies about other groups." The CD and the course should make clear that prejudices are not always based on false information and lies; they may actually be based on information that is true in one case but that has been falsely generalized.
- Community members sometimes speak of foods as being "warm" or "cold" and assign health values to these. Several providers in the course were confused about indigenous beliefs regarding foods categorized in this way and their effects on pregnancy. The course needs more emphasis on understanding indigenous beliefs about the appropriate diet for pregnant women.
- For the following statement, there were more correct responses in the pretest than in the posttest: "Providers should suggest that their clients deliver their babies in the squatting position [en cuclillas], since this is most natural for rural Aymara and Quechua women." The course should reinforce that culturally competent care is based on giving free choice to the client. Providers in the course should be further reminded not to stereotype their clients; they should not think that all rural clients have the same preferences just because they look alike or dress alike.

For Adapting the Course for Other Settings

Much of the material in the Bolivia course can simply be translated and used in other settings with minor changes. Most of the didactic text is relevant for any culture. Some of the dialogues can be applied to almost any culture; however, their appropriateness has to be assessed for each setting.

For all modules, recommended adaptations include:

- The photographs of providers and clients must represent the targeted cultural groups.
- The direct quotes from providers and clients should be from the local environment.
- New dialogues need to be written based on specific problems identified in the focus groups.
- Material can be written to demonstrate how culture impacts other aspects of the client–provider interaction. For example, dialogues could be written demonstrating effective and ineffective counseling and showing how people of different cultures ask questions and relay information differently. These are most effective if they are based on stories from clients describing awkward interactions or positive ones.

For the course introduction:

- Replace Bolivian demographics with data appropriate to the new course setting.
- Replace information about Bolivian national programs with data appropriate to the new course setting.

For the Managing Your Prejudices module:

- The exercises include a list of characteristics about someone that could trigger an associated negative thought or stereotype. These lists should be modified to reflect issues relevant to the new setting (physical characteristics, certain types of dress, religion, etc.).
- One exercise includes photographs that ask the provider to reflect upon what he or she thinks about that person. The photographs should be changed to represent people in the new setting.

For the modules What Is a Good Health Provider?, Cultural Competence in Sexual and Reproductive Health Services, and Working with the Community:

- As noted above, it is likely that some of the dialogues can be used as they are in new settings. Other material will need to be rewritten for the new setting. New photographs will be needed.

Steps and Recommendations for Creating New Dialogues and/or Photonovelas[4]

- Finalize the dialogue content.
- Determine the kind of background setting needed for the scenes.
- Identify photo subjects that represent a diversity of age, gender, ethnicity, etc.
- Obtain permission to photograph the subjects.
- Stage the scenes to match the dialogues. Please note: Depending on the dialogue, it may be necessary to take multiple photographs of the same subject with different facial expressions.
- Begin production.

[4] These recommendations were drafted by Fiona Nauseda.

Recommendations for Delivering the Course

- On the course evaluations, many of the participants stated that the CD-ROM could guide the user through an independent course without a face-to-face training. Most, however felt that the CD is most effective when used in conjunction with face-to-face training.
- The CD and course manual are designed to provide clear guidance for the trainer. The exercises and discussion questions are laid out so that someone with strong facilitation skills should be able to deliver the course, even if he or she is not an expert in cultural competence.
- The pilot training program was delivered over two days, comprising approximately 12 hours of training, plus breaks. It was necessary to complete the program in a condensed period of time, since the main trainer traveled from the United States. Another model could rely on shorter sessions over several weeks. This would allow the participants to practice what they learned between sessions and to share their experiences with the group.
- It may be useful for course participants to view the CD and course manual before a face-to-face training. In the pilot, it was found that participants read at different levels of proficiency and speed, which made it awkward to find the right amount of time to allow for reading during the workshop. Giving "homework" outside of the workshop could solve this problem. The face-to-face time could include a review of the material on the CD but might emphasize group discussions. Such a delivery model could begin with a short session to introduce the topic of cultural competence and to teach the participants how to use the CD. Follow-up sessions would focus on each of the modules.
- It is useful to have participants from the same organization train together, so that they can support one another in changing their behavior with clients in the workplace.
- A good ratio of participants to trainers is 30 participants to two trainers.
- Ideally, each participant would have a computer, and there should be comfortable space for the group discussions.

Appendix 1: Data Collection Instruments

Appendix 1.1: Provider Interview Questions

Instructions for the Interviewer/Focus Group Facilitator

The purpose of this questionnaire is to gather information to be included in the course. It is not intended to test the knowledge of the providers. Through the provider and client interviews and focus groups, we intend to uncover areas of misunderstanding, miscommunication, and mistrust between provider and client that specifically relate to issues of race, ethnicity, and social inequality. Questions in italics are not to be read. They repeat the basic themes— so the interviewer/focus group facilitator can keep in mind what he or she is trying to glean from the answers. The questionnaire is long; the interviewer/focus group facilitator may opt to skip questions once he or she has gotten enough information about the basic theme.

Basic Themes

1. In speaking with clients, what words do providers use to describe anatomy, bodily functions, and sexual acts?
2. What can we learn from providers about what clients are likely to communicate or withhold?
3. How do providers react to their clients' use of traditional methods of healing, family planning, and reproductive health?
4. What do local providers do to establish an open, trusting relationship?
5. How do providers manage their clients' discomfort with nudity?
6. How do providers educate their clients about reproductive health and family planning?
7. Do providers believe that clients adhere to medical advice?
8. How do providers interact with the family members of their clients?
9. Do providers identify and address what is most important to women regarding their reproductive health?
10. Do providers impose their own values on the family planning decisions of their clients?
11. Do providers always maintain the confidentiality of their clients?
12. Does interracial/intercultural prejudice affect the provider-client relationship?
13. Are there historical or current political conflicts that affect how providers and clients feel about one another?

Interview Questions

- To start, can you please tell me a little bit about yourself and the work you do here at X facility?
- What is your title?
- What are your responsibilities?
- How long have you been at this facility?

1. *In speaking with clients, what words do providers use to describe anatomy, bodily functions, and sexual acts?*

2. *What words do you use to describe anatomy, bodily functions, and sexual acts? (Interviewer poses open-ended question, then provides a list of anatomical and physiological terms, asking providers to tell how they refer to these terms with clients.*)
   - Do you use different words for different groups?
   - Do you use different words with male versus female clients?

3. *What can we learn from providers about what clients are likely to communicate or withhold?*
   - Do you think your clients give you complete information about their reproductive health and sexual behavior?
   - Do different cultural groups give you more or less information?
   - Do men and women give you more or less information?
   - What kind of information might they withhold and why?
   - Will clients tell you if they don't understand or agree with what you have told them to do?

4. *How do providers react to their clients' use of traditional methods of healing, family planning, and reproductive health?*
   - What are some of the common traditional healing or family planning practices employed by your clients?
   - What do you think of these practices? What do you think about clients who use these practices?
   - Do you discuss traditional methods of healing or family planning with your female/male clients?
   - What do you say to your clients about these traditional methods?
   - Is it helpful for you to openly discuss traditional methods with your clients?
   - Have you ever spoken with a traditional healer? What did you discuss? Was it helpful in any way?
   - Have you ever delivered a baby and given the placenta to the family? For what reasons? How did you feel about this? What did you say to the family about it?

5. *What do local providers do to establish an open, trusting relationship?*
   - Do you think that your clients trust you, that they talk openly with you about issues related to sexual relationships and family planning use?
   - What do you do to make your clients feel at ease?
   - Do your clients prefer to be called by their first or last names? Is it the same for women and men?

6. *How do providers manage their clients' discomfort with nudity?*
   - How do your clients feel about being naked or exposed during your examination?
   - Is there a private/separate space in your clinic where clients can undress?
   - What do you do if a female client does not wish to undress?
   - What could be done to make female clients feel more comfortable about undressing for an exam?

- Do men feel comfortable during an examination of their sexual organs? Is there a special space for men at the clinic?
- What do you say to your client if she or he has not bathed recently and is not clean?

7. *How do providers educate their clients about reproductive health and family planning?*
   - What do your clients believe about conception and the entire reproductive process? What myths/misconceptions have you heard about reproduction and family planning?
   - What do you say to a client if her/his beliefs about reproduction are wrong?
   - How do you explain the facts of the reproductive process and methods of family planning?
   - How do you reconcile the different belief systems?

8. *Do providers believe that clients adhere to medical/reproductive health advice?*
   - Do your clients (specify women and men) follow your advice about their family planning needs and reproductive health?
   - How might they fail to follow your advice?
   - Why would they fail to follow your advice?

9. *How do providers interact with the family members of their clients?*
   - Who accompanies the client during a family planning visit? During a visit for any other reproductive health service?
   - What role does the person accompanying the client play in the consultation?
   - Should providers include the husband and/or other family members? If so, when?
     - When conducting the examination?
     - When getting the client's medical history?
     - When discussing methods of family planning?
     - When discussing other aspects of reproductive health?

10. *Do providers impose their own values on the family planning decisions of their clients?*
    - Would you provide family planning services to a woman who is unmarried? How would you make this decision?
    - Would you provide family planning services to a woman under the age of X if she were unmarried? How would you make this decision?
    - Would you provide family planning services to a woman without her husband's knowledge? What if she told you her husband had said he did not wish her to use family planning methods? How would you make this decision?

11. *Do providers always maintain the confidentiality of their clients?*
    - When might it be appropriate to reveal something a client has told you in confidence?
    - List examples:
      - If a single young woman wants family planning services
      - If a woman is pregnant
      - If a woman has a sexually transmitted infection
      - If a woman has been physically abused?
    - Who would you share this information with?

