

INTERPERSONAL COMMUNICATION

Manual for Trainers of Health Service Providers

**Ministry of Health and Child Welfare
(Health Education Unit)**



1998

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Acknowledgements

The writing of this module would not have been possible without the broad participation of different categories of health workers. Nurse Tutors, Nurses, Information, Education and Communication focal persons, Public Relations Officers and Health Education Officers from around the country were all involved in the development of this module. These health workers are too numerous to mention here by name.

Special mention should be accorded to a group of Health Education Officers for having dedicated much of their time at different stages of the development of this module from conceptualisation, compilation, pre-testing, editing and finalisation.

Mrs N. Ngwenya (former Chief Health Education Officer), Ms D. Dhliwayo (former Principal Health Education Officer), Mr S. Tsoka (Chief Health Education Officer), Mr W. Chauke and Mr S. Simbi (Health Education Unit), Mrs J. Sibanda (Parirenyatwa Hospital) and Mrs N. Huni (Harare Central Hospital) all worked flat out in the development of this module.

Special thanks are also extended to Mrs J Maradzika (lecturer Medical School Community Medicine Dept.), Ms P Dube (Principal Midwifery Tutor: Harare Hospital) and Sr. S. Mukasa (Health Education Co-ordinator for Chitungwiza Hospital) for their useful contributions and ideas. Mr. P. Siebenhuehner, Dr. Sue. Laver and Mrs. D. Luke assisted in editing the final draft.

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Background/Introduction

The purpose of Interpersonal Communication in Health Education/Promotion is to facilitate, enable and maintain behaviours conducive to health amongst our target audiences.

Interpersonal Communication has the advantage of complementing mass media communication in facilitating changes in attitudes and behaviour. The messages in a face-to-face encounter can be tailor made to suit the specific needs of the target audience by taking into account the socio-cultural and economic contexts of our clients.

Unfortunately, there has not been a deliberate policy or standardised communication package in our health institutions in the past. As a result of the above situation Interpersonal Communication programmes have tended to be ad hoc, prescriptive or didactic i.e. without due regard to clients' needs and circumstances. This lack of policy and guidelines have resulted in sub-standard delivery of health education/promotion interventions thus affecting the realisation of good health and treatment outcomes.

There has also not been a monitoring and evaluation system in place, making it also impossible to assure or measure the quality of communication interventions.

This manual is designed to bridge the gap between what exists and the ideal situation by targeting trainers and supervisors of health service providers.

This manual is designed to provide the trainer with basic skills in patient education, communication and public relations. The manual will also facilitate the monitoring and evaluation of programmes since rapid appraisal protocols for clients, health service providers and management/support systems have also been made available.

UNIT I - THE COMMUNICATION PROCESS

1. Objectives of the Unit:

By the end of the unit the health service provider should be able to:

- Define the communication process
- List the basic elements of effective communication.
- Identify the characteristics of a good communicator.
- Identify barriers to effective communication
- Explain the model of communication
- Describe the role of the communicator in the communication process.

2. The Communication Process

Effective communication is the key to changing people's health behaviour. Communication is necessary in all aspects of health education, such as:

- encouraging community participation
- developing inter-sectoral co-operation
- sharing knowledge about health, so that people can take more responsibility for looking after themselves. Therefore health workers need to develop effective communication skills.

Definition

Communication can be defined as the process by which people share ideas, experiences, knowledge and feelings through the transmission of symbolic messages. The means of communication are usually spoken or written words, pictures or symbols. But we also give information through our body language. Gestures, postures, looks, facial expressions can show how we feel and what we think about an issue or another person. Good communication is mutually beneficial for the sender and the receiver of information. The above definition calls for attention to the following points:

- Communication involves people and therefore involves trying to understand how people relate to each other.
- Communication is about sharing meaning - agreeing on the definition of terms they are using
- Communication is symbolic; this means, gestures, sounds, letters, numbers and words can only represent approximate ideas meant to communicate.
- Communication aims at bringing about desired effects such as improving knowledge, change of attitudes and behaviour of the receiver.

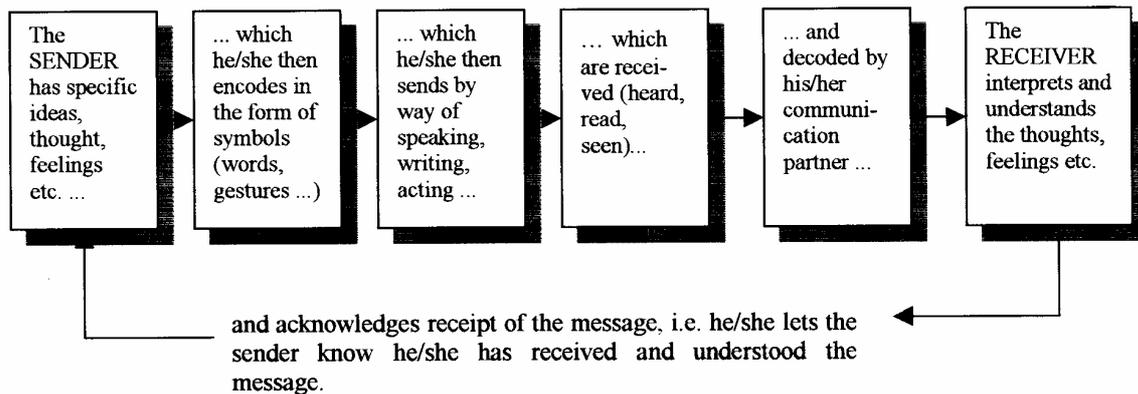
Communication involves a wide range of behaviours such as talking, listening, reading, writing, and thinking. These behaviours occur over time and they overlap with one another. While we seek mutual understanding when we directly communicate with one another, research has proved that communication, never really ends. Research also says that perfect communication is difficult to achieve. While the production of a brochure, poster, video or radio show may have value in getting messages across, communication is more effective when all participants are actively involved and when there is interaction and dialogue between the participants. Interaction, dialogue and active participation enables people to communicate effectively.

Literature recognizes four forms of communication:

- Intrapersonal - communication within oneself.
- Interpersonal - person to person communication
- Mass media - through the mass media
- Organization communications within an organization or among organizations.

Steps in communication

In its simplest form communication consists of the following steps: In a social situation.....

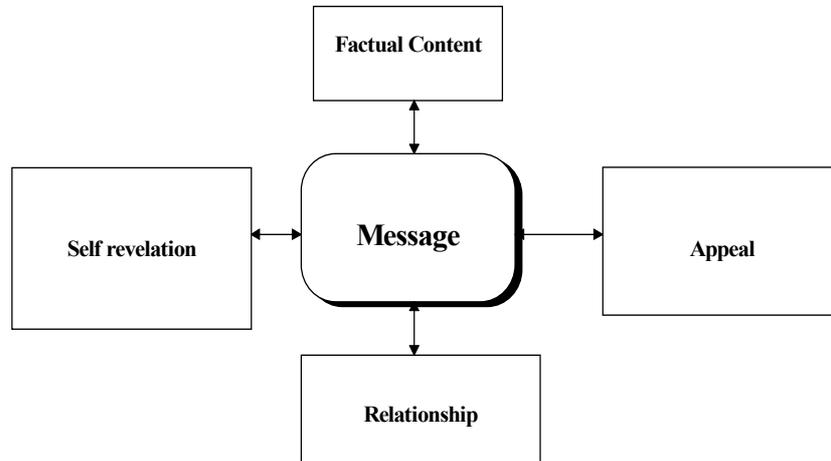


Communication means making oneself understood and trying to understand the communication partner. The person who wants to communicate something is the **sender**. The person to whom this communication is directed is the **receiver**.

1. The **sender** has a message (idea, thought, feeling, opinion, etc.) that he/she wants to communicate.
2. The **sender** must **code** his/her message. He/she must put his/her thoughts or feelings into sounds, words, or written characters (verbal communication) or into gestures, mime, body position, etc. (non-verbal communication) which are understandable to the **receiver**.
3. The **sender** must now **send** the message in such a way that it can be received by his/her communication partner.
4. The **receiver** receives the message over one or more of his/her perception channels. If this takes place without any omissions or distortions, the receiver then has an exact copy of the transmitted message.
5. The **receiver** must decode and interpret, classify, and adopt the message in order to **understand** it correctly.
6. The **receiver** must now **acknowledge** receipt of the message, i.e. he/she must let the sender know that he/she has received, duplicated, and understood the message.

THE PARTS OF A MESSAGE

Every message has **four sides**, which must be properly recognized and taken into consideration while communicating. Regardless of whether you are sending or receiving a message, it is important to learn how to communicate with all four sides. This holds true in particular for people who rely on communication as a tool, such as teachers, counsellors, discussion leaders, and moderators.



1. **Content**

Every message contains some form of information, i.e. a portrayal of facts from the point of view of the sender. This information should be easy to understand and unambiguous.

2. **Self-revelation**

In addition to information on the facts to be communicated, every message contains **information on the sender**.

It is possible to infer from a message how the sender views himself/herself and how he/she would like to be viewed by others. It is also possible to infer characteristics from a message of which the sender himself/herself is not even aware.

Self-revelation therefore encompasses intentional self-portrayal as well as unintentional self-disclosure.

3. **Relationship**

A message also reveals the sender's and receiver's sentiments for each other. A message therefore contains **information on the relationship between sender and receiver**.

This side of a message is often manifested in the tone of voice, gestures, and other non-verbal signals, as well as in the way the message is worded.

4. **Appeal**

A message is not usually "just sent" by the sender for no special reason. Every message is almost always connected with the attempt to influence the other person. The sender does not only want his/her message to be understood; he/she also wants to achieve a specific effect.

3. Characteristics of an effective communicator

Effective communication is a two way process. This calls for establishment of dialogue. As a health counsellor one is both in the situation of the sender and the receiver.

