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Cross-Cultural Adaptability Inventory (CCAI) Training: A Descriptive Multi-Methods Case Study on a Cultural Humility Course from a Premier Public Health Agency

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Abstract

Cross-Cultural Adaptability Inventory (CCAI) Training: A Descriptive Multi-Methods Case Study on a Cultural Humility Course from a Premier Public Health Agency

By Kelsy J. McIntosh

Cultural humility in global health continues to emerge as a topic of utmost importance. Many times, global health practitioners will enter into a situation where they are engaging with those of other cultural backgrounds, which can lead to a number of issues in interactions, particularly in a work setting. There is a relative lack of robust descriptions of programs that are available to prepare staff for cross-cultural engagement in international fieldwork. This multi-method descriptive case study aims to describe in-depth the Cross-Cultural Adaptability Inventory (CCAI) Training course offered by the Center for Global Health (CGH) at the Centers for Disease Control and Prevention (CDC) related to seven dimensions including A) description of the program, B) program genesis, C) specific goals of the program, D) program content, E) implementation strategy, F) evaluation strategy, and G) acceptability and utility. In order to describe this training, a number of methods were employed including documentary analysis, secondary post-course evaluation data analysis, a quantitative post-course survey and analysis, as well as informal conversations with key informants. This training was originally an eight-hour in-person course required for anyone at CDC that is working and living in another country for two or more years. Since the COVID-19 pandemic, the training has been adapted into a four-hour virtual session. Participant feedback is generally positive, and CDC will use this case study as a catalyst for an in-depth evaluation of the program.

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I would like to thank my CDC supervisor, Shelly Bratton, and the rest of the National Public Health Institutes Team at CDC for inspiring me and assisting me in my professional growth over the last two years. I would not have had this thesis opportunity, nor would I have grown nearly as much as a professional without these wonderful people.

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Table of Contents

I. Introduction and Background

Global health continues to grow in importance as an emerging field of study, and as such, there has been a general increase in travel and cross-cultural engagement related to global health work [1]. Travel could be for a variety of reasons, including but not limited to, providing technical assistance, providing primary healthcare, conducting research, or partnering with organizations to address different issues. Interactions of this nature warrant a certain level of understanding in the realm of cultural sensitivity and awareness, in that difficult and often uncomfortable situations arise in the face of collaboration across borders[2]. It is vital that organizations who send staff, volunteers, researchers, or anyone affiliated with their institution to another country to do field work adequately prepare their personnel for these interactions [3].

I am particularly interested in this topic due to my previous volunteer and work experience with a nonprofit organization that operated in rural areas of low- and middle-income countries. This work was primarily funded through volunteer contributions, the majority of which came from universities and colleges in the US and Canada. Students would participate in seven- to ten-day trips to a select number of countries the organization partnered with in order to participate in the work towards which they had contributed monetarily. Many times, students would come on these trips with misinformed intentions about the impact they were having, with the idea that they were saving people's lives and more. This would lead to interactions with local community members that were paternalistic and belittling at times [4].

It came to my attention that training programs to address these types of interactions were extremely necessary to avoid situations that patronize beneficiaries of development programs. I

[1] Adams et al., "The Future of Global Health Education."
[2] Addiss, "Mindfulness, Compassion, and the Foundations of Global Health Ethics."
[3] Steele et al., "How Do We Know What Works?"
[4] DeCamp et al., "An Ethics Curriculum for Short-Term Global Health Trainees."

believe that the responsibility of preparing for a cross-cultural engagement such as this falls partially on the sending organization, and that organization should make the effort to facilitate that process. Therefore, I argue that organizations such as this should invest more resources in developing high-quality, relevant, and evidence-based materials such as training courses to prepare their constituents for fieldwork.

The notion that global engagement comes with a variety of situations that may result in power imbalances and other negative consequences is a relatively new component in conceptualizing the planning, implementation, and expected consequences of public health programs and initiatives [5]. The American Public Health Association defines public health ethics as a collection of standards to which public health practitioners around the world should be held [6]. Some considerations for thinking through ethical scenarios around interventions and policy issues include permissibility, respect, reciprocity, effectiveness, responsible use of scarce resources, proportionality, accountability and transparency, and public participation. The supplementation of a code of conduct with different resources such as training courses is vital to the development of these skills among workforces [7] [8].

II. Statement of Purpose

The purpose of this thesis is to describe one such training program, the Cross-Cultural Adaptability Inventory (CCAI) Training, which is routinely conducted by the U.S. Centers for Disease Control and Prevention (CDC) and is mandatory for any CDC staff traveling to another country for a stay of two or more years. This training was originally an eight-hour in-person

[5] "Making a Commitment to Ethics in Global Health Research Partnerships: A Practical Tool to Support Ethical Practice | SpringerLink."
[6] "Who We Are."
[7] "Public Health Code of Ethics."
[8] Kanekar and Bitto, "Public Health Ethics Related Training for Public Health Workforce."

course that would have participants interacting with each other over one full business day. Since the COVID-19 pandemic has limited in-person interactions since March of 2020, the training has been restructured to fit into a four-hour timeframe via the online platform, Zoom.