12. *Does interracial/intercultural prejudice affect the provider–client relationship? Do the Guarani/Aymara/Quechua (these terms will have to be explored) people receive a different quality of care than (whatever the European descendents or ruling class call themselves)?*
    - How do educated white /European Bolivians refer to the Gurani/Aymaran/Quechua people? Are there any slang terms for them?
    - Do you attempt to provide the same quality services to Guarani/Aymara/Quechua people?
    - What do you think are some of the differences in characteristics between X and Y group? In terms of intelligence? Moral values? What do other doctors/health providers at this facility think?
    - What are some of the differences in health care offered to X clients, as compared with those offered to Y clients? What are the reasons for these differences? How do you feel about these differences?
    - Do you think the Guranai/Aymara/Quechua people are able to make good decisions for themselves about their reproductive health? In what way do they make good decisions? In what way are they unable to make good decisions for themselves? When is it appropriate for the provider to make decisions for the client? When should the provider choose the family planning method for the client?

13. *Are there historic or current political conflicts that affect how providers and clients feel about one another?*
    - Do you believe there is any tension between providers and clients because of historical or current political conflict? What occurred?
    - Do clients have a reason to fear coming to the clinic?

Now, I would like to finish up and receive some additional information about you.

- *Interviewer: Record gender of provider*
- What is your educational background?
- How old are you?
- What is the ethnic breakdown of the clients you see?
- How long have you been working with these populations?
- Have you worked with other populations in the past?
- What are the special challenges you face working with each population?
- Besides Spanish, what are some of the other languages you speak? Which one do you feel most comfortable speaking?
- Given our discussions today on ethnicity and cultural backgrounds, how would you describe yourself?

Appendix 1.2: Client Focus Group Guide (for All Participants) and Interview Guide (for Selected Participants)

Instructions for the Interviewer/Focus Group Facilitator

The purpose of this questionnaire is to gather information to be included in the course. It is not intended to test the knowledge of the providers. Through the provider and client interviews and focus groups, we intend to uncover areas of misunderstanding, miscommunication, and mistrust between provider and client that specifically relate to issues of race, ethnicity, and social inequality. Questions in italics are not to be read. They repeat the basic themes—so the interviewer/focus group facilitator can keep in mind what he or she is trying to glean from the answers. The questionnaire is long; the interviewer/focus group facilitator may opt to skip questions once he or she is has gotten enough information about the basic theme.

Basic Themes

1. What words do people in this culture use to describe anatomy, bodily functions, and sexual acts?
2. What information might clients from this culture want to withhold from providers and why?
3. What are the traditional health beliefs and practices found in this culture with regard to family planning and reproductive health, and is there any conflict with modern medicine?
4. What are the local misconceptions and myths about family planning and reproductive health? What traditional methods are practiced?
5. How do people in this culture make decisions about reproductive health; which family or community members need to be consulted?
6. How do people in this culture feel about nudity in a medical setting?
7. How do people in this culture feel about the health care that is available to them? 7A. Should providers include the husband and/or other family members? If so, when?
8. Do clients believe that what they say to the provider will be kept confidential?
9. How does the gender of the provider affect the client-provider relationship?
10. Do people in this culture perceive a relationship between race, ethnicity, and quality of care?

Interview Questions

Note: The questions in italics are meant to be guides for the interviewer. They should not be read to the client.

1. *What words do people in this culture use to describe anatomy, bodily functions, and sexual acts? What words do women use? What words do men use? Show the client pictures of male and female bodies and asks the client what words he/she uses to describe body parts.*

2. *What information might women and men from this culture want to withhold from providers and why*? *(Present case studies, and ask clients—women and men—what they think the character in the case study would or would not tell their provider. Clients may be more honest about how someone else would behave instead of asking how they would behave themselves.) For example:*
   - Mrs. XX forgot to take her birth control pills for several days. Would she tell her health care provider? Why or why not?
   - Mr. YY had side effects from his treatment and decided to reduce the dosage. Do you think Mr. YY should tell his provider? Do you think people in your culture would tell their provider? Why or why not?

- Mr. YY visits a prostitute when he travels to town. Would he tell this to his provider? Why or why not?
- Mr YY has a wife and three children and has a sexually transmitted infection because he had sex with a sex worker. Do you think that Mr. YY should tell the doctor how he was infected?
- Mrs. XX has been physically abused by her husband or someone else close to her [define abuse: hit, punched, knocked down, hair pulled, forced to have sex]. Do you think she would tell her provider? Why might she hide this information?
- Have you ever heard of anyone who told a provider something—and received a negative response? Was the provider angry? Did the provider criticize the client? Did the provider embarrass the person? Did the provider tell someone something that the client didn't want them to know?

3. *What are the traditional health beliefs and practices found in this culture, and is there any conflict with modern medicine*?
   - What causes (selected illnesses)?
   - What do your doctors think of your beliefs?
   - Do providers ever prescribe a treatment that is wrong or harmful?
   - Do you receive reproductive care from a traditional healer?
   - For what reasons do you go to a traditional healer?
   - What does the traditional healer do?
   - I have heard that some people in your culture use a special treatment…. Do you know anyone who might use this type of treatment?
   - What other types of treatments, herbs, or ceremonies do people in your culture use to improve their health?
   - What do providers think about these treatments?
   - Do people in your culture tell providers when you use these treatments? If not, why not?
   - What would you want your provider to say about traditional treatments?

4. *What are the local beliefs (including misconceptions and myths) about family planning and reproductive health? What traditional methods are practiced?*
   - What causes (selected illnesses):
     - Maternal mortality during pregnancy?
     - Maternal mortality during labor?
     - Eclampsia?
     - Spontaneous abortion?
     - Vaginal discharge?
     - Cervical cancer?
     - Infertility?
     - Sexually transmitted infections (give examples)?
     - Impotency in men?
   - What happens inside your body to make you become pregnant?
   - How does the baby grow?
   - What should pregnant women do to ensure a good pregnancy?
   - What is the best way to help the baby come out safely during childbirth?

- Who should be present during the birth of a baby? (Family members?)
- What would you like to have during your delivery? (Colors, lights, food and drink.)
- How do you feel about the gender of the provider who attends your delivery?
- What should be done with the placenta and why?
- Why do some pregnant women NOT want to deliver in the hospital?
- Why do some men prefer that their wives/women NOT deliver in the hospital?
- What family planning methods are offered at this facility, and how do they work?
- Have you ever heard of any problems associated with these methods of family planning? (Interviewer lists methods.)
- Are there family planning methods used in your community that are not offered at this facility? What are they?
- What do doctors think of these methods?
- Do you tell your doctor if you use traditional family planning methods?

5. *How do people in this culture make health-related decisions; which family or community members need to be consulted?*
   - In your home, who makes decisions about reproductive health?
     - How many children you will have
     - Whether you will use family planning methods, and what kind
     - What you will eat during pregnancy
     - Where you will deliver the baby
     - Who will deliver your baby
     - What kind of medicine you take when you are ill
     - When to go to a doctor
   - When you seek health care, do you usually go alone or does someone else go with you? Who goes with you? For what reasons?
   - Which family or community members should your provider include in health-related discussions?
   - Do providers understand how decisions are made in your home?
   - If husbands do not allow family planning, do providers speak with them?

6. *How do people in this culture feel about nudity in a medical setting?*
   - If husbands do not allow family planning, do providers speak with them?
   - (Present a case.) Mrs. XX refused to undress for the examination. What could the doctor have done to put her at ease so that she would have undressed?
   - Does your doctor ask you to undress to examine you?
   - How do you feel about this?
   - Do you feel differently if the doctor is male/female?
   - Does the age of the provider make a difference?
   - How does your husband feel about this? Does he feel differently if the doctor is male/female? Old/young?
   - Do you want your husband to be present when you are examined?
   - Why do you think the doctor asks you to undress?
   - Why does the doctor want to examine your private parts?

- What has your doctor done that makes you more embarrassed during the exam?
- What has the doctor done to make you less embarrassed during the exam?
- What would make you feel more comfortable?

7. *Should providers include the husband and/or other family members? If so, when?*
   - When conducting the examination?
   - When getting the client's medical history?
   - When discussing methods of family planning?
   - When discussing other aspects of reproductive health?

8. *How do people in this culture feel about the health care that is available to them?*
   - Does this clinic provide good medical care?
   - Does this clinic provide good reproductive health care?
     - Family planning
     - Antenatal care
     - Perinatal care
     - Sexually transmitted infection care
   - What do you like?
   - What do you *not* like?
   - Do the doctors understand your medical problems? What would you like them to understand better?
   - Do they understand your reproductive health needs? What would you like them to understand better? Do they understand what you are asking for?
   - Do people that come to this clinic generally get better?
   - Are their family planning needs met?
   - Have you heard of anyone who got worse because of the care they received at this clinic? What happened?
   - Do clients understand the advantages and disadvantages of the available family planning methods?
   - Have you heard of anyone who developed a problem because of a family planning method prescribed at this clinic? What happened?

9. *Do clients believe that what they say to the provider will be kept confidential?*
   - Do providers in this clinic keep a secret if you want them to?
   - Has a provider ever told someone something about you that you wish had been kept secret?
   - If the woman did not want her husband or others in the community to know something, would the provider keep it a secret? What kind of thing might the provider fail to keep secret? What kinds of things might he or she keep secret? (list examples):
     - If a single young woman wants family planning services
     - If a woman is pregnant
     - If a woman has a sexually transmitted infection
     - If a woman has been physically abused (see earlier definition of abuse)
10. *Do people in this culture perceive a relationship between race, ethnicity, and quality of care?*
    - What name do you call your race or culture?