As a **sender** a good communicator should:

- make sure he has the full attention of the communication partner
- speak in a loud and clear voice
- formulate the message clearly in a way that can be easily understood
- explain technical terms
- be able to adapt the same (health) messages to the educational background of the receiver

As a **receiver** a good communicator should:

- encourage the client to speak openly
- give full attention to the client
- listen carefully
- ensure that the message is understood
- show by way of acknowledgement that message was understood
- take questions and concerns of clients seriously
- answer any questions fully

To be effective, the communicator should aim to develop some of the following attributes:

Adequate knowledge of subject area:	Knowledge of the subject matter, sound understanding of the subject under discussion
Knowledge of the target group:	Having in-depth knowledge of the people in terms of their wishes, needs, concerns, hopes and interests
Confidence:	Trust of one's own ability
Credibility:	The communicator should be accepted and trusted by the community
Friendliness/courteousness:	Being kind, pleasant and helpful, polite, respectful and considerate
Empathy :	Ability to share another's feelings as if they were your own
Tactfulness:	Skill to not offend people; ability to create a favourable impression by saying or doing the right thing.
Flexibility:	Ability to adapt to the needs of the people
Tolerance/patience:	Ability to bear up with something one does not agree with, staying calm without getting short-tempered

4. Barriers to Communication.

Barriers to communication can arise from sender, message, channel and receiver. Following are some of the examples of communication barriers and how to overcome them:

Communication Barriers	Remedy
I. Sender – Receiver Relationship	
<p>Language: clients may speak another language, have different terminology, and might not understand technical jargon</p>	<ul style="list-style-type: none"> • Use simple language that the client understands • Avoid technical jargon, explain technical terms • Use acceptable, inoffensive terminology
<p>Values/Beliefs: Sender and receiver of different cultural or religious background may differ in their values, norms and beliefs</p>	<ul style="list-style-type: none"> • Try to get information on the cultural and religious beliefs of your clients • Respect the beliefs of your clients, but clarify relevant misconceptions, prejudices or fixed ideas • Respect norms of your clients (proper dress, appearance, behaviour)
<p>Sex/Gender and Age: The roles of the sexes in a given culture are shaped during socialisation. Men and women might differ in educational level/ literacy as well as in norms, values etc. The same is true for age: each generation has its own value system not always shared by another generation (generation gap)</p>	<ul style="list-style-type: none"> • Take into consideration, that some people prefer to talk to persons of their own sex and/or their own age group on sensitive subjects • Show a professional attitude and competence when dealing with sensitive issues with persons of the other sex or another age group.
<p>Economic and educational status: Clients as well as health service providers find it hard to relate to a person of different economic or educational status</p>	<ul style="list-style-type: none"> • Show professional self-confidence when dealing with people of a higher status • Treat persons of lower economic status politely and courteously • Take into account the educational background of the clients when counselling
II. Environment and Timing	
<p>Environment: A noisy and disruptive environment can make the client uncomfortable and affect the impact of the message</p>	<ul style="list-style-type: none"> • Ensure a comfortable environment for the consultation • Arrange the environment so that it does not act as a barrier
<p>Timing: The timing of the counselling might not suit the client or group. The clients might not be ready for the message</p>	<ul style="list-style-type: none"> • If possible let the client choose the time • Make sure there is enough time for thorough consultation

Communication Barriers	Remedy
III. Communication Barriers on the part of the Sender	
<p>Attitude: Negative attitudes (biases, prejudices) can affect the impact of the message</p>	<ul style="list-style-type: none"> • Put the client at ease by showing an understanding, helpful attitude • Create a positive, friendly atmosphere
<p>Message: Messages are difficult to understand when they</p> <ul style="list-style-type: none"> - lack clarity - are ambiguous - are too loaded with information - contain too little information 	<ul style="list-style-type: none"> • Give your message a clear structure by beginning with the general and then proceed with details in a logical sequence • Adapt the message to the level of understanding of the client • Give clear, unambiguous instructions • Structure the information: emphasise what the client must know (essential/ important information), should know, could know (nice to know but not essential)
IV. Communication Barriers on the part of the Receiver	
<p>Attitude of Receiver: People will only get a message when they are ready to be a receiver, i.e. when they are motivated to listen with attention and interest.</p>	<ul style="list-style-type: none"> • Create attention and interest by <ul style="list-style-type: none"> - starting from the client's reality (their problems, knowledge, interest, emotions) - pointing out the relevance of the information for the clients (solution to their problems, benefits)
<p>Understanding: misunderstandings are caused by misinterpretation due to</p> <ul style="list-style-type: none"> - preconceived ideas, prejudices, - previous experience - not understanding words and technical terms - contradictory information from other sources 	<ul style="list-style-type: none"> • Support the client's understanding by <ul style="list-style-type: none"> - using clear, simple language - giving examples from the client's sphere of life - explain relationship of facts (e.g. cause-effect relationships) - bringing out and diffusing preconceived ideas and prejudices or misinformation from other sources
<p>Acceptance of a message will only occur when clients are convinced and agree on the content of the message</p>	<ul style="list-style-type: none"> • Convince clients by <ul style="list-style-type: none"> - arguing realistically - giving background data - pointing out the benefits and advantages of what you have to offer - giving clear instructions on how they can use the information to their advantage.

Lesson Plan:

1. Introduction:	Present the topic and the objectives of the session. Ensure that participants understand and agree on the objectives	10 minutes
2. Lecture	Present the communication model: <ul style="list-style-type: none"> - Definition of communication - The communication process - The four sides of a message Discuss the model and answer any questions from the participants	30 minutes
3. Exercise	To demonstrate the difficulties involved in communication use small exercises, e.g. <ul style="list-style-type: none"> - duplication exercise (see page 10, 11) - passing on messages 	30 minutes
4. Group Work	Form working groups and to discuss effective communication, rules for sender and receiver, barriers to communication based on the experience of the audience, e.g.: <u>Group 1:</u> What is expected from sender (counsellor) and receiver (client) to make communication effective <u>Group 2:</u> Which communication difficulties (barriers to communication) do you experience in your field of work and how can the difficulties be overcome? Introduction: Task for the group work Group work phase Presentation and discussion of the results of the group work	10 minutes 60 minutes 30 minutes
5. Summing up	Summary of lessons learnt	10 minutes
		3 hours

Alternative:

Instead of group work you can

- show a **video on communication** 20 minutes (e.g. "Gather", "Making Things Clear" or "Next is not enough" / see page 61)
- do **exercises and roles plays**, e.g. Participant in the role of the sender: Presenting and explaining health messages, adapting the message to the educational background of different groups of clients.

Evaluate the exercise by giving feedback on clarity, factual correctness of the message, adaptation of the message (language, examples, etc.) to the client group.

Exercises

In doing exercises the facilitator will provide clear guidelines/rules for role plays;

In addition the facilitator should take note of the following:-

- Making it possible for each group to steer its self;
- Recognizing difficulties of communication if any;
- Creating a friendly atmosphere;
- Observing moods and encourage reflections and praise learners;
- Acknowledging contributions;

DUPLICATION EXERCISE

The Story:

One executive did not propose a raise in pay for one of his employees.
The employee gave notice to leave the organisation.
His colleagues felt sorry because of this for he was generally well liked.
There was a discussion whether one could do something about it.

Correct answers:

- | | | | |
|---|----------|----------|----------|
| 1. The executive had denied the employee a raise in pay | T | F | <u>?</u> |
| 2. The employee did not receive a raise in pay | T | F | <u>?</u> |
| 3. The employee was angry not to get a raise in pay and gave notice to leave the organisation | T | F | <u>?</u> |
| 4. The reason for the employee's wish to leave the organisation was the refusal to pay him more money | T | F | <u>?</u> |
| 5. The colleagues were sorry because the employee left the organisation | T | <u>F</u> | ? |
| 6. The colleagues discussed with the employee | T | F | <u>?</u> |
| 7. The executive did not take part in the discussion | T | F | <u>?</u> |
| 8. The executive asked the employee to leave the organisation | T | <u>F</u> | ? |
| 9. The colleagues felt sorry because the employee did not get a raise in pay | T | <u>F</u> | ? |
| 10. The employee was generally well liked and there was a discussion whether something should be done | <u>T</u> | F | ? |

T = True

F = False

? = Not sure

Duplication Exercise (Task Sheet for Participants)

Compare the following 10 statements with the information you have received.

Please tick off according to the information:

T = the statement is in agreement with the information of the story

F = the statement contradicts the information in the story

? = not sure

- | | | | |
|---|----------|----------|----------|
| 1. The executive had denied the employee a raise in pay | T | F | ? |
| 2. The employee did not receive a raise in pay | T | F | ? |
| 3. The employee was angry not to get a raise in pay and gave notice to leave the organisation | T | F | ? |
| 4. The reason for the employee's wish to leave the organisation was the refusal to pay him more money | T | F | ? |
| 5. The colleagues were sorry because the employee left the organisation | T | F | ? |
| 6. The colleagues discussed with the employee | T | F | ? |
| 7. The executive did not take part in the discussion | T | F | ? |
| 8. The executive asked the employee to leave the organisation | T | F | ? |
| 9. The colleagues felt sorry because the employee did not get a raise in pay | T | F | ? |
| 10. The employee was generally well liked and there was a discussion whether something should be done | T | F | ? |

UNIT 2 - INTERPERSONAL COMMUNICATION (IPC)

Interpersonal Communication (IPC) is direct face to face communication between two people or groups. In this unit, health care providers will seek to demonstrate its applicability and effectiveness in a health care setting. IPC is the central approach within the broad communication process that brings out people's emotions, needs and feelings. When people reveal themselves to us, we are then able to respond positively to their needs and provide quality care.

1. Objectives of the Unit

By the end of the unit the health service provider should be able to:

- Define the concept of IPC
- Describe the process of IPC
- Discuss approaches and principles in IPC
- Demonstrate skills in IPC
- Identify opportunities in IPC

Definition of Interpersonal Communication (IPC)

Interpersonal Communication is a person to person, two-way, verbal and non verbal interaction that includes the sharing of information and feelings between individuals or in small groups, that establishes trusting relationships. (Hubble J, 1994)

IPC in health care settings takes place between service providers and their clients and members of the community and is a **key element** in maximizing access to quality care. IPC includes the processes of education, motivation and counselling and starts with understanding the critical role of good client service.

Special features of IPC include the following:

- Interpersonal Communication is influenced by attitudes, feelings, values, social norms, and environment of the people involved.
- IPC is an influential means for the adoption of proposed health behaviour and the continued compliance with and maintenance of the health behaviours.

Interpersonal Communication complements, reinforces and elaborates messages presented elsewhere. The mass media can also be used to reinforce Interpersonal Communication.

Application of IPC in Health Care

History-Taking: Each intervention begins with a thorough analysis of the existing situation in a given field. The objective of history-taking is for the provider to gather all the information needed to make an accurate diagnosis and to initiate appropriate treatment. Question-asking techniques, listening to the patient, and probing skills are particularly important to successful history-taking.