Cultural sensitivity is defined by the American Psychological Association (APA) as the awareness and appreciation of the values, norms, and beliefs characteristic of a cultural, ethnic, racial, or other group that is not one's own, accompanied by a willingness to adapt one's behavior accordingly. It is important to note the emphasis on a willingness to adapt, as this will truly define an action as cultural sensitivity, and as such, not appropriation or disrespect. Practitioners of public health and other sciences are undoubtedly presumed to and expected to uphold this latter part of the definition of cultural sensitivity. Yet many times cultural issues arise in the field that make collaboration in partnership either difficult, uncomfortable, or unlikely with the potential for treating one another with an inadvertent level of disrespect.

One qualitative study found focuses on the types of ethical issues that may be encountered in the field [9]. These were associated with four major themes related to cultural differences, professional issues, limited resources, and personal moral development. Issues falling under these themes included informed consent, truth-telling, power dynamics, corruption, autonomy, dealing with moral distress, establishing a moral compass, humility and self-awareness. Case vignettes were identified as useful in curriculum development for ethics training in global health. The argument made is that ethics training programs should be designed with these challenges in mind, with particular emphasis on cultural sensitivity and collaboration.

Many of these challenges stem from a lack of understanding cultural differences in conjunction with limited resources, and trainees frequently report feeling ill-equipped to deal

[9] Harrison et al., "What Are the Ethical Issues Facing Global-Health Trainees Working Overseas?"

with such issues [10]. A need for predeparture training that would enable participants to develop a strategy for recognizing and resolving these ethical problems is vital [11].

Lack of rich description

Despite the need for training around cultural sensitivity and navigating power and resource imbalances, there is a relative lack of high-quality training programs currently being employed by premier global health agencies [12] [13]. Much of what describes global health ethics and recommendations is catered towards medical or nursing practice or conducting research with other cultures and in other countries and does not address public health practice such as international technical assistance and support that is offered by the CDC [14].

In recent months and particularly in the United States since the deaths of various unarmed people of color, there has been an uptick in the desire for cultural sensitivity training around racial and ethnic differences, as many people who had previously had the privilege of remaining relatively unaffected by a lack of cross-cultural understanding[15]. Among CDC staff, the need has increased dramatically in the past calendar year (See Appendix 1b). In 2021, CDC Director Dr. Rochelle P. Walensky, MD, MPH announced that unconscious bias training will become a requirement for all CDC supervisors, to be taken every two years[16]. This general lack of training suggests that there is still a considerable amount of work to do to ensure cultural sensitivity and ethical engagement in public health [17]. In looking to implement such training programs, it

[10] Shoeb et al., "Teaching Global Health Ethics Using Simulation."
[11] Hall-Clifford et al., "Global Health Fieldwork Ethics."
[12] Rivera et al., "Many Worlds, One Ethic."
[13] Hunt, Schwartz, and Elit, "Experience of Ethics Training and Support for Health Care Professionals in International Aid Work."
[14] Hunt, Schwartz, and Elit.
[15] Kramer, "The 10 Commitments Companies Must Make to Advance Racial Justice."
[16] Felicia Warren and Duncan, Informal conversations with key informants.
[17] "International Research Ethics Education | Global Health | JAMA | JAMA Network."

becomes apparent that there is a relative lack of comprehensive descriptions of these programs by premier public health agencies.

III. Significance

It is important to conduct an environmental scan of existing cultural humility and engagement trainings geared towards a public health audience for a variety of reasons. A clear, concise, and well-supported theory of change and definition are chief components of understanding any program before deciding whether or not it is effective. Without robust descriptions of the programs that people already implement, it makes it very difficult to evaluate those programs. This is partly because it is unclear what the program actually is, and the nature of the implications of its implementation. It is also difficult to think clearly about the program and be able to identify gaps that may be present both during and after program implementation, and particularly if those gaps relate to ethics. It is very difficult to know about the fit between problems and programs without these frameworks in place. This project has been deemed a priority by CDC and contributions that this inquiry makes have a pathway for potential impact in the form of some level of revision, rethinking, or redesigning of the course itself.