- What is the race or culture of your providers?
- What is the race or culture of other people you know?
- Do people from your culture receive the same quality of care as people from other cultures? How is the care different for each culture?
- Did you ever feel that you received worse medical care compared to that received by other clients? For what reason? How was the care worse?
- Do you ever feel that providers give better care to women or to men? If yes, why does this happen?

11. *Are there historic or current political conflicts that affect how providers and clients feel about one another?*
    - Do you feel uncomfortable with health care providers because of (history of conflict, war, class struggle)? What happened?
    - Is there any reason for a client to fear coming to the clinic?

12. *Client demographic characteristics*
    - Gender of client
    - How old are you?
    - How many years of education have you had?
    - What cultural group do you consider yourself to belong to? (need list)
    - Are you single, married, or unmarried with a partner?

Appendix 1.3: Electronic Products Survey

Name (Optional): _____

Primary Language Spoken: _____

Work location: _____

Thank you in advance for completing the following questionnaire. The questionnaire is divided into three components: learning styles, training, and technology and should take you approximately 15 minutes to complete.

Your responses will help us to design a more effective learning program.

General

1. What are your expectations of the pilot cultural competence project?

2. How much time each week would you be able to dedicate to the program?
   - ☐ 0–30 minutes
   - ☐ 30 minutes1 hour
   - ☐ 1–2 hours
   - ☐ 2 or more hours
   - ☐ Other _____

Learning Styles

3. a. Think about a recent successful learning experience, such as a training, conference, or self-study, etc. What made it a positive experience for you? Please describe.

   b. Think about a recent unsuccessful learning experience. What made it a negative experience for you? Please describe.

4. How do you like to learn new things? Please rate the following items using a scale of 1–5, where 1 = Strongly dislike and 5= Strongly like)

   a. Reading material
   1 2 3 4 5

   b. Completing assignments (written, self-reflection, activity-based, etc.)
   1 2 3 4 5

   c. Completing self-assessments
   1 2 3 4 5

   d. Watching and/or listening to presentations
   1 2 3 4 5

   e. Watching videos
   1 2 3 4 5

   f. Listening to audio clips
   1 2 3 4 5

g. Learning new terms and definitions
1 2 3 4 5

h. Analyzing case studies
1 2 3 4 5

i. Learning by doing
1 2 3 4 5

j. Discussing topics with colleagues
1 2 3 4 5

k. Participating in role plays
1 2 3 4 5

l. Other (please describe)
_____

5. What motivates you to do your job well?

Training

6. a. Have you participated in on-the-job trainings during the past two years?
☐ Yes
☐ No (please skip to question 7)

b. If yes, please describe them (including their frequency.). What do you like about them? What do you dislike about them?

7. a. Have you ever participated in a distance learning course?
☐ Yes
☐ No (please skip to question 8)

b. If yes, please describe. What did you like about it? What did you dislike about it?

8. a. Have you ever participated in e-mail discussion groups?
☐ Yes
☐ No (please skip to question 9)

b. If yes, please describe. What did you like about it? What did you dislike about it?

Technology

9. a. Do you have reliable access to a computer?
☐ Yes
☐ No (please skip to question 9c)

b. If yes, is the computer your own computer?
☐ Yes
☐ No

c. If you do not currently have reliable access to a computer, would it be feasible for you to participate in a distance learning program by using an Internet café or by some other means?
   - ☐ Yes
   - ☐ No
   - ☐ I do not know

   Please explain: _____

10. If your access to the Internet is not free, would the cost of using a computer at an Internet café be prohibitive for you to participate in a distance learning program?
    - ☐ Yes
    - ☐ No
    - ☐ I do not know

11. Does the computer you have access to have:
    a. A CD-ROM drive
       - ☐ Yes
       - ☐ No
       - ☐ I do not know

    b. Speakers
       - ☐ Yes
       - ☐ No
       - ☐ I do not know

    c. An operating system other than Windows (e.g, Macintosh OSX)?
       - ☐ Yes (please specify: _____)
       - ☐ No

    d. Adobe Acrobat Reader?
       - ☐ Yes
       - ☐ No
       - ☐ I do not know

    e. Macromedia Flash Player?
       - ☐ Yes
       - ☐ No
       - ☐ I do not know

12. Are you comfortable using software programs such as Word, Excel, and PowerPoint?
    - ☐ Yes
    - ☐ No

13. a. Do you have reliable access to the Internet?
       - ☐ Yes
       - ☐ No (please skip to question 14)

    b. If you have access to the Internet, on average, how long do you stay online each week?
       - ☐ 0–30 minutes
       - ☐ 30 minutes–1 hour

- ☐ 1–2 hours
- ☐ 2–5 hours
- ☐ 5 or more hours

c. What speed Internet connection do you have?
- ☐ 28Kbps
- ☐ 56Kbps
- ☐ 128Kbps
- ☐ 256Kbps or higher
- ☐ I do not know

d. What Internet browser do you use?
- ☐ Internet Explorer_____ (please note version if known)
- ☐ Netscape/Firefox _____(please note version if known)
- ☐ I do not know

14. What do you use the Internet for? Please check all that apply.
- ☐ Visiting news web sites
- ☐ Checking e-mail
- ☐ Visiting social networking sites (e.g., Myspace, Orkut, Friendster)
- ☐ Conducting research
- ☐ Shopping
- ☐ Participating in online learning
- ☐ Other _____

15. a. Do you have an e-mail account at work?
- ☐ Yes
- ☐ No (please skip to question 16)

b. If yes, on average, how often do you check your account?
- ☐ Never
- ☐ Once a month
- ☐ Several times a week
- ☐ Once a day
- ☐ Several times a day

16. a. Do you have a personal e-mail account?
- ☐ Yes
- ☐ No (please skip to question 17)

b. If yes, on average, how often do you check your account?
- ☐ Never
- ☐ Once a month
- ☐ Several times a week
- ☐ Once a day
- ☐ Several times a day

17. Do you have access to a printer?
- ☐ Yes
- ☐ No

18. Would you access and use resources online if they were only available in English?
    - ☐ Yes
    - ☐ No

May we contact you to ask you any follow-up questions regarding your responses?

☐ Yes
☐ No

If yes, please indicate a phone number or e-mail address where we may reach you:

_____

Thank you!

Appendix 1.4: Provider Pretest/Posttest

Provider Pretest/Posttest

Modified Based on Pilot

Note: The explanations below each question are not part of the pretest or posttest. They are here to help the reviewers understand the question and answer. The explanations will also be included in the final CD-ROM product for providers who take the course independently. The explanations will be revealed on the CD-ROM after the provider has made his or her selection. This is not for testing purposes, but to reinforce learning

1. **Treating a client disrespectfully may be offensive to the client, but it is unlikely to affect the client's physical health.**

   True False

   Answer: **False**

   If a client is treated disrespectfully, he/she may choose not to return for medical care. He/she may not ask questions about how to take medicine or use a contraceptive device and may do it incorrectly at home. He/she may not speak to the provider about symptoms, which may lead to an incorrect diagnosis.

2. **A really conscientious health provider can eliminate his or her own prejudices or negative assumptions about certain types of clients.**

   True False

   Answer: **False**

   All of us have uncomfortable feelings about certain groups of people, based on race, ethnicity, age, sex, socioeconomic class, etc. Internal cultural competence is an ability to recognize and manage our prejudices so they do not affect our work with clients.

3. **Which of the following is true?**
   a. A culturally competent provider is willing to question or put into doubt his negative thoughts about others.
   b. A provider who is prejudiced considers each individual in a group to be unique.
   c. A culturally competent provider recognizes that prejudices are always based on false information and lies about other groups.

   Answer: **a**

   Everyone has negative thoughts about certain groups of people. Some of these negative thoughts may in fact be true about some individuals within the group. A culturally competent provider will question these thoughts about others and will look for evidence as to whether that thought is correct about each individual. A prejudiced provider will assume that everyone in the group is the same. A culturally competent provider considers each person to be unique.

4. **When talking to a client about traditional medical providers (e.g., *curanderas*), it is important to explain that such providers have no medical training and can offer no useful medical advice.**

   True False

   Answer: **False**

Many traditional providers, such as *curanderas,* are highly respected and trusted in their communities. It is unlikely that a doctor or nurse will be able to change this simply by speaking ill of the *curandera*. It is more effective to differentiate roles. "I have an expertise in modern medicine. The *curandera* is knowledgeable about something else. It is important that you come to receive treatment from me (modern medical provider) and that you tell me what the *curandera* suggests, so that I can ensure that our advice does not conflict."

5. **If you find that your client is using traditional medicine, you should gently explain that what she is doing is not based in modern science and is wrong.**

   True False

   Answer: **False**

   Many people simply will not believe you if you tell them that a lifelong belief or practice is wrong. It is often best is to talk about *differences* in belief systems and practices. "I understand that in your community, you do X. In medical school, we learn that Y is most effective. Perhaps you can do both." This type of dialogue is more effective than explaining to the client that his or her beliefs and practices are wrong, even if you say it nicely. Only when the practice is dangerous should the provider tell the client to stop doing it.