Channelling: The objective of channelling is to motivate the community to utilize the preventive and curative health services offered. This is carried out through one-to-one communication and group education sessions.

Counselling: The objectives of counselling are:

- to share information about the disease and treatment options;
- to promote compliance through negotiation with the client over positive treatment and behaviour changes.
- to help clients make informed decisions. Effective giving of information, checking for understanding and comprehension, establishing achievable behavioural objectives with the patient are important counselling skills.

Dialogue with Patients/clients: The objective of dialogue is to:

- determine what services are needed by the clients/patients and what is the best way to provide those services. This dialogue provides an opportunity to learn how patients/client understand health and disease, and negotiate with them about the organization and delivery of services.
- Management of diseases, conditions and rehabilitation of patients and clients when they go to health institutions. There are a lot of opportunities that can be utilized for IPC in this context and are discussed below as follows:-

Overall Socio-Emotional Communication: The objective of effective socio-emotional communication are:-

- to establish and maintain a positive rapport with the patient throughout the encounter. This is an integral part of all Interpersonal Communication.
- to enhance patients to open up and comply. Socio- emotional skills include the ability to use (effectively and appropriately) statements to show empathy, concern, positive regard, and to give reassurance.

2. The Process of IPC

The following norms for quality in Interpersonal Communication focuses on the process of communication throughout the encounter. The norms are based on the collective experience of Quality Assurance Programmes with staff in a variety of countries in Africa, Asia and Latin America.

2.1 History Taking

Standard: During the history-taking session of the encounter, the health service provider will use interviewing skills to effectively elicit from the client the information needed to make an accurate diagnosis. Interviewing skills include question-asking, listening, and dialogue.

Guidelines: The following list of specific norms related to the content and methods used in an interview can help the health service provider communicate more effectively. This list is illustrative, and is not intended to be exhaustive. These norms may be adapted according to the local context.

- **Effective Listening:** Health service providers show concern and interest while the client is speaking; they demonstrate understanding by acknowledging the clients statements and do not interrupt the client unnecessarily, etc.
- **Dialogue:** Good communication means that the client has the opportunity to give information and to ask questions.
- **Probing:** Health service providers encourage client inputs by using methods such as probing, paraphrasing when appropriate, and encouraging clients to tell them more about their conditions.
- **Appropriateness:** Effective questions take into account factors such as the social and cultural context, the medical condition in question, the educational level of the patient, etc.
- **Completeness:** A complete interview includes questions about all symptoms and all relevant medical history.

2.2. Counselling

Counselling is of high quality when the information is sufficient, relevant, comprehensive and acceptable. Skills such as verification, organization of information into blocks, and the employment of social support networks when possible are some methods which enhance counselling.

Standard: During the counselling session of the encounter, the health service provider effectively uses information-giving, and educational skills to orient the client about his or her condition. To promote compliance with medical treatment and/or behavioural changes that will improve the health of the client, the provider uses negotiation skills. There is need to:

- create rapport with client;
- allow client to tell their side of the story without interruption;
- listen actively;
- give information and education to orient the client about her condition;
- help client to make an informed decision.

Guidelines: The following list of specific norms related to the content and methods used in counselling can help the health service provider communicate more effectively. This list is illustrative and not intended to be exhaustive. These norms may be adapted according to the local context.

- **Appropriate Language:** The health service provider delivers counselling in the client's language of fluency. Local language and/or translations should be used when necessary.
- **Comprehension:** The health service provider communicates in ways that are easy to understand, i.e. avoiding technical jargon, and by taking into account the cultural and educational level of the client.
- **Organisation of information:** The health service provider presents the information in blocks according to a few categories in order to make it easier for the client to remember.
- **Acceptability:** The health service provider presents treatment options, solicits information about client preferences, and involves the client in decision-making, in order to ensure that the treatment and other recommendations are acceptable to the client.
- **Sufficiency:** The health service provider gives enough information to the client to enable him or her to understand the illness, participate in decisions about treatment, and follow the treatment protocol.
- **Relevance:** The health service provider focuses on the information that is most important to the client during the particular encounter, thus reflecting an awareness of the priority and relevance of the message(s).
- **Empowerment:** Counselling enhances the client's self-esteem, confidence, and sense of competence in order to promote compliance and behaviour change specific to the condition, as well as overall health and well-being.
- **Behavioural recommendations:** The health service provider makes recommendations in concrete, behavioural terms, rather than in terms of outcomes. For example, rather than telling a client to lose 25 kgs, the provider might recommend specific behaviours (daily walks, cutting out sweets) that will help the client to move gradually toward the goal. Good recommendations also take into account the client's social, cultural and economic context (e.g. can the client afford to follow the recommendations?), as well as enabling and reinforcing factor for behaviour being promoted specifically to the client.
- **Utilise social support networks:** The health service provider explores the client's social network in order to determine whether these supports can be used to enhance treatment.
- **Verification:** The health service provider checks for client comprehension and understanding during the session at the end of the session by asking the client to repeat key messages by posing questions such as, "What are the most important things that you are going to do when you leave?" rather than a less effective question: Did you understand what to do at home?

2.3 Socio-Emotional Communication

Standard: The health service provider establishes and maintains a positive rapport with the client throughout the encounter. The behaviours discussed below can help the provider to achieve this goal.

Guidelines: The following list of specific norms relate to the methods used in effective socio-emotional communication. This is illustrative, and is not intended to be exhaustive. These norms may be adapted according to the local context.

- **Framing of the encounter:** The health service provider make a statement which establishes a positive environment for the client to share his/her feelings, attitudes and beliefs so that the client feels that the health service provider is interested in his or her perspective. For example, the health service provider might say, "Good morning, Mrs Moyo, my name is Dr. Tinarwo, and I want you to tell me about anything that you think may be affecting your health."
- **Attention:** The health service provider focuses attention on the client and does not engage in **other activities** during the encounter.
- **Constructive non-verbal behaviours:** Behaviours, such as forward body lean, eye contact, smiling and touching, are appropriate and conducive to dialogue, when deemed culturally acceptable.
- **Positive regard:** The health service provider shows respect and positive regard for the client, irrespective of differences of age, social and educational status, race, gender, religion, etc.
- **Empathy:** The health service provider will elicit feelings from the client and reflect or restate those feelings to the client. This expression of empathy with the patient helps to establish rapport.
- **Non-judgemental:** The health service provider makes an effort to validate the way the client is feeling without judgement, so that the client will feel free to be frank and open.
- **Concern:** The health service provider shows that he/she cares about the client and the client's problem. For example, he or she might use statements such as, "I'm worried about you," or "I'm concerned that you are not taking care of yourself".
- **Reassurance:** The health service provider encourages and reassures the client when appropriate while avoiding premature or unjustified reassurance.

Team Work in continuity of care

The IPC process is dependable upon team work. Every discipline is part of the team at whatever level. In order to provide comprehensive quality of care programme at institutional level, each discipline has a special role to play.

Co-ordination and collaboration is encouraged between all the stakeholders from time to time. Mechanism to evaluate efforts should be encouraged, in the form of:-

1. meetings
2. suggestion boxes
3. the COPE methods

so that consensus is reached at all times. Appreciation of efforts should be encouraged rather than negative feedback which may be discouraging.

Lack of teamwork and lack of a proper service attitude are the main **Barriers to IPC**:

- **Competition within departments:** Competition may have positive and negative aspects. Unhealthy aspects would be monopolizing and hiding (material) resources meant for sharing between departments.
- **Unclear definition of roles and responsibilities:** Unclear job descriptions may lead to lack of accountability, e.g. “this is not my job”.
- **Workload:** If a unit is understaffed or distribution of manpower is inequitable, this may lead to poor performance due to pressure of work and health workers being irritable.
- **Top down approach on clients:** “Giving” information (one-way communication) without involving the client in a dialogue is less effective than sharing information (two-way communication)
- **Discrimination** on the grounds of tribal, political, colour, gender, religion, status and age will prevent effective IPC.
- **Inadequate induction:** Lack of exposure of new staff members may not communicate properly due to lack of information.
- **Lack of consultation:** There is a need to consult other health workers when in doubt. Taking unilateral decisions, i.e. not asking others when in doubt, might prove to be dangerous.

3. Methods and Approaches to IPC

- Identify trained personnel.
- Training of Service Providers in different departments
- Media groups
- Pro-approach (Promotion of service providers)
- Advocacy and community mobilization
- Organizational mobilization

Interpersonal Communication can be in the form of lecture, role plays, group discussions, drama, meetings, counselling. In addition, visual aids, such as posters, charts, flyers, pamphlets, and audio visual aids such as, video, films, radio, taped messages These can be used to reinforce IPC.

The IPC process should take into consideration, the following key aspects:

- Motivation/persuasion
- Information
- Specific method
- Client assessment

4. Minimum Message Strategy

One of the strategies which can be employed to enhance IPC is **the Minimum Message Strategy**. e.g. the focus on key essential communication elements during a curative visit or a counselling session. For example, if a mother comes with a child with diarrhoea to the Out-Patient Department, a minimum message strategy could take this form:

- Find out why the mother has come to the hospital
- Assess behaviour of mother and reinforce where appropriate
- Determine or assess whether the mother has knowledge about the disease
- Obtain context of illness and treatment.
- Counsel appropriately and enter into responsive discussion

Lesson Plan:

1. Introduction:	Present the topic and the objectives of the session. Ensure that participants understand and agree to the objectives	10 minutes
2. Lecture - Guided Dialogue	Present the topic of Interpersonal Communication. Together with participants elaborate opportunities for IPC.	30 minutes
3. Video	Show a video on IPC (client's perspective) and discuss with participants rules and guidelines.	40 minutes
4. Role Plays	Conduct a number of role plays with participants taking the role of health service provider and client.	2 hours
	<p>1. History Taking: To practice interviewing skills the participant in the role of the health service provider will mainly be the receiver applying the rules for non-directive dialogue guidance (see annex)</p> <p>2. Counselling: In these role plays the participant in the role of the health service provider will combine interviewing with listening skills (receiver and sender). Practise counselling skills using "GATHER" approach. Some participants should pair in two's and practise GATHER skills for 15 minutes and other participants to evaluate. Facilitator to explain GATHER.</p> <p>Preparation: Have participants prepare for the role of the client by establishing background, reason for visit, kind of disease etc.</p> <p>Role play</p> <p>Evaluation of the role play – trainer and participants give feedback to the role-players using the criteria laid down as guidelines.</p> <p>The first role plays can be conducted in the plenary so that participants know what to observe and how to give feedback. Then form groups to conduct further role plays to coach participants in taking different roles of health service provider, client, observer.</p>	4 hours
5. Visits	Visits to different departments	1 hour
		8 hours, 20 minutes

5. The Functions of Questions

Questioning to Check Understanding and Interest

When one is the receiver one can check that one has understood the message of a communication partner. This 'feedback-question' is usually combined with a summary of the partner's message: "I understand you to say Does this accurately summarize your points ?"