IV. Methods

Overview

This case study looks at seven domains of the CCAI Training program including A) a description of the program, B) program genesis, C) specific goals of the program, D) program content, E) implementation strategy, F) evaluation strategy, as well as G) acceptability and utility of the training itself. Finally, the case study will cover the level of transferability of this training to other global organizations in order to bolster efforts of preparing staff for cross-cultural collaboration in a way that sets up stakeholders for success, limits ethical dilemmas, and

optimizes partnership. The creation of a robust, in-depth and well-defined description of training programs such as these will act as a catalyst for a thorough evaluation of the training itself.

I employed a number of methods in order to synthesize this case study, which focused on documentary analysis supplemented with a short quantitative survey conducted via Survey Monkey™ and number of informal conversations with key informants. This case study is not considered human subjects research, as it was undertaken in collaboration with the CDC Operational Policy and Training Team as part of their routine quality improvement process for staff training endeavors. For these reasons, neither IRB approval nor a waiver for IRB approval was required.

Data Collection

The documentary analysis was conducted first by examining a table created by CDC staff that categorized each document by its purpose and content. The purpose of this table was to give me context as to which documents would produce information relevant to each previously mentioned domain I am interested in learning more about. The documents I looked at as part of this analysis included PowerPoint presentations, pdf documents, Word documents, and Excel spreadsheets containing vital data for executing this description. See Table 1 for a summary of the documents analyzed for the purpose of this case study. Next, I drew both independent and common themes out of each document per domain of interest and noted those findings accordingly.

In addition to this analysis technique, I developed a short survey with the help of my key informants to send to past participants as a follow-up to the data originally collected through a post-course survey. These questions focused primarily on the domain of course utility and acceptability, such as frequency that participants referred back to the course materials and

whether or not they felt supported or hindered in employing concepts learned from the training program. These questions were adapted from the CDC's Recommended Training Effectiveness Questions for Postcourse Evaluations User Guide, which is an evidence-based resource used to measure training outcomes [18].

Data used in a secondary analysis were originally collected by CDC staff from a post-course survey sent out to people who had completed the course at least one time in since 2017. There were 170 responses to this survey out of 352 participants, contributing to a 48% response rate. I performed this analysis of these qualitative and quantitative data using Microsoft Excel, where I examined trends in responses and feedback by course participants. Further details on the content of the survey I analyzed can be found in the results section and in Appendix B.

I supplemented the information amassed from these data with informal conversations with two key informants involved in the program's design and implementation. These conversations acted as unofficial interview opportunities where I was able to ask any questions that I thought may yield insight into the thesis results.

Finally, I had the opportunity to participate in an offering of the course alongside 19 other participants from CDC and locally employed country-level staff. I took thorough notes during this session about the flow of the course, the content, and reactions from other participants that provided insight into the domains reviewed in the results section.

Rationale

Having this training program described in the format of a case study will be useful as an internal CDC project for quality improvement. Since CDC is so large and influential, it is

[18] "Recommended Training Effectiveness Questions For Postcourse Evaluations User Guide."

important for the agency to provide trainings of high quality, as well as have staff represent them internationally in a positive manner. This case study will allow the agency to do just that.

V. Results

As mentioned, I had the opportunity to participate in an offering of the course alongside 19 other participants from CDC and locally employed country-level staff. This experience was insightful and informational in allowing me to put what background information I had gathered into context. I will present a description of the case study along with my critical analysis of some of the key issues that are most relevant to the ongoing evaluation of the program.

A. Description of the Program

The program is essentially a facilitated discussion with context and background information interspersed throughout the dialogue. Smaller breakout discussions are mixed into the training that provide participants an opportunity to get to know each other, build trust, and discuss activities that will enhance their cultural humility skills. These activities include filling out an inventory document, which is an Excel spreadsheet with a collection of statements about the respondent, where they rank their agreement with the statement using a Likert scale of agreement measure.

B. Program Genesis

The CCAI Training program was originally an in-person course where participants would gather and have a discussion-based learning session. The training began being offered in 2017. The format was adapted to be delivered in a virtual format in 2020 due to the COVID-19 pandemic. There are both pros and cons to the online approach. On one hand, the shift to a virtual delivery allowed for locally employed staff in other countries to join in on the training,

which added a vital perspective to the discussions had during the course as per post-evaluation data[19].

The in-person version of the course allowed for a lot more time for the participants to get to know each other, achieve a certain level of familiarity with and confidence in one another, and therefore have more open and in-depth conversations. Given that the course resonates more with participants when they were able to create personal connections, it should be noted that an in-person session may be preferrable over a virtual session, despite the subsequent lack of foreign participants when held in person. I believe this topic is important enough to warrant even a multi-day in-person implementation strategy, particularly since many of those who are required to take the training are high-level decision-makers and influential people in their roles. They have the capacity to influence others' ways of thinking and create change around what it means to engage respectfully with other cultures.