6. **Many rural Aymara and Quechua women believe that colostrum is harmful for the newborn because it is yellow and resembles pus. Many believe that colostrum has accumulated a long time in the breast and might have accumulated "bad" things, such as worries, pains, and other harm that happened to the mother. What is the most effective way for the provider to convince his client that this belief is wrong? (*Note:* This is a modified version of the original question; see Appendix 3.5: Provider Pretest/Posttest with Results and Analysis.)**

   a. Tell her that educated women know that colostrum is healthy for the baby.
   b. Tell her that without colostrum, her child will not have sufficient antibodies and will probably die.
   c. Rather than trying to change her mind by speaking to her alone, try to educate the community as a whole to change social norms.

   Answer: **c**

   Many clients will not believe a health provider who contradicts the ideas of the community. It is often more effective to speak with members of the community in groups, so that everyone can engage in a discussion and learn something new at the same time. It is not useful to invoke what "educated" women know. Many clients will simply think "those women must be different from us." Regarding the consequences of ignoring medical advice, it is never a good idea to exaggerate, thereby frightening the client. This will only lead to mistrust in the future.

7. **What have rural Aymara and Quechua women reported about having a gynecological exam?**

   a. They fear that their husbands will be jealous of a male doctor.
   b. They fear a male doctor may be sexually excited during the exam.
   c. They feel it is shameful to expose their genitals.
   d. All of the above

   Answer: **d**

8. **Why do many Aymara and Quechua women choose natural family planning methods rather than modern methods?**

   a. They are not concerned about how many children they have.

   b. They believe that God should decide how many children they have.

   c. They are worried about gaining weight, getting cancer from modern family planning methods, or not being able to work as hard.

   Answer: **c**

   Rural women who must do a lot of physical work are concerned that modern family planning methods such as the IUD can cause pain or weakness. Some women are concerned that modern family methods can cause weight gain. Others fear certain methods may cause cancer.

9. **Which of the following is NOT true about the beliefs of rural Aymara and Quechua clients?**

   a. Many believe that too many antenatal examinations can be harmful for the fetus.

   b. Many believe there is an invisible cat that can cause a child's breath to sound like a cat, while stealing the child's "anima."

   c. Many believe that a pregnant woman should eat only warm foods.

   Answer: **c**

   Pregnant women are supposed to consume foods that are considered to be "cold."

10. **Providers should suggest that their clients deliver their babies in the squatting position (*en cuclillas*), since this is most natural for rural Aymara and Quechua women.**

    True False

    Answer: **False**

    Providers should ask about their clients' preferences rather than making such suggestions. Some, but not all, rural Aymara and Quechua clients prefer to deliver their babies *en cuclillas*. Others prefer to recline. Similarly, some (but not all) clients will want to take possession of the placenta.

11. **Which is an example of an open-ended question?**

    a. "Do you have pain when you urinate?"

    b. "How is your illness?"

    c. "Are you getting better?"

    Answer: **b**

    An open-ended question cannot be answered "yes" or "no." The question encourages a broader answer. Closed-ended questions can be answered with a very short response, such as "Yes" or "No" or "A lot." When getting information from a client, it is useful to use both types of questions.

12. **A client who is fearful of the doctor will be more likely to do what the doctor says.**

    True False

    Answer: **False**

    Clients who are fearful of their providers avoid coming. Further, when they do not understand something, they do not ask questions.

13. Providers who come from the same culture or socioeconomic class as their clients:

a. Have no reason to treat their clients disrespectfully

b. May have a better understanding of their clients' beliefs

c. Both "a" and "b" are true.

Answer: **b**

Some providers have worked hard to distance themselves from the culture or socioeconomic class of their birth. This may cause them to show disrespect for clients who share their cultural or socioeconomic background.

14. Providers should always get the medical history directly from the client rather than from a *promotora*.

True False

Answer: **False**

Clients may feel more comfortable speaking to the *promotora* about their health and may want the *promotora* to relay this information to the provider. This can help put the client at ease and may help the provider get more complete and accurate information. The provider can then ask the client follow-up questions directly.

15. During an antenatal visit, the husband should be encouraged to take a central role in describing his wife's symptoms.

True False

Answer: **False**

Many women are timid in the presence of a medical provider and may be doubly timid in the presence of their husband. The woman knows her symptoms better than her husband does. The provider should encourage the woman to be the protagonist in the visit and should encourage her husband to take a secondary role.

16. Which of the following is true about *señoras de pollera*. (*Note:* This is a modified version of the original question; see Appendix 3.5: Provider Pretest/Posttest with Results and Analysis.)

a. They all have a very poor understanding of anatomy and physiology.

b. They all tend to listen to the advice of traditional healers (such as *curanderas*) and ignore the advice of modern medical providers.

c. They all want to have many children.

d. none of the above

Answer: **a**

Señoras de pollera are unique individuals with different wishes, levels of understanding, and practices.

Appendix 2:
Informed Consent Statements[5]

Appendix 2.1: Informed Consent for Provider Interviews

Interviewer: Please Read to Participant

Hello. My name is _____. I am working with two international entities—the ACQUIRE Project, an international project working in family planning and reproductive health, and Management Sciences for Health (MSH), an international agency working in health—to learn about cultural issues. As part of this, I would like to ask your experiences with and opinions towards health care at this facility.

We will protect information about you and your taking part in this research to the best of our ability. You will not be named in any reports. However, the staff of MSH and EngenderHealth may sometimes look at records. You will not be asked to sign this consent form. Instead, when we tape-record the interview, we will ask you to give verbal consent for being in this research. Your consent will be recorded on tape.

We will not write your name on the audiotape used to record the interview or on anything else that might let someone know what you said. If you decide to take part in our research, your name will not appear on any document. Your name will not be linked with the research information in any way.

Your participation is voluntary. There is no penalty for refusing to take part. You are free to stop participation at any time in the study. Your employment here will not be affected if you refuse to participate in or if you drop out of this study.

There is no risk to you in participating in the study beyond mild discomfort you may feel talking about family planning and intercultural issues.

This interview should take approximately an hour to an hour and a half to complete. You are free to ask questions, and you only need to respond to those questions that you wish to answer.

Do you have any questions? Do I have your agreement to participate?

If you need to contact us after the discussion with any questions, please contact (insert names of directors for CIES and APROSAR).

[5] *Note:* These are model forms. Many agencies may have their own informed consent forms.

Certification by the Facilitator

I, the undersigned, certify that I have reviewed the informed consent form with the interview participant, and s/he has voluntarily agreed to participate in this interview. I further agree to keep confidential anything that is said in the interview.

_____

Facilitator's name (print clearly)

_____ _____

Facilitator's signature Date

Appendix 2.2: Informed Consent for Focus Group Discussion

Facilitator: Read aloud to participants separately. When the group comes together, read aloud again to confirm consent as a group.

Hello. My name is _____. I am working with two international entities—the ACQUIRE Project, an international project working in family planning and reproductive health, and Management Sciences for Health, an international agency working in health—to learn about cultural issues. We are working with the Ministry of Health to improve cross-cultural communication between providers and clients in order to provide quality reproductive health services. As part of this effort, I would like to ask your experiences with and opinions towards health care at this facility.

We will protect information about you and your taking part in this research to the best of our ability. You will not be named in any reports. You will not be asked to sign this consent form. Instead, when we tape-record the interview, we will ask you to give verbal consent for being in this research. Your consent will be recorded on tape

We will not write your name on the audiotape used to record the interview or on anything else that might let someone know what you said. If you decide to take part in our research, your name will not appear on any document. Your name will not be linked with the research information in any way.

Although we will make every effort to protect your confidentiality, other people in the group will hear what you have to say, and might tell others about it. We will ask all participants to refrain from telling others about what they hear in this discussion today.

Your participation is voluntary. There is no penalty for refusing to take part. You are free to stop participation at any time in the study.

There is no risk to you in participating in the study beyond mild discomfort you may feel talking about family planning and intercultural issues.

There are no direct benefits to you for taking part in this research, although you will be given a nominal stipend of _____ to pay for your travel. What we learn in this research may benefit others in your community. It may help improve information about family planning.

Do you have any questions at this time? Do you agree to participate?

If you need to contact us after the discussion with any questions, please contact the family planning in-charge at the center.

Certification by the Facilitator

I, the undersigned, certify that I have reviewed the informed consent form with interview participant, and they have voluntarily agreed to participate in this interview. I further agree to keep confidential anything that is said in the interview.

_____

Facilitator's name (print clearly)

_____ _____

Facilitator's signature Date

Appendix 2.3: Informed Concent for Client Interviews

Interviewer: Read the following aloud to the participant.

Hello. My name is _____. I am working with two international entities—the ACQUIRE Project, an international project working in family planning and reproductive health, and Management Sciences for Health (MSH), an international agency working in health—to learn about cultural issues. We are working with the Ministry of Health to improve cross-cultural communication between providers and clients in order to provide quality reproductive health services. As part of this, I would like to ask your experiences with and opinions towards health care at this facility.

We will protect information about you and your taking part in this research to the best of our ability. You will not be named in any reports. However, the staff of MSH and EngenderHealth may sometimes look at records. You will not be asked to sign this consent form. Instead, when we tape-record the interview, we will ask you to give verbal consent for being in this research. Your consent will be recorded on tape.

We will not write your name on the audiotape used to record the interview or on anything else that might let someone know what you said. If you decide to take part in our research, your name will not appear on any document. Your name will not be linked with the research information in any way.

Your participation is voluntary. There is no penalty for refusing to take part. The health care you receive now and in the future will not be affected. You are free to stop participation at any time in the study.