Doing this

- shows that one is listening attentively
- demonstrates that the partner's message is important
- acknowledges the message and avoids misunderstanding.

The sender uses questions from time to time

- to make sure that the listener has understood his/her own message by asking: "Have I explained that to your satisfaction"
- to check the receiver's reaction: "How does this look to you ?"

Questioning to Bring Attention Back to the Subject

If the listener's attention wanders, a question might serve to bring the concentration back to the subject. Sometimes the lack of attention is only momentary and can be cured by any kind of question. If the listener's boredom and inattention is very obvious and prolonged, one can make this the subject of one's questions and find out why there is a lack of interest and how one can improve one's communication.

Questioning to Start a Communication Partner Thinking

Questions that ask for opinions and suggestions serve to get the communication partner thinking and activate him/her to contribute information, experience, expertise etc. This helps to develop a trusting relationship in which one can work together to achieve common goals and objectives.

Questioning to give Positive Strokes and Build Trust

Asking somebody for his/her opinion is a form of flattery. It shows that the partner's viewpoints are valued and thus helps to build a bond of trust.

Questioning to Determine 'Style'

By giving a person an opportunity to talk, one can discover the personal 'style' of the communication partner: the style of communication, the emotional disposition, attitudes, opinions, and other traits of personality. This helps to get to know the other person and to find a common level of communication and understanding. To do this one can ask questions about, goals, hobbies, likes and dislikes, strength and weaknesses etc.

Source : P. L. Hunsaker & A. J. Alessandra: "The Art of Managing People", Prentice Hall, 1980

THE FUNCTIONS OF QUESTIONS

Questioning to Activate the Communication Partner

Questions will help to activate the communication partner and help them to open up and to participate in a conversation or in a problem-solving process. Greater participation will lead to more commitment. By getting the employee talking and volunteering information you will build trust and will not have the feeling that they are only responding to the manager's demands.

Questioning to Gain Information about Facts or Situations

These questions are mostly direct which are used to find out more about a person or a situation. In an interview with a person applying for a job they can be used to find out about the applicant's educational and professional background, experience, motivation, goals, objectives, needs and wishes.

Questioning to Uncover Motives and Gain Insight

The questions help to understand the employee's viewpoints and perspectives. In any situation it is necessary to understand the viewpoint and the needs and motives of the actors before one can make meaningful suggestions (or guide the actors to make their own suggestions). These can be direct questions but often one can uncover hidden motives only by asking open questions in a non-directive way.

Questioning to Reach Agreement

If one wants to come to a mutual agreement, one has first to find out about the present positions of the communication partners. It is necessary to explore the areas of agreement and disagreement. In doing this one should be seriously interested in the other's viewpoints. Salesmen often use a tactic by asking a series of rapid fire questions to which the other has to respond with 'yes' in order to get a 'yes' to the crucial question. These tactics are manipulative and will often lead to a breakdown of trust.

Source: P. L. Hunsaker & A. J. Alessandra: "The Art of Managing People", Prentice Hall, 1980

6. Types of Questions

OPEN AND CLOSED QUESTIONS

There are many types of questions, but there are only two basic forms:

- open questions, which are non-directive
- closed questions which are directive.

Open Questions

Open questions are used to draw out a wide range of responses. They leave a wide spectrum for answering without limiting or suggesting a specific response. Open questions

- Cannot be answered simply by yes or no
- Usually begin with what, where, why or how
- Do not lead in a specific direction
- Increase dialogue by drawing out the partner's feelings and opinions
- Encourage the communication partner to elaborate on objectives, needs, wants problems, and current situations
- Help the communication partner to discover things for him-/herself
- Allow the communication partners to exhibit their 'style' more readily and accurately than other types of questions

Examples:

- "What do you think about the situation?"
- "How did the situation develop?"
- "What is the most important objective we should follow?"

Closed Questions

Closed questions are often specific and require narrow answers, usually a yes or no. Closed questions do not yield as much unbiased information as open questions, but they

- Allow specific facts to be obtained
- Require little thought by the person answering
- Are used to gain commitment to a definite position
- Can be used to direct a conversation into a desired area

Closed questions can be

Direct questions: "Where were you born?"

Alternative questions: "Do you like better to work in an institution or as a free-lancer?"

Suggestive questions: "Don't you think you should be a bit more cautious?"

Source: P. L. Hunsaker & A.J.Alessandra: "The Art of Managing People", Prentice Hall, 1980

TYPES OF QUESTIONS: DIRECTION OF THE QUESTIONS

Fact-Finding Questions

These factual questions are asked to gain information about specific facts, on current situations, goals and objectives. The fact-finding questions usually take the form of **closed questions**. They are simple to answer and can be used to establish trust in an interview.

Fact-finding questions in an interview

- should be easy to answer
- should be sensitive, non- threatening and non-judgemental
- should only concern information that is necessary to the present interview.

It is important that the information received from the interview partner is heard and recorded accurately. It is usual to take notes and to summarize the information at the end of this phase in order to check their correctness.

Feeling-Finding Questions

In order to change the attitudes or the behaviour of a person, it may be necessary to help the person to gain more insight and self-knowledge. This can be achieved by feeling-finding questions. They are used to find out about the interview partner's feelings, attitudes, convictions, motivations. They usually have the form of **open questions**.

The feeling-finding questions in an interview

- are more personal and can address sensitive areas
- should be asked only after a strong rapport and a trust bond has been established
- allow the interview partner to find out more about him-/herself

In asking this type of questions the interviewer should show empathy and practice active listening skills by using acknowledgement, summarizing or paraphrasing the statements. It might disturb the atmosphere of the interview if the interviewer takes too many notes during this phase.

Source: P. L. Hunsaker & A. J. Alessandra: "The Art of Managing People", Prentice Hall, 1980

TYPES OF QUESTIONS: QUESTIONS TO GUIDE THE CONSERVATION

Clarifying Questions

Clarifying questions are a form of feedback. They are used to verify the content or emotional quality of the interview partner's message. They have the form of paraphrasing or restating the message in the own words of the interviewer.

Clarifying questions may be used to

- Interpret in different words the speaker's message
- Invite the partner to expand and/or clarify an idea or statement
- Help to clarify ambiguities
- Uncover the real opinions
- Ensure that both interview partners speak the same language and understand each other

Examples:

"If I understand you correctly, your major concerns seem to beIs that so?"

"Are you referring to the personnel or the training department?"

Developmental Questions

Developmental questions are used to stimulate the interview partner to give additional or more detailed information. They encourage the interview partner to expand and elaborate upon a topic or issue.

Examples:

"Can you give me an example of what you mean by that?"

"Can you tell me more about it?"

"What other suggestions do you have?"

Echo Questions

These questions are used, to draw more information on something the interview partner has said by taking up one part of the message: A word or sentence is repeated in a questioning tone of voice. In many situations it is sufficient to echo back key words.

Example:

Interviewed person: "I could do much more, if I had the proper support."

Interviewer: "Proper support....?"

Source: P. L. Hunsaker & A. J. Alessandra: "The Art of Managing People", Prentice Hall, 1980

UNIT 3 - QUALITY ASSURANCE

Introduction

The overall goal of the Ministry of Health and Child Welfare is to provide quality services to all citizens of Zimbabwe. The Ministry of Health is committed to the provision of quality care given the limited resources that are available. All health care providers should aim to provide services that satisfy the consumers.

Health care providers and the community are expected to work together to assess health needs and to select an appropriate health care approach. Quality assurance promotes confidence, improves communication and fosters a clearer understanding of community needs and expectations. In order to provide a comprehensive package of quality care, all health care disciplines are expected to work as a team.

Objectives of the Unit

By the end of the unit the health service provider should be able to:

- Define quality assurance.
- Outline the quality assurance cycle
- Define the concept of quality of care
- Describe the dimensions of quality care
- Develop tools and methods to monitor quality of care

Quality Assurance:

There are various definitions of quality assurance. The Quality Assurance project (USA) summed them up as:

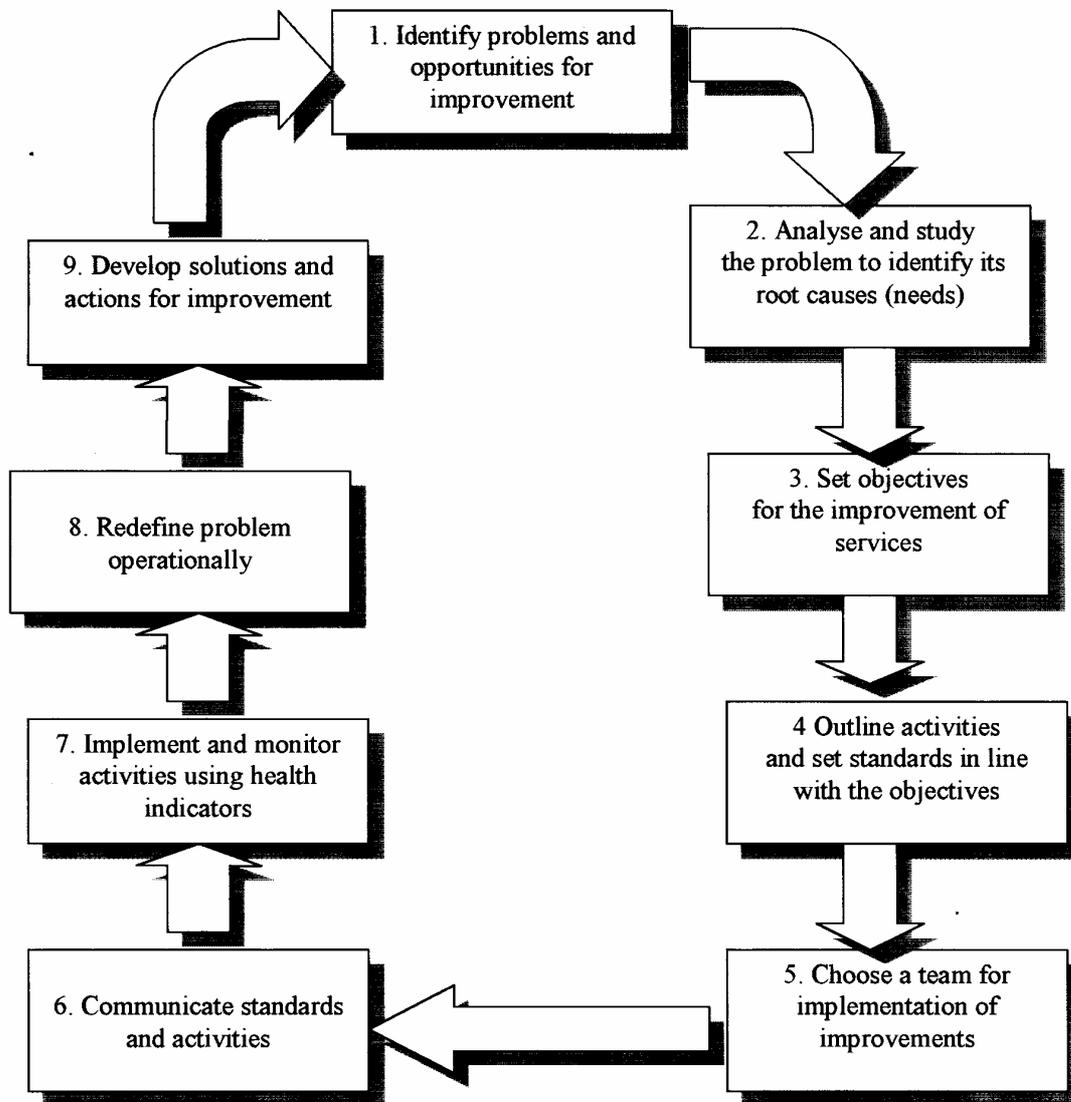
Quality Assurance: a set of activities that are carried out to set standards and to monitor and improve performance so that the care provided is effective and as safe as possible.

Quality Assurance programmes involve:

- Orientation towards meeting the needs and expectation of the patient and the community.
- Focusing on systems and processes, i.e. dealing with root causes of health problems
- Use of data to analyse service delivery
- Encourage team approach to problem solving.

The Quality Assurance Cycle

The following cycle could be used for the Quality Assurance programmes.



Steps in the Quality Assurance Cycle:

1. Assess quality of care needs and organisational scope of operation.
2. Define the problem; define gaps between actual performance and expected performance.
3. Develop solutions and actions (think critically).
4. Develop guidelines, protocols, procedures and standards.
5. Communicate guidelines, standards and specifications.
6. Provide support and supervision regarding guidelines.
7. Implement quality improvement efforts.
8. Monitor and evaluate

NB: Planning is continuous and therefore a component of all stages. Quality assurance programmes are continuous as they aim at giving the clients better services. Evaluation is equally important at all stages.

Definition of Quality of Care

The quality of technical care consists of the application of medical science and technology in a way that maximises its benefits to health without correspondingly increasing its risks. The degree of quality is therefore the extent to which the care provider is expected to achieve the most favourable balance of risks and benefits (Donabedian 1980).

From the above, quality is a comprehensive multifaceted concept which includes the following:

- Technical Competence
- Access to Service
- Effectiveness
- Interpersonal Relations
- Efficiency
- Continuity
- Safety
- Amenities/Facilities.

Quality of care implies serving clients in a way that meets their needs and makes them feel they are cared for and makes them want to recommend these services to their friends and relatives.

The following **dimensions** contribute to effective quality of care:

- Quality demands sacrifice
- Time well spent with a patient is time saved
- Quality costs less
- Satisfaction of needs between the consumer and the provider.
- Optimum care to clients, regardless of their ability to pay.
- Being friendly and courteous to consumers and clients
- Commitment and respect
- Observing ethical practices.
- Listening attentively
- Sharing information and explaining procedures
- sensitive to client's opinion
- providing appropriate constellation of service e.g. immediate attention, listening and avoiding delays

In conclusion, holistic care that fulfils the needs and the rights of a patient/client take into account the following:

1. choice of care and treatment
2. providing relevant information to client.
3. the right to:
 - a. be treated with dignity and respect;
 - b. know names of people serving you;
 - c. have privacy and confidentiality of your records;
 - d. receive explanations, education and counselling;
 - e. consent to or refuse any care or treatment.

In addition to the above, the patient also has the right to speak out, complain and acknowledge good performance.

Some methods of assessing Quality Care are as follows:

COPE is the newest method of accessing quality care. This will be explained further.

COPE stands for:-

- C - Client
- O - Oriented
- P - Provider
- E - Efficiency

COPE is defined as:

- a. a process and practical set of tools used to improve quality of health services at clinics, hospitals or organisations
- b. is one of the methods used to assess quality of care.

The following are some of the methods that can also be used:

- Focus Group Discussions
- Client self assessments
- Chart Interviews
- Analysis of patients notes
- Client suggestion boxes
- Exit Questionnaires and/or interviews
- Discharge Care plan - review date
 - instructions
 - booking

Team work in continuity of care.

Quality of care depends upon team work. Every discipline is part of the team at whatever level. In order to provide comprehensive quality of care programmes at institutional level, each discipline has a special role to play.

TEAM stands for

- T** Together
- E** Everyone
- A** Achieves
- M** More

Co-ordination and collaboration is encouraged between all the disciplines from time to time. Mechanisms to evaluate efforts should be instituted.

Lesson Plan:

1. Introduction:	Present the topic and the objectives of the session. Ensure that participants understand and agree to the objectives	5 minutes
2. Lecture - Guided Dialogue	Present the topic of Quality Assurance. Definition Quality Assurance Cycle Quality Assurance Methods	30 minutes
5. Visits	Let groups of participants visit different departments and look out for problems and opportunities for improving quality of care and services (including interviewing staff and patients)	45 minutes
3. Group Work	Form working groups and let participants elaborate recommendations and plans to improve Quality Assurance on the basis of their observations Group work Presentation and discussion of the results of the group work	45 minutes 30 minutes
4. Role Plays	Conduct a number of role plays with participants taking the role of health service provider and client. 1. Interviews on quality of care: Participants take the role of the health service provider interviewing staff and clients on their <ul style="list-style-type: none"> • view of the quality of services • recommendations for improvements 2. Reacting to complaints of client's: calming an angry client. Preparation: Have participants prepare for the role of the client or staff members and decide on their needs, complaints, areas for improvement of quality, etc. Role play: Finding out about client's views of quality issues Evaluation of the role play – trainer and participants give feedback to the role-players using the criteria laid down as guidelines. Evaluation criteria: <ul style="list-style-type: none"> • use of active listening skills exercises • helping clients express their concerns • taking clients concerns seriously • not getting angry yourself 	2 hours
		4 hours 30 minutes

Other suggestions:

- Client centred discussions;
- Recording compliments and complaints;
- Keeping records and suggestion box;
- Conducting exit interviews with clients;
- Interviews with individual clients from different groups;

UNIT 4 - CLIENT/PATIENT EDUCATION

Introduction

The concept of communication is enhanced through IPC with counselling being the central facilitating tool in the provision of quality care. Awareness of these factors promote client satisfaction which is the goal of the health care delivery system. Patient education programmes are based on the premise that patients have a right to know the current status of their health, what they can do to achieve optimum health and prevent recurrence of illness. The entry point of a proper patient education programme can start with a proper need assessment.

Objectives of the Unit

By the end of the unit the health service provider should be able to:

1. Define concepts of patient and health education
2. Outline the steps involved in planning patient education
3. Provide basic principles and concepts of the Patients Charter
4. Outline major elements of the Patient's Charter
5. Describe the common areas of potential legal liability

1. What is Patient/Client Education?

Definition of Health Education

There are many definitions of Health Education but in this module health education is defined as “any combination of learning experiences designed to pre-dispose, enable and reinforce voluntary adoption of behaviour conducive to health” (Green 1991).

Definition of Patient Education

Patient Education is one of the major elements of health education. Patient Education can be defined in various ways:

- Patient Education is the term for one-to-one and group education provided to patients in clinics and hospitals for the treatment and rehabilitation process. A well organized patient education programme can speed up the recovery process, enables a hospital to discharge patients more quickly, release hospital beds, and reduce complications and the need for follow-up. (Hubble, J. 1994)
- Bruce (1989) defines patient education as providing appropriate constellation of service e.g. immediate attention, listening and avoiding delays to clients/patients.
- Patient education is a term for educational activities in health care settings, linked to treatment procedures, medication, home care and rehabilitation procedures. Other activities of patient education include, AIDS education, dental and mental education to bring about change in behaviour.

Purposes of Patient Education

Counselling and interpersonal skills of health care providers should be improved in order to:

- provide effective and efficient services to consumers in a healthy working environment.
- ensure that patients have a right to know their current health status and what they can do to achieve health.
- provide clear information to clients with dignity, consent and respect.
- provide hospitality to patients/clients in a more friendly atmosphere.
- improve the corporate image of the hospital, institution or organization.

2. How to establish a Patient Education Programme.

Guidelines for setting up Patient Education Programmes:

- The responsibility for patient education programmes should be assigned to a selected committee in a hospital.
- Parameters for the development of patient education programmes must be according to available resources.
- The goals must be specific and should be expressed in measurable terms for the purpose of evaluation.
- An informed patient is an essential member of the health team. Ensure that patients participate fully in establishing education goals.

According to Maradzika, J. (1994) a successful patient education programme depends on the following factors: policy statements agree with patient education programme, establishing of a patient education committee, assessment of patient's needs and identification of strengths, weaknesses, opportunities and threats as well as outlining people's roles.

Steps involved in planning for patient education

Step 1: Find out what your intended audience thinks and feels about health issues and services.

Step 2: Identify learning needs of the patient: which hard facts need to be explained in patient education; which decisions have to be taken, which attitudes should be encouraged e.g. positive attitudes towards recovery and confidence in one's own ability to cope.

Step 3: Apply the understanding gained in the two steps above and select most appropriate advice to give.

Step 4: Decide where and when the patient education should take place: e.g. in the waiting area, in the hospital ward, or at the home of the patient, during consultation, after consultation.

Step 5: Decide who should do the patient education: e.g. doctor, nurse, counsellor, social worker.