When adapting the course from the previous in-person version, the OPTT took into consideration CDC's Quality Training Standards in ensuring it was of quality and to par with the agency's requirements [20]. An important point to take into account is whether these standards are robust to begin with. To achieve this level of vigor, the standards should be based on other validated data, and realize a certain degree of stringency in terms of what content could prevent disrespectful and short-sighted interactions in the field[21] [22].

In adapting the course, the OPTT piloted the course among their team to ensure timing was accurate and the facilitators knew what to say and keep the course on track in terms of timing. This allowed for a trial-and-error approach to the initial implementation so that the

[19] Felicia Warren and Duncan, Informal conversations with key informants.
[20] "Quality Training Standards | Training Development | CDC."
[21] Crump and Sugarman, "Ethics and Best Practice Guidelines for Training Experiences in Global Health."
[22] Watts et al., "Are Ethics Training Programs Improving?"

facilitators were well-prepared for real-time course delivery.

C. Specific Goals of the Program

The philosophy of the program is that the CCAI workshop helps participants identify individual strengths and weaknesses in four skill areas. These skill areas are fundamental to effective cross-cultural communication and interaction, and include i) emotional resilience (ER), ii) flexibility and openness (FO), iii) perceptual acuity (PAC), and iv) personal autonomy (PA)[23]. The contexts that the CCAI program aims to prepare people for include daily tasks involving interacting with people of different cultures and from different countries as part of their job description. Having tools such as pre-departure preparation will be useful in mitigating uncomfortable cultural encounters.

D. Program Content

The content of the program is taken from HRDQ, which is a company that creates and publishes training tools for developing people skills in the workforce. Organizations purchase these materials from HRDQ in order to use them and/or adapt them to be relevant to whatever the goal is of the organization purchasing the resources. HRDQ emphasizes experiential learning[24]. The cost of the CCAI resource from HRDQ is $26 USD, which warrants the question of whether or not an agency as large and influential as the CDC could potentially afford a more robust training.

To their credit, CDC did hire a facilitation expert from HRDQ to come in and train the OPTT on how to properly conduct the training. This expert relayed information about facilitation techniques such as liberating structures that the course instructors could use to move along the

[23] "Cross-Cultural Adaptability Inventory."
[24] "About HRDQ."

conversation [25]. These liberating structures are intended to break down barriers that may exist in the way of fostering a trusting and open environment in which to dissect topics that are traditionally uncomfortable for some people to talk about, such as their internal or external biases towards others.

The training uses a PowerPoint presentation to guide the conversation. Each participant receives a copy of the course materials prior to the meeting so they are able to refer back to them throughout the training.

E. Program Implementation Strategy

The implementation strategy of the program is quite straightforward. This training was adapted and is conducted by the Operational Policy and Training Team at CDC, which is made up of experts in the fields of monitoring and evaluation, facilitation, and training of staff on a variety of topics. The credentials of these staff members support the argument that they have the proper authority to be discussing and teaching these issues. The team is currently making efforts to employ a Training of Trainers (ToT) model in order to increase the number of qualified course facilitators from one to many.

The course is currently structured as a Zoom session and is open to anyone who would like to take it and who has access to Zoom. The session starts off with a round of introductions from the facilitators and organizers. The organizers from the Operational Policy and Training Team are not always in attendance, however they were a part of the training for this particular session that I was able to attend. The organizers first share the intention of the course and set expectations for learning, as well as logistics for the session. From the team, one person is tasked with acting as the primary facilitator. Another assists that person with advancing slides, and

[25] "Liberating Structures - Introduction."

another person stands by to monitor the Zoom chat and handle any technical difficulties that may arise among participants. Other team members take notes during each portion of the training and disseminate that information to participants afterwards.

The course moves from a short presentation on defining culture into a smaller breakout group, where participants are able to begin to get to know each other. Here, participants discuss pre-determined questions in-depth, and start to build trust with one another, and one person is designated as a note-taker and/or small group representative. After bringing the breakout groups back together, the representative from each group shares what was discussed, and facilitators have the opportunity to add nuance to the conversation or insert any guiding points or vital concepts that relate to the discussions by the participants. This cycle happens three times over the course of the program, each time mixing participants among breakout groups to allow for as many people to meet and talk with each other as possible.

The facilitators allow deviation from their plans in order to foster high quality discussion and facilitate learning of the concepts. I believe this is a vital component of the implementation strategy because it provides the space for participants to ask questions and come to an understanding instead of feeling rushed or constrained by time, keeping in mind that the session is only four hours long. Partially for this reason, the ideal class size is between 15 and 20 participants. This will allow for everyone to share and get to know each other on a slightly more personal level than if there were over 50 participants, which has been a challenge for past training sessions.