There is no risk to you in participating in the study beyond mild discomfort you may feel talking about family planning and intercultural issues.

This interview should take approximately an hour to an hour and a half to complete. You are free to ask questions, and you only need to respond to those questions that you wish to answer.

Do you have any questions? Do I have your agreement to participate?

If you need to contact us after the discussion with any questions, please contact (insert names of directors for CIES and APROSAR).

Certification by the Facilitator

I, the undersigned, certify that I have reviewed the informed consent form with the interview participant, and s/he has voluntarily agreed to participate in this interview. I further agree to keep confidential anything that is said in the interview.

_____
Facilitator's name (print clearly)

_____ _____
Facilitator's signature Date

Appendix 2.4: Informed Concent for Photo Documentation and Storytelling

Photography/Story Consent Form

By checking below, I hereby consent to have my picture taken and/or my story used, for reproduction, display, and dissemination worldwide in a variety of ways around the world for the public to see and read. EngenderHealth promotional materials include, but are not limited to: newsletters, brochures, reports to EngenderHealth's financial supporters, and/or Web site articles. I also understand that my participation is voluntary and there is no penalty for refusing to take part. *When applicable: If you choose not to be interviewed or have your photo taken, your current and future care at this facility will not be affected in any way.*

Please check your preference:

Photo

_____ I agree to allow EngenderHealth to use both my image and my name.

_____ I agree to allow EngenderHealth to use **only** my image. I do not want my name associated with the photo.

Story

_____ I agree to allow EngenderHealth to use my story/interview as described above.

_____ I agree to allow EngenderHealth to use my story/interview and **not** my name.

Signature: _____

Date: _____

The information below is to be completed by the photographer/interviewer.

N

Name of Subject/(Client, Provider, etc.): _____

Photographer/interviewer name: _____

Location/Country: _____

Photo/Story Subject: _____

Name of Hospital/Clinic/Village, etc. _____

Notes: _____

Appendix 3:
Evaluation Instruments and Results

Appendix 3.1: Client Exit Interview Instructions

Client Exit Interviews will be used to measure changes in provider communication skills as reported by clients. It will also measure changes in how clients felt about the clinical visit. The interview will be in the form of a multiple-choice pretest/posttest that will be read to the client. A total of **91 female reproductive health clients** will be interviewed at CIES and APROSAR over a two-week period prior to initiating the training.[6] Another 91 clients will be interviewed beginning two weeks after the conclusion of the training, over a two-week period (weeks 3 and 4 after the training). The purpose for waiting two weeks after the training is to allow the providers some time to think about and integrate what they have learned into their practices.

Selection of Clients

The 91 clients will be made up of 45 clients from CIES and 46 clients from APROSAR. Within APROSAR, 23 clients will be interviewed in the clinic and 23 clients will be interviewed in *el campo*.

Interviewers: You will need to confirm the following with clients before proceeding with the interview.

Client Selection Criteria

1. Female reproductive health clients of any age, either married or unmarried.
2. Reproductive health clients are defined as clients who receive: counseling in family planning, receive an IUD, injectable contraceptives, condoms, or any other form of contraceptive; who receive prenatal or postnatal care; or who are seen for any gynecological problem including infection or discomfort. **If the client has not received any of these services, thank her and proceed to another client.**
3. Seen today by one or more of the providers participating in the training. **If the client has not received any of these services from doctors who will be participating in the training, thank her and proceed to another client.**
4. Most recent pelvic exam was done today or in the past by a provider participating in the course. **If the client has not undergone a pelvic exam with doctors who will be participating in the training, thank her and proceed to another client.**

Recommendations for Conducting the Client Exit Interviews

1. Read the question just as it appears on the page. Do not add your own explanation or interpretation of the question, as this could jeopardize the standardized nature of the survey. It is essential for the successful completion of this survey.
2. If the respondent responds "I do not know" to a question, you can say "Do not worry. Take your time and think about it."

[6] The sample refers to estimated sample size. Actual sample sizes were 105 at pretest and 100 at posttest.

3. If the respondent provides more than one answer that does not relate to the question, you can "Would you say it is closer to _____ or to _____" or else "If you had to give one response, what would it be?"
4. If the respondent provides an answer that does not relate to the question, respond to the respondent's question (saying "Yes, I understand"), but then repeat the question exactly as it appears in the survey. Do not try to interpret the question for the respondent.

Appendix 3.2: Client Exit Survey

Interviewer: **Introduce yourself to the client and read the following greeting**.

Site: ☐ CIES ☐ APROSAR

Client code: | | | |

Round of data collection: ☐ Pretest ☐ Posttest

Date: | | | DAY | | | MONTH | | | | YEAR

Informed consent for interviews with clients

Hello. My name is _____. I am working with two international entities—the ACQUIRE Project, an international project working in family planning and reproductive health, and Management Sciences for Health (MSH), an international agency working in health—to learn about cultural issues. We are working with the Ministry of Health to improve cross-cultural communication between providers and clients in order to provide quality reproductive health services. As part of this, I would like to ask your experiences with and opinions toward health care at this facility.

We will protect information about you and your taking part in this research to the best of our ability. You will not be named in any reports. However, the staff of MSH and EngenderHealth may sometimes look at records. You will not be asked to sign this consent form, but will be asked to give verbal consent.

We will not write your name on this form or on anything else that might let someone know what you said. If you decide to take part in our research, your name will not appear on any document. Your name will not be linked with the research information in any way.

Your participation is voluntary. There is no penalty for refusing to take part. The health care you receive now and in the future will not be affected. You are free to stop participation at any time in the study.

There is no risk to you in participating in the study beyond mild discomfort you may feel talking about family planning and intercultural issues.

This interview should take approximately X–X minutes to complete. You are free to ask questions, and you only need to respond to those questions that you wish to answer.

Do you have any questions? Do I have your agreement to participate?

If you need to contact us after the discussion with any questions, please contact (insert names of directors for CIES and APROSAR).

Certification by the interviewer

I, the undersigned, certify that I have reviewed the informed consent form with the interview participant, and s/he has voluntarily agreed to participate in this interview. I further agree to keep confidential anything that is said in the interview.

_____

Facilitator's name (print clearly)

_____ _____

Facilitator's signature Date

A. Did the client receive reproductive health services? By reproductive health services, we mean be counseled about family planning; receive an IUD, injectable contraceptives, condoms, or any other form of contraceptive; receive antenatal or postnatal care; or be seen for any gynecologic problem, including infection or discomfort.

Yes No (If "No," thank the client and terminate the interview.)

B. Was the client seen today by one or more of the providers participating in the training?

Yes No (If "No," thank the client and terminate the interview.)

C. Did the client undergo a pelvic exam today or in the past by a provider participating in the course?

Yes No (If "No," thank the client and terminate the interview.)

If the client answered "Yes" to questions A–C, proceed with the survey.

1. The providers at CIES/APROSAR use words that are difficult for me to understand.

Always Frequently Rarely Never

2. I feel comfortable telling the providers at CIES/APROSAR about personal things about my body.

Always Frequently Rarely Never

3. The providers at CIES/APROSAR treat me with respect.

Always Frequently Rarely Never

4. The providers at CIES/APROSAR explain things clearly.

Always Frequently Rarely Never

5. The providers at CIES/APROSAR treat me with disrespect because of the color of my skin or the clothes I wear.

Always Frequently Rarely Never

6. I tell the providers at CIES/APROSAR about my use of traditional medicine (such as herbs and the use of animals).

Always Frequently Rarely Never

7. My doctor makes me feel comfortable during an examination of my private parts.

   Always Frequently Rarely Never

8. I understand why it is important for my doctor to examine my private parts.

   Completely Mostly A little Not at all

9. I understand how to use the contraceptives that the providers at CIES/APROSAR have prescribed.

   Completely Partially Not at all Not applicable

10. When I do not understand what my doctor says, I ask questions.

    Always Frequently Rarely Never

11. I prefer to receive health services from the *curandera* than from the providers at CIES/APROSAR.

    Always Frequently Rarely Never

12. I speak openly with the providers at CIES/APROSAR about the side effects of contraceptives and other medication.

    Always Frequently Rarely Never

13. I trust that the providers at CIES/APROSAR are concerned about my well-being.

    Always Frequently Rarely Never

14. The providers at CIES/APROSAR know how to take care of a pregnant woman better than healers [use correct term for this kind of healer] in my community.

    Always Frequently Rarely Never

15. The providers at CIES/APROSAR say things that hurt my feelings.

    Always Frequently Rarely Never

May I ask you some more questions, to learn a little bit more about you?

16. What is your current marital status?

    Married Single Divorced Separated Widowed Concubine

17. Do you have any children?

    Yes No

18. Overall, how satisfied would you say you are with the service you received today?

    Completely Very A little Not at all

19. Do you normally wear traditional clothing, such as *una pollera*?

    Yes No

Appendix 3.3: CIES Client Exit Interview Results

1. The providers at CIES use words that are difficult for me to understand.

	Pretest	Posttest
a. Always	a. 4%	a. 4%
b. Frequently	b. 2%	b. 0%
c. Rarely	c. 31%	c. 25%
d. Never	d. 63%	d. 71%

2. I feel comfortable telling the provider at CIES personal things about my body.

	Pretest	Posttest
a. Always	a. 58%	a. 56%
b. Frequently	b. 10%	b. 16%
c. Rarely	c. 31%	c. 27%
d. Never	d. 2%	d. 0%

3. The providers at CIES treat me with respect.

	Pretest	Posttest
a. Always	a. 90%	a. 96%
b. Frequently	b. 6%	b. 4%
c. Rarely	c. 4%	c. 0%
d. Never	d. 0%	d. 0%

4. The providers at CIES explain things clearly.

	Pretest	Posttest
a. Always	a. 54%	a. 58%
b. Frequently	b. 25%	b. 27%
c. Rarely	c. 21%	c. 15%
d. Never	d. 0%	d. 0%

Note: Comparing questions 1 and 4 demonstrates that it is useful to ask the same question with different words.