Step 6: Decide which method(s) to use: e.g. one-to-one counselling, small group education or large meeting.

Step 7: Decide what learning aids would be required to support the programme: e. g posters, charts, slides, videos, take home reminders such as a leaflets.

Step 8: Decide on how you will evaluate the outcome of patient education in the short and long term.

Initiating Patient Education

- Identify interested persons
- Train a pool of the interested persons
- Appoint a health education officer or co-ordinator responsible for planning
- Design scope of content
- Suggest an approach in a hospital composed of other stake holders.

The composition of a **patient education team** may include the following persons;

- health education officer;
- physician;
- dietician;
- social worker;
- nurse;
- pharmacist;
- physiotherapist;
- radiographer;
- Laboratory technologist
- IEC Co-ordinator
- Nurse aid
- EHT
- EHO

Responsibilities of the team:

- Identify training needs;
- Carry out training.
- Media design and development;
- Implement Patient Education Programme
- Monitor and Evaluate;

NB: There is need for a focal person to co-ordinate the programme.

3. Patient Education in Practice.

Typical examples of patient/client education priorities

Education should be about:

- explaining how much, how often and when medicines should be taken and possible side effects.
- providing special diets and self administering of injections of insulin for diabetic patients.
- explaining in advance, details of operation to reduce anxiety.
- providing advice for persons diagnosed to be suffering from an illness such as asthma, diabetes, HIV/AIDS
- explaining to the parents of a dehydrated child on how to prepare and give their child oral re-hydration solution.

Example of a Plan for a Patient Education Session/Talk

- Select appropriate educational methods to meet each educational goals set for the patient and the family.
- Identify opportunities and situation for patient and family education for each of the goals.
- Determine specifically what should be taught by whom, where, when and how.
- Reiterate target groups
- Analyze behaviour to be changed
- Outline objectives
- Outline resources
- Ascertain venue
- Implement
- Monitor and evaluate.

Evaluation of Patient Education Activities

- To what extent were the education methods appropriate?
- To what extent were the educational needs from the medical point of view adequately identified?
- To what extent were patient and family knowledge adequately assessed?
- To what extent were educational goals realistic and timely?

4. The Patient's Charter

The patients charter aims to improve the relationship between patients and health care providers. It includes the information that patients receive to enable them to make informed judgements about their care and treatment. The patient's charter should facilitate the following outcomes;

- improving the quality of all public health services in Zimbabwe;
- making services more responsive to the needs of individual citizens and
- ensuring value for money.

All Zimbabweans have a right of access to health care services in time of need either as non paying or paying patients. The Ministry of Health and Child Welfare, provides services to meet the client's individual needs and expectations.

The client can expect to:

- be treated with care, consideration and respect in all their dealings with the health care providers.
- receive emergency care and treatment at any time on the basis of need, regardless of her/his ability to pay.
- give or withhold her/his consent to medical or other care and treatment.
- choose whether to take part in research or student training.

Aspects of the Patient's Charter include information about the following:

- Services
- Confidentiality
- Privacy
- Discrimination

- Consent
- Inter hospital transfers
- Outpatient services
- Care in the community
- Free services in Zimbabwe
- If things go wrong, what to do.

The Patient's Charter improves the service provider-client dialogue, thereby reducing the incidence of medico-legal Hazards

5. Medico-Legal Hazards

The main potential legal liability for the health workers is medical negligence, that is, act of omission or commission that may lead to prosecution of the health worker by the law.

Omission: failing to perform a duty that was expected of one

Commission: performing a duty not expected of one.

The law expects the Health Service Providers to be safe practitioners and to undertake only those duties for which their training has prepared them. Unreasonable risks should be avoided and it is up to the Health Service Providers to keep up to date with matters that affect their practice.

Ignorance is no defence in legal proceedings.

Areas of potential legal liabilities.

1. Incomplete records:

All records must be regarded as legal documents. Records containing the following must be carefully kept:

- a. Proper identification of patient
- b. Physical and mental condition of patient at admission
- c. Method by which patient was admitted, i.e. whether walking, in a wheelchair or on a stretcher
- d. Vital signs on admission and subsequently (as failure to communicate changes in patient's condition may lead to serious outcome like haemorrhage, asphyxia or even death). The reports on patient's condition must be clear and concise so that they can be understood by everybody.
- e. Kitting, clothes and valuables

2. Lack of knowledge

- Duties and responsibilities
- Code of ethics
- Procedures which may lead to adverse effects, e.g. blood transfusion
- Prevention of cross infection

3. Injury to patient due to:

- Use of defective equipment
- Abandonment – leaving a patient unattended to in the ward, on trolleys in the corridor or in unfamiliar surroundings
- Falling out of bed or stretchers, falling on slippery floors

- Burns from hot bath, incubators or heaters
- Over-exposure to X-rays
- Restrainers used incorrectly
- Damaged bedpans and urinals
- Suffocation in oxygen tents without oxygen
- Aspiration of feeds
- Trauma during procedures, etc.

The list is not exhaustive, one can come up with lots of other examples of incidents in which the patient may be injured and the health worker is found liable.

4. Infection or spread of infection from:

- Inadequate precautionary measures in the prevention of cross infections.
- Dirty drains, walls, floors, equipment, utensils, incubators, oxygen tents and bath tubs.
- Bad ventilation.
- Lack of isolation wards.
- Incorrect sterilisation methods and care of sterile apparatus.
- Incorrect aseptic technique.

5. Inadequate and incorrect treatment.

- Giving the wrong drugs or giving drugs to the wrong patient.
- Incorrect technique in giving drugs.
- Omitting a drug.
- Incompatible blood transfusion.
- Tight plaster.

6. Assault and battery

The law says, that any treatment, examination, operation etc. performed without the consent of the patient constitutes an assault for which the aggrieved patient can recover damages. Medical paternalism is neither ethically or legally acceptable.

Thus assault means threatening or attempting to make bodily contact without consent. Actually carrying out the threat is battery. Consent however, should be informed.

In cases where parents of minor children unreasonably withheld consent, one can obtain written authority to proceed from the Medical Superintendent or the magistrate. The law also intervenes when withholding consent can endanger a third party, e.g. the public health act calls for compulsory treatment of infectious diseases.

Consequences of Medico Legal Hazards.

The consequences of medico-legal hazards are many both for the patient and to the health service provider.

Consequences for the patient include:

- worsening of condition
- prolonged hospitalisation with extra expenses
- disability
- social and financial disruptions
- death.

Consequences to the health service provider depend on the branch of the law that is taking up the case:

1. **Criminal prosecution:** the health service provider may be brought to the criminal court of law by the state. Punishments range from fine to imprisonment.
2. **Civil prosecution:** the health service provider is sued for damages in the civil court of law by a patient or his/her dependants.
3. **Disciplinary action:** The employing agent or the Health Profession Council may take disciplinary action in the form of a warning, suspension or dismissal or being struck from the practising register, in which case one cannot legally practise anywhere in the country.

The health service provider should remember that the clients in this country are usually much enlightened and aware of their rights.

Conclusion

The success of client/patient education programmes depend on the attitude and effective communication of health workers and clients and on good public relations.

Lesson Plan:

<p>1. Introduction:</p>	<p>Present the topic and the objectives of the session. Ensure that participants understand and agree to the objectives</p>	<p>5 minutes</p>
<p>2. Lecture - Guided Dialogue</p>	<p>Present the topic on Patient Education</p> <ul style="list-style-type: none"> - What is Patient Education - How to establish a Patient Education Programme - The Patient Charter - Medico-legal Hazards 	<p>30 minutes</p>
<p>3.Role Plays</p>	<p>Conduct a number of role plays with participants taking the role of health service provider and client. Chose from the following situations:</p> <ol style="list-style-type: none"> 1. Educate patient by explaining how much, how often and when medicines should be taken and possible side effects. 2. Educate patient on special diets and self administering of injections of insulin for diabetic patients. 3. Explain in advance, details of operation to reduce anxiety. 4. Providing advice for persons diagnosed to be suffering from an illness such as asthma, diabetes, HIV/AIDS 5. Inform patients on their rights. <p>Preparation: Have the participants prepare the message and prepare to act the role of the health service provider Role play: Conduct education session Evaluation of the role play – trainer and participants give feedback to the role-players using the criteria laid down as guidelines.</p> <p>Evaluation guidelines:</p> <ul style="list-style-type: none"> • Was a proper atmosphere created for the education? • Was the message clearly formulated? • Was the message adapted to the patient’s understanding taking into account background, education etc.? • Were patient’s questions answered and patient’s concerns taken up? 	<p>2 hours</p>
		<p>2 hours 30 minutes</p>

UNIT 5 - PUBLIC RELATIONS

Introduction

The Ministry of Health and Child Welfare's mission is to provide quality health care services. Proper dealing with clients/patients, and especially skilful and honest handling of their complaints, has become a vital mechanism which will enable the health institution to retain people's loyalty. In this regard, every health service provider has a public relations role to play.

Objectives of the Unit

By the end of the unit the health service provider should be able to:

1. Define public relations
2. Explain the role of public relations in the health care delivery system
3. Outline the 10 steps of handling client/patients complaints and dealing with rude people
4. Describe the techniques of handling clients'/patients' complaints

Definition:

Public relations is about marketing the image of the institution/organisation so that patients and health care providers are appreciative of each other's responsibilities, making everyone's job less complicated. The image of an organisation is formed by the ideas and opinions about this organisation in peoples' mind. A positive image of the health system can be created through the deliberate provision of information, but most of all through what clients /patients experience when dealing with health care providers.

Public relations is a continuous and systematic effort to promote mutual understanding between the client and the institution.

- **Continuous and systematic effort:**

Not a once only action but a policy. An ongoing, planned, sustained, improvement process that systematically measures client satisfaction and takes necessary action to maintain and improve health services.

- **Mutual understanding:**

Gain information on patients'/clients', needs and expectations, and use it for the design and improvement of health services

- **Make sure the client is aware of your efforts in making them satisfied.**

The 10 easy steps of complaint handling

1. Listen.
2. Thank the patient for-informing you.
3. Acknowledge- empathise. Even if you do not agree with the patient, you can show your concern and understanding of the problem.
4. Identify the exact nature of the problem.
5. Investigate/research the matter, if necessary.
6. Apologise.
7. Offer a solution.
8. Let the patient decide whether the solution is acceptable. Ask the patient what he or she feels needs to be done to correct the situation. Learn the boundaries of your authority and work within those limits.
9. Take action immediately.
10. Keep the patient informed and follow up with a phone call or a letter.