The course utilizes a variety of materials in its implementation. These materials included the CCAI Dimension Profile (ER, FO, PAC, PA), summaries of the small group discussions, an action plan created by each participant at the end of the course, and the CCAI Passport. The

CCAI Dimension Profile is aggregated from the inventory mentioned previously and is the only material that the OPTT requires participants to complete prior to joining the training, which takes about 15 minutes. The CCAI passport contains all of the materials used in the course offering, as well as resources for further engagement with the topic such as a document listing popular books and tools for children who may be making the move alongside their family.

F. Program Evaluation Strategy

After each session, the OPTT sends out a short survey via Survey Monkey™ to each participant. Data are then collected on a few domains. These include whether the participants had previous understanding of the concepts covered in the course, level of comprehension of concepts after taking the course, motivation levels to use the concepts in practice, relevance of the course, satisfaction with course length, as well as knowledgeability of the facilitators. Questions are included in this survey about any suggestions the participants may have for future iterations of the course, in addition to anything they may feel needs to be removed from the course. The OPTT created this preliminary evaluation by looking towards Will Thalheimer's Learning-Transfer Evaluation Model [26]. Reference to a validated and standardized method of measuring learning retention is an advantage for the strength of the training.

These data are analyzed on a course-by-course basis as well as in aggregate form across the course's history. The course can be iterated slightly between sessions to incorporate participant feedback but is often quite uniform in its delivery each time. Uniformity will also depend on the participants themselves, how large the class size is, and to what extent the participants are contributing. The team recognizes the importance of improving and expanding the training, and for that reason, this case study will act as a catalyst for an in-depth evaluation of

[26] Thalheimer, "The Learning-Transfer Evaluation Model:"

the CCAI program through thoroughly defining the program in all its dimensions.

G. Acceptability and Utility of Training

The OPTT has received mostly positive feedback about the CCAI training from recent participants. I used the post-evaluation survey that I created alongside OPTT members to inform this dimension. Out of 163 recent course participants that were sent the survey, there were 37 respondents, contributing to a 23% response rate. Respondents reported referring back to the course materials at some point after taking the training (See Appendix B). These materials included the CCAI Dimension Profile (ER, FO, PAC, PA), summaries of the small group discussions, an action plan created by each participant at the end of the course, and the CCAI Passport.

VI. Discussion

These findings present both positive comments of the CCAI training as well as gaps in its different dimensions including implementation and evaluation. As part of the methodology of describing this program, I will pose a critical perspective on areas of improvement for the future use of the training at the CDC.

The CCAI training course has proven an effective tool for engaging CDC staff in conversation around their own cultural background, biases, and interactions they may encounter working in CDC-appointed positions overseas. That being said, it can only be considered an entry-level training course as it just scratches the surface of nuance around engaging respectfully with different cultures. This is due inherently to the brief nature of the program. At four hours, it is difficult to build the trust required of a truly productive conversation such as the one intended to dissect these issues.

One opportunity for improvement for the training is to incorporate different methods of facilitation into the course content. There are several research studies conducted about the effectiveness of situational and simulation-based learning around ethics for overseas engagement [27]. Having conversations based on real-life examples of things that can go awry culturally is also an important component of how well the course philosophy is absorbed by the participants [28]. It could be useful to involve past participants in the course development itself, perhaps with a combination of focus groups and in-depth interviews to get at some examples of challenges in cultural engagement, as well as strategies for addressing those challenges. This firsthand perspective would add a level of ownership to the training and transform it from an "off-the-shelf" course into something truly transformative in utility for CDC staff.

VII. Limitations

Some limitations for this case study were due in part to the ongoing COVID-19 pandemic, as virtual training sessions may present some level of unfamiliarity, thereby making it more difficult to build the rapport necessary to solicit certain potentially sensitive data from participants. Another limitation was a lack of time as an investigator. For this reason, I was not able to collect anecdotes from course participants that could have added nuance around the types of situations this training would be useful to prepare for, as well as their personal experiences with employing the training in context. This angle would have added an additional layer of contextual perspective useful for describing the dimensions of the philosophy of the program and its acceptability and utility.

It should be expected that there is a certain level of improbability of having resources that are catered to every different culture or type of person one may encounter working in a global

[27] Asao Shunei et al., "Ethics Simulation in Global Health Training (ESIGHT)."
[28] DeCamp et al., "An Ethics Curriculum for Short-Term Global Health Trainees."

health setting. There is such a large degree of variation across cultures that it is highly unlikely to achieve universal relevance. This is due in part to limited human, financial, and other resources that many organizations experience in the realm of global health.

A final limitation was a lack of representation from HRDQ. The HRDQ perspective could have been useful in informing the description of the training program's rationale and content development. I also lacked the opportunity to inquire about the program's evaluation by HRDQ. It could have been useful to gather information around whether or not Subject Matter Experts (SMEs) are periodically reviewing the content and sharing any updates with organizations that purchased versions of the training that are out of date.