5. The providers at CIES treat me with disrespect, because of the color of my skin or the clothes I wear.

	Pretest	Posttest
a. Always	a. 0%	a. 0%
b. Frequently	b. 0%	b. 0%
c. Rarely	c. 4%	c. 0%
d. Never	d. 96%	d. 100%

6. I tell the providers at CIES about my use of traditional medicine (such as herbs and the use of animals).

	Pretest	Posttest
a. Always	a. 0%	a. 4%
b. Frequently	b. 0%	b. 0%
c. Rarely	c. 10%	c. 4%
d. Never	d. 90%	d. 93%

7. My doctor makes me feel comfortable during an examination of my private parts.

	Pretest	Posttest
a. Always	a. 54%	a. 44%
b. Frequently	b. 12%	b. 25%
c. Rarely	c. 31%	c. 29%
d. Never	d. 4%	d. 2%

8. I understand why it is important for my doctor to examine my private parts.

	Pretest	Posttest
a. Completely	a. 40%	a. 42%
b. For the most part	b. 56%	b. 40%
c. A little	c. 4%	c. 16%
d. Not at all	d. 0%	d. 2%

9. I understand how to use the contraceptives that the providers at CIES have prescribed.

	Pretest	Posttest
a. Completely	a. 65%	a. 29%
b. In part	b. 15%	b. 24%
c. Not at all	c. 2%	c. 2%
d. Never	d. 15%	d. 45%

Discussion: This question is flawed, in that it should have had "I do not use contraceptives" as one of the choices.

10. When I do not understand what my doctor says, I ask questions.

	Pretest	Posttest
a. Always	a. 45%	a. 29%
b. Frequently	b. 17%	b. 24%
c. Rarely	c. 37%	c. 42%
d. Never	d. 10%	d. 5%

11. I prefer to receive health services from a *curandera* than from the providers at CIES.

	Pretest	Posttest
a. Always	a. 12%	a. 5%
b. Frequently	b. 2%	b. 2%
c. Rarely	c. 12%	c. 5%
d. Never	d. 75%	d. 87%

12. I speak openly with the providers at CIES about the side effects of contraceptives and other medications.

	Pretest	Posttest
a. Always	a. 25%	a. 29%
b. Frequently	b. 10%	b. 11%
c. Rarely	c. 33%	c. 13%
d. Never	d. 33%	d. 47%

Note: This question is flawed in that it should have had "I do not use contraceptives" as one of the choices.

13. I trust that from the providers at CIES are concerned about my well-being.

	Pretest	Posttest
a. Always	a. 52%	a. 56%
b. Frequently	b. 21%	b. 16%
c. Rarely	c. 27%	c. 20%
d. Never	d. 0%	d. 7%

14. The providers at CIES know how to take care of a pregnant woman better than the [healers] in my community.

	Pretest	Posttest
a. Always	a. 83%	a. 87%
b. Frequently	b. 15%	b. 7%
c. Rarely	c. 2%	c. 4%
d. Never	d. 0%	d. 2%

15. The providers at CIES say things that hurt my feelings.

	Pretest	Posttest
a. Always	a. 2%	a. 0%
b. Frequently	b. 0%	b. 0%
c. Rarely	c. 12%	c. 11%
d. Never	d. 87%	d. 89%

16. What is your current marital status?

	Pretest	Posttest
a. Married	a. 52%	a. 67%
b. Single	b. 25%	b. 20%
c. Divorced	c. 0%	c. 0%
d. Separated	d. 0%	d. 0%
e. Widowed	e. 0%	e. 2%
f. Concubine	f. 23%	f. 11%

17. Do you have any children?

	Pretest	Posttest
a. Yes	a. 67%	a. 64%
b. No	b. 33%	b. 36%

18. Overall, how satisfied would you say you are with the service you received today?

	Pretest	Posttest
a. Completely	a. 8%	a. 16%
b. Very satisfied	b. 58%	b. 60%
c. A little	c. 27%	c. 20%
d. Not at all	d. 4%	d. 4%
e. No response	e. 4%	e. 0%

19. Do you normally wear traditional clothing, such as *una pollera*?

	Pretest	Posttest
a. Yes	a. 4%	a. 13%
b. No	b.94%	b. 87%
c. No response	c.2%	c. 0%

Appendix 3.4: APROSAR Client Exit Interview Results

The selection of clients at APROSAR was problematic, and those data cannot be used to evaluate the effectiveness of the provider training. For the pretest, some of the APROSAR clients were to be interviewed on-site at the clinic, and other APROSAR clients were to be interviewed in a rural area. It was later determined that 28 clients who were interviewed in the rural area of Quillacas had not been seen by an APROSAR provider and therefore had to be eliminated from the sample. More problematic was that because only a small number of clients were coming to the clinic, the interviewers went to clients' homes to interview them. These were selected by a nurse, who chose clients whom she knew best. After the provider training, one participant left APROSAR and was replaced by another. This meant that the impact of the training on the provider who left could not be measured. Further, some of the clients interviewed for the posttest were reporting on the behavior of a provider who had not participated in the training. Nevertheless, the APROSAR data are very interesting in regard to clients' responses about the care they receive. Unfortunately, the data are not relevant for evaluating the training program delivered in this project. Perhaps it could be used for a future project. This data are labeled "first and second round" of interviews because they do not relate to pretraining and posttraining. Clients in the first and second round are not comparable. Clients in the first round are more likely to have been selected by the nurse who knew them personally.

1. The providers at APROSAR use words that are difficult for me to understand.

	First Round	Second Round
a. Always	a. 12%	a. 20%
b. Frequently	b. 0%	b. 7%
c. Rarely	c. 48%	c. 49%
d. Never	d. 40%	d. 24%

2. I feel comfortable telling my provider at APROSAR personal things about my body.

	First Round	Second Round
a. Always	a. 60%	a. 29%
b. Frequently	b. 4%	b. 20%
c. Rarely	c. 36%	c. 42%
d. Never	a. 0%	d. 9%

3. The providers at APROSAR treat me with respect.

	First Round	Second Round
a. Always	a. 88%	a. 87%
b. Frequently	b. 4%	b. 4%
c. Rarely	c. 4%	c. 9%
d. Never	d. 0%	d. 0%

4. The providers at APROSAR explain things clearly.

	First Round	Second Round
a. Always	a. 44%	a. 38%
b. Frequently	b. 16%	b. 20%
c. Rarely	c. 36%	c. 38%
d. Never	d. 4%	d. 4%

Note: Comparing questions 1 and 4 demonstrates that it is useful to ask the same question with different words. What is remarkable about Question 4 is that for APROSAR, only 60% of clients in

the first round and 58% in the second round reported that their providers explained things clearly "always" or "frequently."

5. The providers at APROSAR treat me with disrespect, because of the color of my skin or the clothes I wear.

	First Round	Second Round
a. Always	a. 0%	a. 0%
b. Frequently	b. 0%	b. 0%
c. Rarely	c. 4%	c. 4%
d. Never	d. 96%	d. 96%

6. I tell the providers at APROSAR about my use of traditional medicine (such as herbs and the use of animals).

	First Round	Second Round
a. Always	a. 0%	a. 9%
b. Frequently	b. 0%	b. 0%
c. Rarely	c. 16%	c. 16%
d. Never	d. 84%	d. 93%

7. My doctor makes me feel comfortable during an examination of my private parts.

	First Round	Second Round
a. Always	a. 36%	a. 9%
b. Frequently	b. 12%	b. 22%
c. Rarely	c. 44%	c. 51%
d. Never	d. 8%	d. 13%

8. I understand why it is important for my doctor to examine my private parts.

	First Round	Second Round
a. Completely	a. 40%	a. 16%
b. For the most part	b. 40%	b. 51%
c. A little	c. 12%	c. 42%
d. Not at all	d. 4%	d. 4%

9. I understand how to use the contraceptives that the providers at APROSAR have prescribed.

	First Round	Second Round
a. Completely	a. 40%	a. 20%
b. For the most part	b. 20%	b. 18%
c. A little	c. 0%	c. 13%
d. Not at all	d. 40%	d. 49%

Discussion: This question is flawed, in that it should have had "I do not use contraceptives" as one of the choices.

10. When I do not understand what my doctor says, I ask questions.

	First Round	Second Round
a. Always	a. 32%	a. 24%
b. Frequently	b. 8%	b. 13%
c. Rarely	c. 38%	c. 44%
d. Never	d. 4%	d. 18%
e. No response	e. 8%	e. 0%

11. I prefer to receive health services from a *curandera* than from the providers at APROSAR.

	First Round	Second Round
a. Always	a. 20%	a. 7%
b. Frequently	b. 8%	b. 0%
c. Rarely	c. 16%	c. 16%
d. Never	d. 56%	d. 78%

12. I speak openly with the providers at APROSAR about the side effects of contraceptives and other medications.

	First Round	Second Round
a. Always	a. 24%	a. 22%
b. Frequently	b. 8%	b. 9%
c. Rarely	c. 12%	c. 20%
d. Never	d. 56%	d. 49%

Discussion: This question is flawed in that it should have had "I do not use contraceptives" as one of the choices.