Dealing with rude people

Once in a while you may meet someone who is trying to provoke you into a heated response or to beat the system by threatening behaviour. A patient's nervousness may translate into aggressive posturing. Remember, that rude people generally believe that rude behaviour is the only way they can get satisfaction. Make it a challenge to prove them wrong.

Common sense, good manners and a command of the 10-step process of complaint handling as outlined above will help you deal with rude people. In summary:

- Never get personally upset with offensive comments. Remain professionally detached.
- Let the person get everything off his chest, let him explode.
- Remain calm and patient, as by doing so you may just shame a person into behaving better.
- Concentrate on the facts and ignore the emotive tactics the person is using.
- You can control a conversation by bringing the discussion back to the facts.

Techniques of handling patients'/clients' complaints

- Don't be defensive.
- Be calm at all times.
- Don't take criticism personally. It is not you the client is angry with; try to be objective and put yourself in their shoes.
- Offer an apology even if the disservice is not your fault.
"I'm terribly sorry you are so upset" does not admit blame, but does establish some rapport with the client.
- Show empathy by using such phrases as, *"I can understand how you feel"*, *"I appreciate what you are saying"*.
- Address patient by name.

How to handle patient's complaints

It is inevitable that you shall have to deal with dissatisfied patients some time. Dealing with an aggrieved patient may be demanding, but if you make every effort to resolve all complaints while the patient is still on the premises, almost every problem can be resolved. In failing at the initial stage to deal adequately with a disappointed patient, you are actually creating your own demanding patient who will be far more difficult to deal with as his problem escalates.

When communicating with an unhappy client/patient you are the public face and voice of your institution. Therefore, your ability to communicate well with a client is of paramount importance.

Consider all the aspects of communication:

- how you look (clothing and adornment)
- how you act (facial expression, head movements, gesture)
- what you say (content) and how you say it (tone and pitch of your voice)
- how you speak to transmit a positive attitude
- what your body language tells about you (smile, establish eye contact and have a good posture).

*Try and remember the basics of good client communication. These can be summed up in the process described by the memory aid **SARAH***

SARAH contains five key aspects:

1. Stop talking, give the patient the opportunity to explain his/her concerns
2. Adopt active listening, do not simply hear what is being said, but really listen,
3. **R**eflect content or feeling, show that you have understood what the patient has said,
4. **A**ct with empathy, indicate that you understand and appreciate the feelings and the motivation of the client. Show that you care.
5. **H**andle the subject matter, correct the problem.

Below we will see how to implement these aspects in the routine of complaint handling.

Complaint handling

In your encounter with a distressed patient you first need to realise that the complaint is a request for help and not a reflection on your personality. Maintain your composure and leave personal feelings and opinions out

Complaint handling should be simple and organised. The following steps which have been built around the five key aspects of patient communication (SARAH will help you be as effective as possible when dealing with dissatisfied patients in any situation).

- All communication should be in the first person. Use: *"I apologise"*, not the royal "We".
- Don't make excuses or blame others in your organisation. The client wants a solution to the problem, not an inquisition of your internal operations.
- Give the client your full attention and establish eye contact. Sympathetic nods help defuse situations and many clients feel they are receiving a fair hearing if they see someone jotting down a few notes.
- Paraphrase their complaint in your own words to determine if you have correctly understood the situation. Play the situation back to them to check for understanding: *"I just want to check that I have understood you correctly"*
- If you don't know the answer to their problem, don't lie. Adopt the old teaching maxim and admit you don't know but make a commitment that you will find out and get back to them within a specific time.
- Do call back when you say you will, even if, for some reason, you haven't been able to obtain a satisfactory answer by then
- Make the client part of the solution - not part of the problem.

Conclusion

**Good public relations is making people feel good when you help them,
and feeling good yourself when you help others.**

Lesson Plan:

1. Introduction:	Present the topic and the objectives of the session. Ensure that participants understand and agree to the objectives	5 minutes
2. Lecture - Guided Dialogue	Present the topic of Public Relations - The importance of public relations - Communication rules for creating a favourable impression Rules for dealing with complaints	40 minutes
3. Brainstorming	Brainstorming on how to handle patient's complaints and how to deal with rude people.	20 minutes
4. Role Plays	<p>Conduct a number of role plays with participants taking the role of health service provider and client. Chose from the following situations:</p> <p>1) Handling patients complaints 2) Dealing with rude people</p> <p>Preparation: Have participants prepare for the role of the patient and define their complaint or criticism Role play: Conduct a series of role plays on handling complaints and dealing with rude people. Evaluation of the role play - trainer and participants give feedback to the role-players using the criteria laid down as guidelines.</p> <p>Evaluation guidelines:</p> <ul style="list-style-type: none"> • Did the participants in the role of the health care providers observe the 10 steps of handling complaints? • Did they succeed in calming the patient/client? • Did they reach a mutual understanding? 	<p>2 hours</p> <p>40 minutes 40 minutes</p>
5. Discussion	Discuss with participants which factors will contribute to a positive image and good public relations	20 minutes
6. Field Visit	Visit different departments and observe the premises and the interaction with patients with an eye on public relation issues	2 hours
		4 hours 40 minutes

ANNEX 1: NEEDS ASSESSMENT QUESTIONNAIRE FOR PATIENTS/CLIENTS

Please kindly help us improve the quality of our service by responding to some questions we are going to ask you. Be as open as possible since your responses will be kept confidential and only be used in the improvement of our services in the future.

1. Name of hospital
2. Date 3. Age:yrs
4. Sex: M []
F []
5. Religion
6. Occupation
7. Level of education: Never went to formal school []
Primary Education []
Secondary Education []
Tertiary Education []
8. Which departments did you visit? Where you happy or not with the services offered?

DEPARTMENT	HAPPY	NOT HAPPY	COMMENTS
Security			
Registration			
X-Ray			
Casualty			
Out Patients Dept.			
Pharmacy			
Mortuary			
Rehabilitation			
Laboratory			
Wards (Specify).....			
Other (specify)			

9. Would you recommend our services to any of your friends/relatives? YES []
NO []

10. (a) Did health care providers talk to you about the following:

	YES	NO
Your condition	[]	[]
Your treatment	[]	[]
Your tests	[]	[]
Your results	[]	[]

11. (a) Would you like to get more information on health issues? YES []
NO []

(b) If yes, in which 3 health issues would you like more information?

- i. .
- ii. .
- iii. ..

12. In which ways would you prefer to learn about health issues?

- a. Pamphlets []
- b. Booklets []
- c. Video/films []
- d. Radio []
- e. Newspapers []
- f. Health workers []
- g. T.V []
- h. Other (specify)

13. Comment on the following:

- a. Staff attitudes: Friendly []
Indifferent []
Hostile []
Mixed []
- b. Waiting Time (Before being attended to):
Less than 1 hour []
1 hour - 4 hours []
More than 4 hours []
- c. Cleanliness of Institution: Clean []
Very clean []
Dirty []
Very Dirty []

14. Can you give us suggestions for the improvement of services at this hospital.

.....

.....

.....

ANNEX 2: TRAINING NEEDS ASSESSMENT
QUESTIONNAIRE FOR HEALTH CARE PROVIDERS IN
INTERPERSONAL COMMUNICATION

Please fill in this questionnaire to facilitate the improvement of patient care through Interpersonal Communication (IPC).

1. Name of Institution
2. Designation/Title
3. Department/Unit.....
4. Are you involved in patient education? YES/NO
5. What are the aims and objectives of patient education?
.....
.....
6. What is Interpersonal Communication?
-
-
7. State five qualities of a good communicator?
 - a).....
 - b).....
 - c).....
 - d).....
 - e).....
8. What are the barriers to Interpersonal Communication?
 - a).....
 - b).....
 - c).....
 - d).....
 - e).....
9. What are some of the skills required in Interpersonal Communication?
 - a).....
 - b).....
 - c).....
 - d).....
 - e).....

10. What are the essential element of the IPC process?
 a).....
 b).....
 c).....
 d).....
 e).....
11. What are the oppotunities of Interpersonal Communication in your department??
 a).....
 b).....
 c).....
 d).....
 e).....
12. According to Patients Charter what are the rights and obligations of the patients.
- a. Rights of patients
 a).....
 b).....
 c).....
- b. Obligations of patients
 a).....
 b).....
 c).....
13. What is quality care?

14. What is Public Relations?

15. In which conditions or diseases would you require more information and management skills?

CONDITION/DISEASE	INFORMATION	MANAGEMENT SKILLS
TB ARI Malaria HIV/AIDS Diabetes Mellitus Hypertension Epilepsy Eye conditions Mental Health Breastfeeding Sexual Abuse Antenatal Care Postnatal Care Malignant Conditions Diarrhoeal Diseases e.g Cholera, Dysentery Other (Specify)		

**ANNEX 3: NEEDS ASSESSMENT QUESTIONNAIRE FOR
INTERPERSONAL COMMUNICATION (IPC)
MANAGEMENT AND SUPPORT SYSTEMS.**

Please fill in this questionnaire to enable us improve patient care through Interpersonal Communication (IPC).

Instructions:

- Do not write your name on this questionnaire
- Tick where appropriate.

Institution: Date:

BACKGROUND STATISTICAL DATA

Catchment Population	MALE	FEMALE	TOTAL
Population under 1 year			
Population under 5 years			
Population 14-49 years			
49 years + Adult males			
GRAND TOTAL			

2. a) TOTAL ATTENDANCES (1995, 1996, 1997)

YEAR	eg 1995	eg 1996	eg 1997
OUTPATIENTS			
ADMISSIONS			

3. A) **TYPES OF ILLNESS (TOP 5 IN PRIORITY ORDER)**

ILLNESS	1995 <5	>%	1996 <5	>5	1997 <5	>5
1.						
2.						
3.						
4.						
5.						

3. B) **CAUSES OF DEATHS (IN PRIORITY ORDER)**

CAUSE	1995 <5	>5	1996 <5	>5	1997 <5	>5
1.						
2.						
3.						
4.						
5.						

4. (e) (i) Nurse - patient ratio =
(ii) Doctor - patient ratio =

5. **HEALTH EDUCATION MATERIALS AVAILABLE**

TYPE (PRINT/ELECTRONIC)	SUBJECT
a)	
b)	
c)	
d)	

6. **HEALTH EDUCATION EQUIPMENT AVAILABLE**

TYPE	NUMBER	WORKING	NOT WORKING
a) TV/Video Cassette Recorder			
b) Radio Cassette Recorder & Radio			
c) Overhead Projector			
d) Slide Projector			
e) Display Boards			
f) Pamphlet Stands			
g) Flipchart stands etc.			