VIII. Conclusion and Recommendations

Despite these limitations, I was able to conclude the following points: 1) the CCAI training is generally well-received by participants, 2) the implementation strategy is effective, although there is room for improvement, and 3) the CCAI training should be expended. I would recommend that the CDC reconsider their training requirements to broaden the CCAI to be required for anyone traveling abroad on behalf of the CDC for any amount of time, given it is logistically feasible for the employee to take the training in a timely fashion.

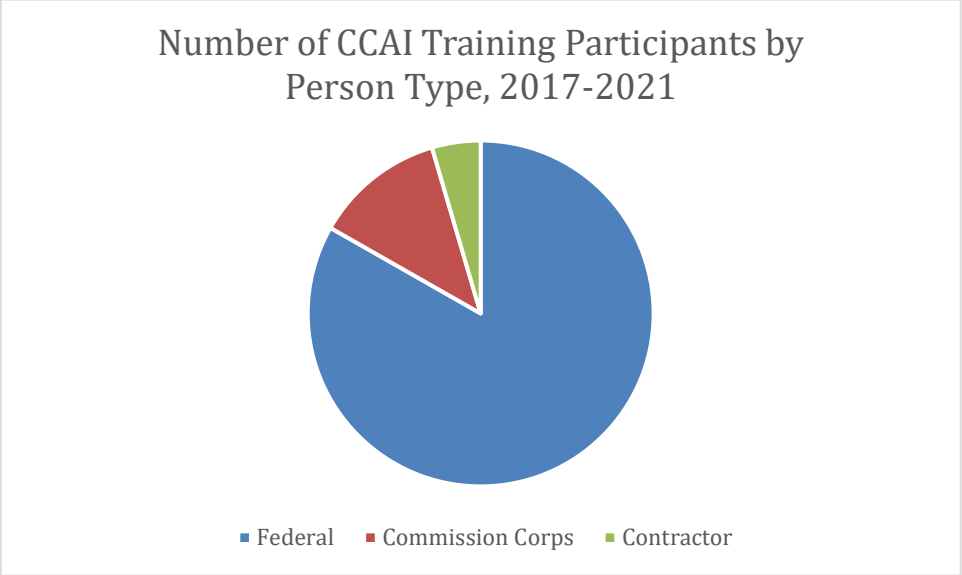
IX. Tables and Figures

Table 1: Documentary Analysis Overview

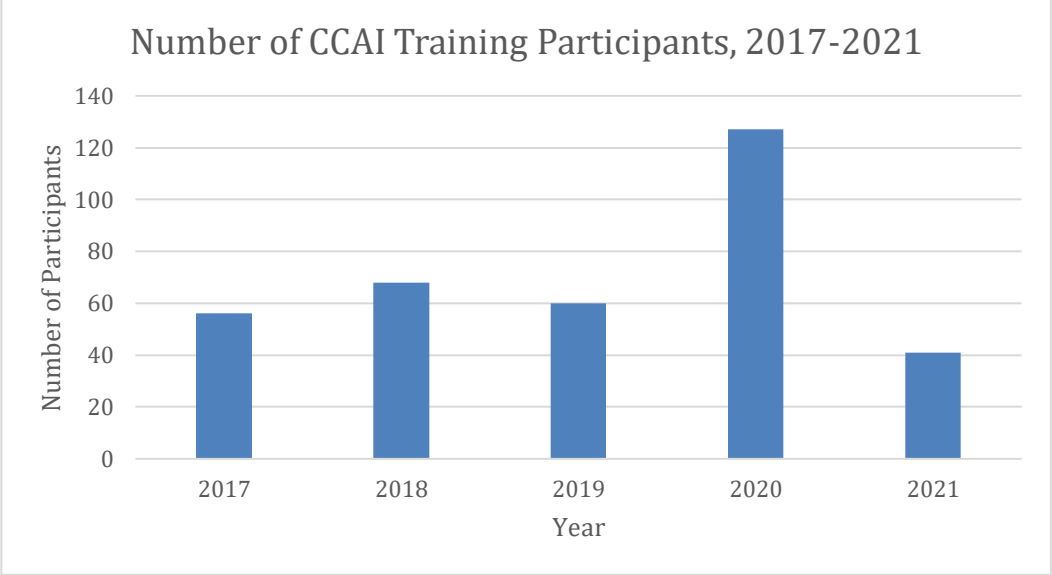
Document Title	Document Type	Description
1. CCAI Info Kit 2. Cross Cultural Adaptability 2017	1a. Pdf document 2a. PowerPoint	Original CCAI course materials and Center for Global Health's in-person adaptation (2017) from HRDQ
3. Storyboard for Cross-Cultural Adaptability_July 13 2020 4. Cross-Cultural Awareness Resources 5. CCAI PowerPoint (with notes) 6. CCAI Passport – New 7. CCAI Electronic Inventory for…	3a. Word document 4a. Word document 5a. PowerPoint 6a. Word document 7a. Excel spreadsheet	Center for Global Health's virtual adaptation (CCAI) resources
8. CCAI Assessment	8a. Word document	CCAI Assessment against CDC Quality Training Standards (QTS)
9. Virtual Facilitation Training Handbook	9a. PowerPoint	Virtual Facilitation Best Practices presentation
10. Learner Assessment 11. Learner Assessment Quantitative Analysis Summary 12. Learner Assessment Qualitative Analysis Summary	10a. Pdf document 11a. Word document 12a. Word document	Virtual Training Learner Assessment and Analysis tools and results