13. I trust that the providers at APROSAR are concerned about my well-being.

	First Round	Second Round
a. Always	a. 44%	a. 40%
b. Frequently	b. 14%	b. 18%
c. Rarely	c. 32%	c. 33%
d. Never	d. 4%	d. 9%
e. No response	e. 4%	e. 0%

14. The providers at APROSAR know how to take care of a pregnant woman better than the [healers] in my community.

	First Round	Second Round
a. Always	a. 68%	a. 73%
b. Frequently	b. 24%	b. 11%
c. Rarely	c. 4%	c. 13%
d. Never	d. 4%	d. 2%

15. The providers at APROSAR say things that hurt my feelings.

	First Round	Second Round
a. Always	a. 0%	a. 0%
b. Frequently	b. 0%	b. 0%
c. Rarely	c. 28%	c. 7%
d. Never	d. 72%	d. 93%

16. What is your civil status?

	First Round	Second Round
a. Married	a. 48%	a. 87%
b. Single	b. 16%	b. 2%
c. Divorced/separated	c. 4%	c. 2%
d. Widowed	d. 0%	d. 0%
e. Concubine	e. 32%	e. 9%

17. Do you have any children?

	First Round	Second Round
a. Yes	a. 88%	a. 93%
b. No	b. 12%	b. 7%

18. Overall, how satisfied would you say you are with the service you received today?

	First Round	Second Round
a. Completely	a. 8%	a. 2%
b. Very satisfied	b. 64%	b. 40%
c. A little	c. 28%	c. 44%
d. Not at all	d. 0%	d. 13%

19. Do you normally wear traditional clothing, such as *una pollera*?

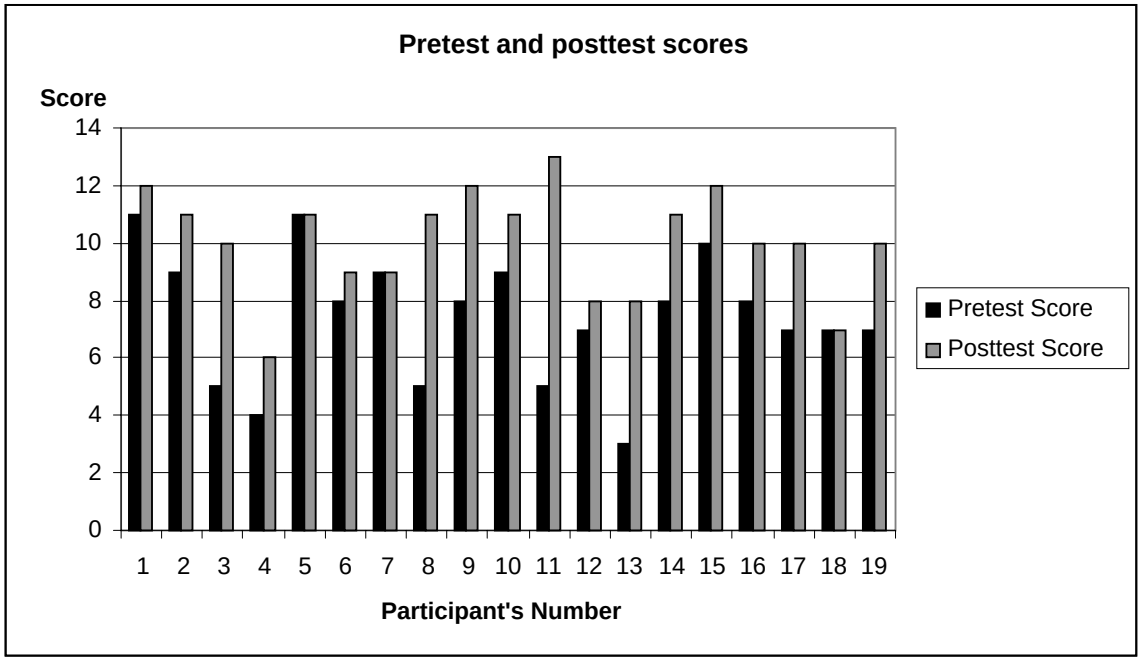
	First Round	Second Round
a. Yes	a. 44%	a. 58%
b. No	b. 56%	b. 42%

Appendix 3.5: Provider Pretest/Posttest, with Results and Analysis

Analysis by participants
(note that 19 participants were included in this analysis)

Providers' pretest and posttest scores for the cultural competency training are presented in Figure 1 below.

Figure A-1. Pretest and posttest scores, by participant



The pretest yielded a mean of eight correct answers out of 16 possible ones.

In general, participants improved their knowledge as tested by the instrument. The posttest yielded a mean of 10 correct answers. Mean improvement was 2.4 correct answers (median 2, mode 1, range -1 to 8).

To determine whether the difference in scores between the pretest and posttest was statistically significant, we used a paired t-test.

Table A-1: Results of t-test

	Pretest	Posttest
Mean	7.42	10.05
Variance	5.04	3.39
Observations	19	19
Pearson correlation	0.45	
Hypothesized mean difference	0	
df	18	
t stat	–5.30	
P(T<=t) one-tail	0.0000	
t Critical one-tail	1.73	
P(T<=t) two-tail	0.0000	
t Critical two-tail	2.10	

In Table A-1, Rows 1, 2, and 3 present the mean, variance, and number of observations for each test. So we can see that the mean score rose from 7.4 at pretest to 10.0 at posttest, and the variance dropped over time. Row 4 is the "pooled" variance (i.e., for both samples together), which is used to calculate the t statistic. Row 5 gives the hypothesized mean difference (usually zero). Row 7 presents the t statistic: The higher the absolute value of the t statistic is, the less similar the means of the two samples are. Row 8 gives the one-tailed probability that the t statistic calculated for the data is lower than or equal to the critical t-value (given in row 9). Rows 10 and 11 give the probability and critical t-value for two tails.

We used a Pearson correlation to determine if there was a relationship between the overall group's pretest and posttest. The Pearson correlation show that there is a strong relationship ($r = 0.45$) between the pretest and the posttest. We computed a paired sample t-test to determine the paired differences between the pretest and posttest. Our results show the mean of the paired differences was 2.6 ($SD = 2.2$). The difference showed a t value of –5.3 with a p value of <.0000. The data results show there was a statistically significant difference between the pretest and the posttest.

Limitations of the Provider Pretests and Posttests

1. This was a small sample. There were only 20 providers, and one provider entered the course late, so there were only 19 matched results.
2. The professional and educational levels of the participants were heterogeneous, with some having difficulty using the CD-ROM because of limited computer experience and some having low literacy. Many of the participants had little experience with multiple-choice questions and were not able to handle combined answers (such as "Both 'a' and 'b' are true") or negative questions (such as "Which of the following is NOT true?").

Below we present an analysis by question, with a description of the correct answer and the pre- and posttest tallies.

Analysis by questions

1. Treating a client disrespectfully may be offensive to the client, but it is unlikely to affect the client's physical health.

   True False

   Answer: **False**

   If a client is treated disrespectfully, he/she may choose not to return for medical care. He/she may not ask questions about how to take medicine or use a contraceptive device and may do it incorrectly at home. He/she may not speak to the provider about symptoms, which may lead to an incorrect diagnosis.

Question 1	**Pretest**	**Posttest**
Correct Answers	12	15

2. A really conscientious health provider can eliminate his or her own prejudices or negative assumptions about certain types of clients.

   True False

   Answer: **False**

All of us have uncomfortable feelings about certain groups of people, based on race, ethnicity, age, sex, socioeconomic class, etc. Internal cultural competence is an ability to recognize and manage our prejudices so they do not affect our work with clients.

Question 2	Pretest	Posttest
Correct Answers	6	1

Note: More emphasis should be made in the CD-ROM and the course that prejudices can NOT be *eliminated*, but can be *managed*.

3. Which of the following is true?
   a. A culturally competent provider is willing to question or put into doubt his negative thoughts about others.
   b. A provider who is prejudiced considers each individual in a group to be unique.
   c. A culturally competent provider recognizes that prejudices are always based on false information and lies about other groups.

   Answer: **a**

   Response B: A prejudiced provider will judge a person based on the group to which he or she belongs, assuming that everyone in the group is the same. A culturally competent provider considers each person to be unique.

   Response C: Biases are not always based on incorrect information or lies. Often they are based on real experiences. Nevertheless, this does not justify generalizing these experiences to all and to each member of the same group of people.

   Certain negative thoughts or prejudices may in fact be based on information that MAY or MAY NOT be true about individuals within a group. A culturally competent provider questions his/her negative thoughts about others and looks for evidence as to whether that thought is correct about each individual. The resulting thought pattern becomes, "Some people with green hair are foolish." instead of "All people with green hair are foolish." With more exposure to individuals with green hair, the provider may conclude that, "Very few people with green hair are foolish."

Question 3	Pretest	Posttest
Correct Answers	7	11

Note: Many respondents chose answer C. More emphasis in the CD and in the course should be made that prejudices are not always based on false information and lies, but can actually be based on real information on one case, which was then falsely generalized.

4. When talking to a client about traditional medical providers (e.g., *curanderas*), it is important to explain that such providers have no medical training and can offer no useful medical advice.

   True False

   Answer: **False**

   Many traditional providers such as *curanderas* are highly respected and trusted in their communities. It is unlikely that a doctor or nurse will be able to change this simply by speaking ill of the *curandera*. It is more effective to differentiate roles. "I have an expertise in modern medicine. The *curandera* is knowledgeable about something else. It is important that you come to receive treatment from me (modern medical provider) and that you tell me what the *curandera* suggests so that I can ensure that our advice does not conflict."