7. **AVAILABILITY OF OPERATIONAL POLICY/GUIDELINES**

	YES	NO
* Hospital	[]	[]
* Departmental	[]	[]
* Programme	[]	[]
(Specify).....		
.....		

8. **STAFF ESTABLISHMENT**

CATEGORY	NUMBER	1995	1996	1997

9. **COURSES ORGANISED/IMPLEMENTED**

TYPE OF COURSE	TARGET GROUP	NUMBER	COURSE	YEAR	SPONSORING AGENCY

10(a) Is there a patient education committee? YES/NO

(b) If NO why?

.....

11. a) Is there a planned and comprehensive patient education programme? YES/NO

CONSTRAINTS AND OPPORTUNITIES

12 a) What are the opportunities for Patient Education in this institution?

- 1.....
- 2.....
- 3.....

12. b) What are the constraints in Patient Education?

- 1).....
- 2).....
- 3).....

Annex 4: Twenty Hints for Happier Patients

- Always receive and welcome patients with a smile and address them as Mr/Mrs/Miss or by the name; Never "next"
- Explain any delay expected in keeping the appointment to time. A patient who is told the reason for a delay remains cooperative. One who is ignored will be resentful.
- Prepare the treatment room before the patient enters. Get everything possible ready according to the record card. The patient's entry should be the last action, not the first. No trace of a previous patient's treatment should remain visible.
- Offer to help patients with their bags, baskets shopping etc, don't wait until they have put them in the wrong place and then reprimand them.
- Choose words used within the patients' hearing with discretion in order to avoid scaring the patient unnecessarily.
- Try to make the patient as physically comfortable as possible under the circumstances. Don't leave them in uncomfortable or embarrassing positions for longer than necessary.
- Don't go away and leave the patient in the room without explanation (e.g. to answer the phone). The patient will wonder what is going to happen.
- Never carry on a private conversation with another health worker in the presence of a patient. This will make them feel uncomfortable and "in the way".
- Never show a patient an appointment book. It is confidential. Patients should not dictate when they will come next.
- Never say "there's none" "it's finished" in front of a patient. The patient will think he is getting second best.
- Always remember that a patient is more important than someone on the end of a telephone. Keep your attention to the patient until you have finished dealing with them.
- Don't leave the room for a time while looking for something, leaving the patient in an uncomfortable position.
- Do not send patients with more serious injuries back to the bench to upset all those following. Take them elsewhere to recover.
- Always tell patients the truth so that they know what to expect, but help them accept it by being supportive and optimistic.
- Slight physical contact with the patient is reassuring.
- Talk to patients about what you are doing and why.

- Keep history taking confidential in all cases and at all times.
- Remember that the layout of the building itself may mean it is easy for people waiting outside to overhear you talking with the patient. Make every effort to maintain confidentiality.
- Make every effort to warn patients if their appointment has to be delayed. Don't let them come to the health centre and then tell them to "come back tomorrow".
- Always remember the patient is a V.I.P. at all times. Be kind and thoughtful.

Adapted (Ministry of Health Seychelles 1993)

Annex 5: ELEMENTS OF THE NONDIRECTIVE DIALOGUE **GUIDANCE**

Acknowledgement

- **non-verbal signs** that the receiver is listening: full attention directed towards the sender, eye-contact, nodding, pauses, silent listening
- **"half"-acknowledgement:** verbal signs that the receiver is listening - assenting or consenting mumbling: "hhhmmm" ("Go on, I'm listening")
- **"Full" acknowledgement:** "good" - "ok" - "fine" - "thank you" ("Stop. I have got the message.")

Summarising

- **Summarizing** the content of the message (Demonstrating that the receiver has understood correctly)
- **Echo Questions:** Repeating of the message or parts of the message (steering the conversation by encouraging the sender to give more information)
 - Repetition of the whole sentence or parts of the sentence
 - Repetition of selected words
- Taking up **body language** (encouraging the sender to give more information) ("*You smile...*" - "*You frown...*" - "*You're shaking your head...*")
- Taking up the **emotional aspects** of the message, to encourage the sender to speak about his/her feelings ("*You are concerned...*" - "*You felt angry...*" - "*You feel disappointed....*")

Questions

- **Open Questions** should be widely used. They
 - encourage the sender to open up
 - leave a wide spectrum from answering
 - often begin with a "w": "what" - "why" - "where" - "when" - "who" ... etc.
- Chose the direction of the question to explore

the past:	<i>"How did the situation develop?"</i>
the present	<i>"How do you see the situation now?" - "What is your assessment of the problem?"</i>
the future:	<i>"What should happen next?"- "What are your plans?" - "What do you expect?"</i>

- Avoid "closed" questions which influence the other person and suggest specific answers
 - alternative questions: *"Do you tend to react aggressively or to withdraw instead?"*
 - suggestive questions: *"You do agree to take rather strict measures?"*
 - covert solutions: *"Why don't you try negotiating with your opponent?"*

ANNEX 6: COPE

COPE is a process and a set of tools used to improve quality of health service at clinics, hospitals or organisations.

Rationale for COPE

- simple to use
- easy to understand
- cost effective
- uses no resources at all
- it works
- it empowers

COPE components

- self assessment
- client interviews
- client flow analysis
- action plan

Self Assessment

Managers should learn to assess themselves, and encourage people to create a conducive environment for the staff, particularly in the following areas;

- equipment
- staff development
- safety
- appreciation

OR

"Can I do more for the clients I have just examined"

- Did I do my best?
- Was I careful?
- How did I communicate?
- Did I treat clients with respect?
- Did I allow choice?
- Could I have done better?

Client Interviews

- Staff themselves should find out how their clients feel about services offered
- Staff should seek for ways of improving service
- Staff is objective and want change

Client flow analysis (C.F.A.)

- Method of tracking clients from the time they enter the hospital to the time they leave the hospital (Client flow analysis forms may be used).
- Identify bottle necks.
- Identify missed opportunities
- Identify missed contacts
- Measure client waiting time.
- Provide personnel cost estimates.
- Identify unscheduled client contacts.

Action Plan

After obtaining data, you should come up with an action plan that states the following:-

- The identified problem.
- Recommend solutions or strategies
- Who is going to carry out plan?
- What facilities/resources are needed?
- How are you going to monitor and supervise
- Evaluation.

Remember COPE belongs to the institution therefore solutions to be developed are for the institution.

Annex 7: How to prepare for Practical Exercises

The trainer should;-

- Motivate participants to learn by practical applications;
- Provide examples of practical applications;
- Assist learners to reflect on the need to apply skills learning as this assists participants to transfer from theory to practice;
- Prepare for possible difficulties with practical applications;
- Stress importance of exercise and point objectives.

List characteristics which indicate that the exercise is being carried out correctly:-

- Allow practical applications/demonstrations;
- Follow steps in the correct order;
- Familiarise participants and demonstrate with participants;
- Repeat exercise with participant;
- Do one theory at a time;
- Give feed back on results during the exercise;
- Carry out error analysis of the outcome and allow corrections to be made;
- Remember to keep attention and interest;
- Observe change; speech, voice loudness, voice modulation, speed.

Interaction

- S** - Share conversation
- H** - Help strengthen client participation
- A** - Agree on mutual focus.
- R** - Respect each other
- E** - Equal Input

Exercise to demonstrate skills

Emotion - Handling skills

- Design a case study
- Conduct role play on the case study
- Discuss and evaluate the role plays.

Problem solving skills

Aims to help Health Care Providers to gather information on people needs.

- Encourages people to actively listen
- Encourages dialogue by asking open questions
- Avoid interceptions

Good social skills aim at making people feel comfortable when they visit health institutions/clinics.

- Greet the client and welcome them
- Ask about the persons feelings
- Praise the persons' efforts
- Encourage them to say more
- Show support and understanding. Help them not to worry too much by suggesting alternatives

Counselling and Education

They are effective ways to explain health issues and treatment.

- Find out the person's views on their illness.
- Correct misunderstandings.
- Use appropriate language
- Present information in a logical manner.
- Check whether the clients understands what you have told them about their illnesses.
- Be specific.
- Make sure they know when to come back.
- Ask if there is anything else they would like to know.

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Support Materials for Trainers

Key sources for lists of available IPC training materials worldwide

AHRTAG (now called Health Link)
Farringdon Point
29-35 Farringdon Road
London EC1M 3JB, UK
Tel: 44 171 242 0606
Fax: 44 171 242 0041
E-mail: ahrtag@geo2.geonet.de

TALC (Teaching Aids at Low Cost)
PO Box 49
St Albans
Herts AL1 5TX
Fax: 44 1727 846852
E-mail: talkuk@btinternet.com

Specific Resources recommended for IPC

Communicating Health: an action guide to health education and health promotion. J Hubley. TALC £6.30

Health Care Together. Edited by M Johnstone and S Rifkin. Training exercises for HCWs in communication skills and teaching methods. TALC, £3.80

Children for Health - key health messages and communication ideas for HCWs dealing with children in/out of the health care setting. TALC, £2.00

Communicating with Children, Naomi Richman. Aims to help those working with children to develop their listening and communication skills to identify and help children with particular needs. TALC £2.80

Learning to Listen to Mothers, J Vella and V Uccellani, trainer of trainers manual in IPC skills for community health workers. Focus on nutrition and child development monitoring.

Slide set from TALC (self mounting £5.50)

Raising Awareness of Safe Motherhood, excellent slide set for all levels of health workers on how to communicate the importance of, and issues around safe motherhood to patients/members of the local community.

Challenges in AIDS Counselling - this video is an essential training tool for better IPC related to dealing with patients at risk of HIV/AIDS.

"*Gather*" - video obtainable at ZNFPC - IEC Unit.

"*Making Things Clear*" - video obtainable at Ministry of Health and Child Welfare (Health Education Unit).

"*Next is not enough*" - video obtainable at ZEDAP c/o Pharmacy Department, Ministry of Health and Child Welfare.

More videos are available via Media for Development Trust, 135 Union Av., PO Box 6755, Harare, Zimbabwe. Tel: 263 4 733364/5, Fax 263 4 729066 E-mail: mfd@mango.zw)