13. CCAI 2017-2021	13a. Excel spreadsheet	Spreadsheet with participant data from 2017-2021

X. Appendix A: Secondary Analysis Results

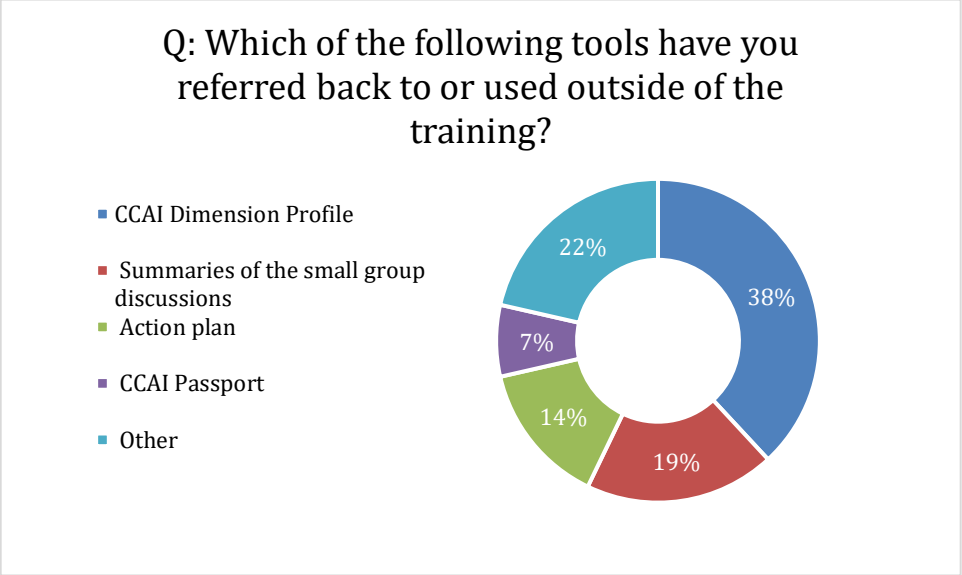


A1. CCAI Training Participants by Person Type

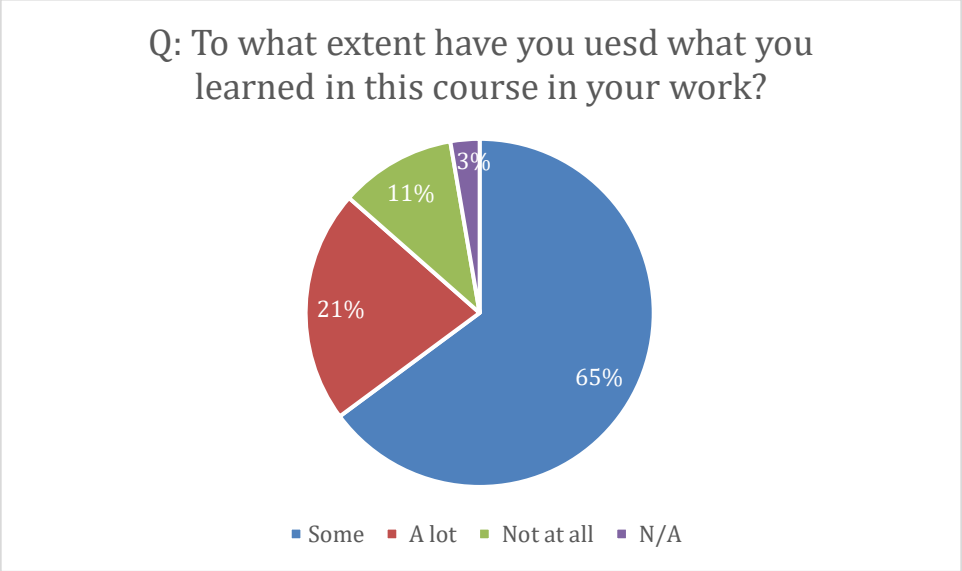


A2. Number of CCAI Training Participants

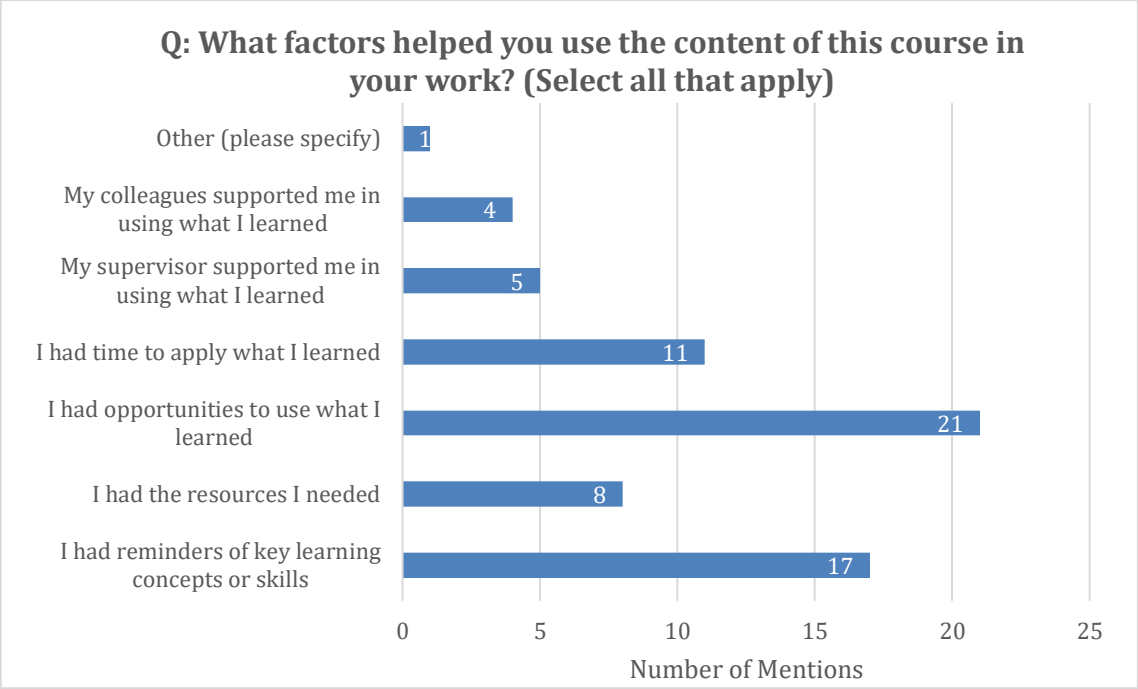