Question 4	Pretest	Posttest
Correct Answers	12	17

5. If you find that your client is using traditional medicine you should gently explain that what she is doing is not based in modern science and is wrong.

   True False

   Answer: **False**

   Many people simply will not believe you if you tell them a lifelong belief or practice is wrong. It is often best is to talk about *differences* in belief systems and practices. "I understand that in your community you do X. In medical school, we learn that Y is most effective. Perhaps you can do both." This type of dialogue is more effective than explaining to the patient that his beliefs and practices are wrong, even if you say it nicely. Only when the practice is dangerous should the provider tell the client to stop doing it.

Question 5	**Pretest**	**Posttest**
Correct Answers	13	17

6. Many rural Aymara and Quechua women believe that colostrum is harmful for the newborn because it is yellow and resembles pus. Many believe that colostrum has accumulated a long time in the breast and might have accumulated "bad" things such as worries, pains and other harm which happened to the mother. What is the most effective way for the provider to convince his client that this belief is wrong?
   a. Educate her community about the health benefits of colostrum.
   b. Tell her that educated women know that colostrum is healthy for the baby.
   c. Tell her that without calostrum, her child will not have sufficient anti-bodies and will probably die.

   Answer: **a**

   Many clients will not believe a health provider who contradicts the ideas of the community. It is often more effective to speak with members of the community in groups, so that everyone can engage in a discussion and learn something new at the same time. It is not useful to invoke what "educated" women know. Many clients will simply think "those women must be different from us." Regarding the consequences of ignoring medical advice, it is never a good idea to exaggerate, thereby frightening the client. This will only lead to mistrust in the future.

Question 6	**Pretest**	**Posttest**
Correct Answers	17	18

   Note: Question 6 did not modify substantially from 17 to 18 correct answers. This question will be modified so the correct answer reads, "Rather than trying to change her mind by speaking to her alone, try to educate the community as a whole in order to change social norms."

7. What have rural Aymara and Quechua women reported about having a gynecological exam?
   a. They fear their husbands will be jealous of a male doctor.
   b. They fear a male doctor may be sexually excited during the exam.
   c. They feel it is shameful to expose their genitals.
   d. All of the above.

   Answer: **d**

Question 7	**Pretest**	**Posttest**
Correct Answers	8	12

8. Why do many Aymara and Quechua women choose natural family planning methods rather than modern methods?
   a. They are not concerned about how many children they have.
   b. They believe that God should decide how many children they have.
   c. They are worried about gaining weight, getting cancer from modern family planning methods, or not being able to work as hard.

   Answer: **c**

   Rural women who must do a lot of physical work are concerned that modern family planning methods such as the IUD can cause pain or weakness. Some women are concerned that modern family methods can cause weight gain. Others fear certain methods may cause cancer.

Question 8	**Pretest**	**Posttest**
Correct Answers	8	13

   Question 8 improved from 8 to 13 correct answers.

9. Which of the following is NOT true about the beliefs of rural Aymara and Quechua clients?
   a. Many believe that too many antenatal examinations can be harmful for the fetus.
   b. Many believe there is an invisible cat that can cause a child's breath to sound like a cat, while stealing the child's "anima."
   c. Many believe that a pregnant woman should eat only warm foods.

   Answer: **c**

   Pregnant women are supposed to consume foods that are considered to be "cold."

Question 9	**Pretest**	**Posttest**
Correct Answers	7	7

   Note: Question 9 did not improve from seven correct answers. The course needs more emphasis on the difference between "fresh" versus "warm" foods.

10. Providers should suggest that their clients deliver their babies in the squatting position (*en cuclillas*), since this is most natural for rural Aymara and Quechua women.

    True False

    Answer: **False**

    Providers should ask about their clients' preferences rather than making such suggestions. Some (but not all) rural Aymara and Quechua clients prefer to deliver their babies *en cuclillas*. Others prefer to recline. Similarly, some (but not all) clients will want to take possession of the placenta.

Question 10	**Pretest**	**Posttest**
Correct Answers	10	3

    Note: Question 10 worsened from 10 to 3 correct answers. The course should reinforce that cultural competent care is based on giving free choice to the client. Providers in the course should be further reminded not to stereotype patients—they should not think all rural patients have the same preferences just because they look alike or dress alike.

11. Which is an example of an open-ended question?
    a. "Do you have pain when you urinate?"
    b. "How is your illness?"
    c. "Are you getting better?"

    Answer: **b**

    An open-ended question cannot be answered yes or no. The question encourages a broader answer. Closed-ended questions can be answered with a very short response, such as "Yes" or "No" or "A lot." When getting information from a client, it is useful to use both types of questions.

Question 11	**Pretest**	**Posttest**
Correct Answers	5	13

12. A client who is fearful of the doctor will be more likely to do what the doctor says.

    True False

    Answer: **False**

    Clients who are fearful of their providers avoid coming. Further, when they do not understand something, they do not ask questions.

Question 12	**Pretest**	**Posttest**
Correct Answers	14	17

13. Providers who come from the same culture or socioeconomic class as their clients:
    a. Have no reason to treat their clients disrespectfully.
    b. May have a better understanding of their clients' beliefs.
    c. Both "a" and "b" are true.

    Answer: **b**

    Some providers have worked hard to distance themselves from the culture or socioeconomic class of their birth. This may cause them to show disrespect for clients who share their cultural or socioeconomic background.

Question 13	**Pretest**	**Posttest**
Correct Answers	11	16

14. Providers should always get the medical history directly from the client rather than from a *promotora*.

    True False

    Answer: **False.**

    Clients may feel more comfortable speaking to the *promotora* about their health and may want the *promotora* to relay this information to the provider. This can help put the client at ease and may help the provider get more complete and accurate information. The provider can then ask follow-up questions directly of the client.

Question 14	**Pretest**	**Posttest**
Correct Answers	8	15

15. During an antenatal visit, the husband should be encouraged to take a central role in describing his wife's symptoms.

    True False

    Answer: **False**.

    Many women are timid in the presence of a medical provider and may be doubly timid in the presence of their husband. The woman knows her symptoms better than her husband does. The provider should encourage the woman to be the protagonist in the visit and encourage her husband to take a secondary role.

Question 15	**Pretest**	**Posttest**
Correct Answers	6	16

16. Which of the following is true about *señoras de pollera*?
    a. They all wear traditional clothing.
    b. They all have a very poor understanding of anatomy and physiology.
    c. They all tend to listen to the advice of traditional healers (such as *curanderas*) and ignore the advice of modern medical providers.
    d. They all want to have many children.
    e. All of the above.

    Answer: **a**

    The only thing that ALL *señoras de pollera* have in common is that they wear traditional clothing. *Señoras de pollera* are unique individuals with different wishes, levels of understanding, and practices.

Question 16	**Pretest**	**Posttest**
Correct Answers	10	5

The last question deteriorated from 10 to 5. The question was ambiguous, in that while the expression *señoras de pollera* refers to women who use traditional dress, they may not always use it and can actually change to modern dress occasionally. Therefore the question will be changed to eliminate option "a", while changing the correct answer to "none of the above" (see Appendix 1.4: Provider Pretest/Posttest).

Appendix 3.6: Participant Course Evaluation

Please answer the following series of questions regarding various aspects of the training workshop Competencia intercultural en atención de salud sexual y reproductiva ("Cultural competency in sexual and reproductive health care").

Course Content

How helpful was the content of each module?

Module:

Course Introduction

____Very Helpful ____Helpful ____Somewhat Helpful ____Not Helpful

Managing Your Prejudices

____Very Helpful ____Helpful ____Somewhat Helpful ____Not Helpful

Cultural Competency for Reproductive and Sexual Health Services

____Very Helpful ____Helpful ____Somewhat Helpful ____Not Helpful

What Is a Good Health Care Provider?

____Very Helpful ____Helpful ____Somewhat Helpful ____Not Helpful

Working with the Community

____Very Helpful ____Helpful ____Somewhat Helpful ____Not Helpful

Name two useful thing you learned in the training workshop.

_____
_____
_____
_____

How will you interact differently with clients as a result of the training workshop?

_____
_____
_____
_____

Face-to-Face Workshop

Please give us your opinion about the facilitation of the workshop.

Usefulness of facilitators' inputs

____Very Helpful ____Helpful ____Somewhat Helpful ____Not Helpful

Did the facilitator make it easy for participants to share ideas with one another?

___Yes _____Sometimes _____No

What information, if any, would have been helpful to you prior to the start of the workshop? Please be as specific as possible.

_____

_____

What suggestions do you have for improving the written program materials? Please be as specific as possible.

_____

_____

Would you recommend this workshop to other providers? Why or why not?

_____

_____

Do you have any other comments and/or suggestions about the workshop?

_____

_____

CD Rom

Was the CD-ROM easy to use?

___Very easy ____Easy ___ Difficult ___Very difficult

Please rate the following about the CD-ROM

	Very useful	Useful	A little useful	Not useful
Exercises				
Fotonovelas				
Questions for discussion/self-reflection				
Provider/client testimonials				

What suggestions do you have for improving the CD-ROM? Please be as specific as possible.

_____

_____

_____

Will you use the CD-ROM again in the future? For what purpose?

_____

_____

_____

Do you think the CD-ROM would be an effective training tool without the face-to-face training?

_____

_____

_____