XI. Appendix B: Quantitative Survey Results



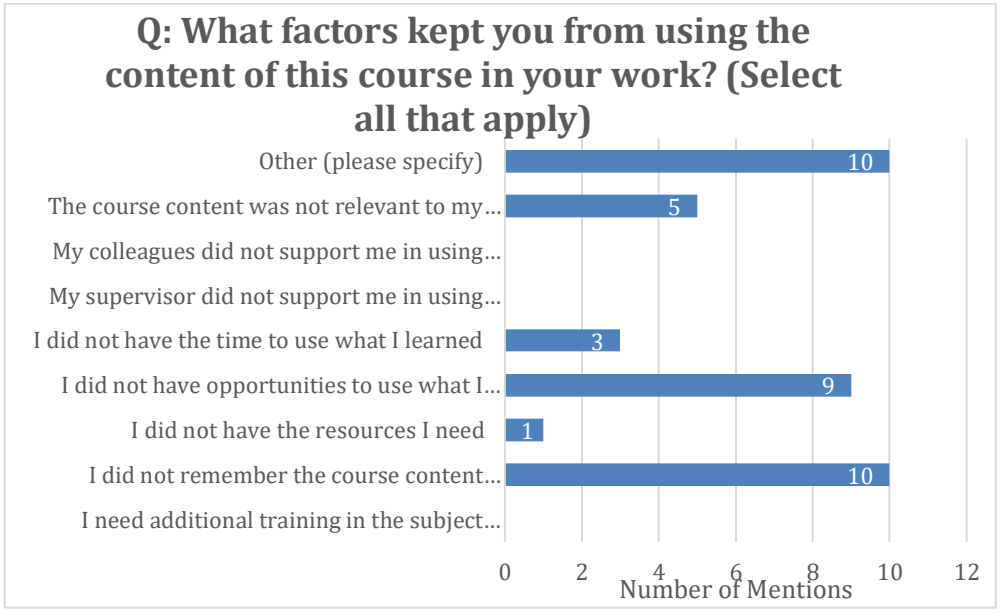
B1: Tools referred to outside of training.



B2: Extent of use of course learning.



B3: Factors that help use of course learning.



B4: Factors that inhibit use of course learning.

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