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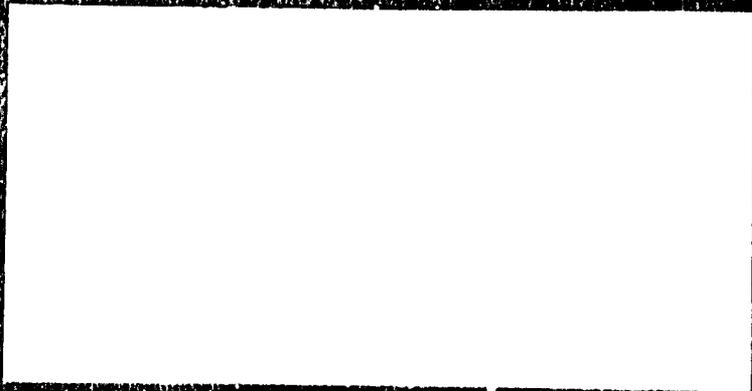
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**A REPORT ON  
TECHNICAL ASSISTANCE IN  
DEVELOPING HUMAN RELATIONS SKILLS  
FOR HEALTH CENTER STAFF IN PANAMA**

**A Report Prepared By:  
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## **EXECUTIVE SUMMARY**

## EXECUTIVE SUMMARY

### Purposes of the Assignment

The purposes of this two-week assignment in Panama were to identify problems in the delivery of family planning services that are influenced by poor attitudes and procedures of clinic personnel; to work with MOH personnel in designing a short-term training program to improve human relations in the delivery of family planning services; to test and evaluate the program that was designed; and to prepare a checklist for clinic personnel involved in the delivery of family planning services.

### Methodology

During this assignment, meetings were held with relevant individuals in the local AID mission and in the Ministry of Health (MOH); relevant reports, studies, and other materials available in-country were read; staff and patients at four health centers were observed and interviewed; and observations were reviewed with relevant MOH personnel. Following the identification of the problems, solutions were explored with MOH personnel. Pilot training courses for health center directors and other health center staff were developed in conjunction with appropriate MOH personnel and were tested in one trial of each of the two courses. The trials were evaluated in conjunction with the MOH personnel involved. Discussions to outline future steps were held with MOH training personnel, the head of Maternal and Child Health (MCH) in the MOH, the AID Population Officer, and the directors of the health regions where the pilot courses were conducted.

### Findings

Findings at the health center level point to problems in the treatment of patients and in relationships between clinic personnel. Patient obstacles include the need to come early and spend many hours at the center; lack of privacy (for example, the patient is required to tell the clerk which family planning method is being used or is desired; there is also a lack of privacy in the examining room); the lateness or non-attendance at clinics of obstetrician-gynecologists; the paternalistic attitude of the staff; abrupt treatment of patients by staff; staff impatience with patients' "slowness"; and staff unwillingness (or inability) to spend time counseling patients. Personnel felt frustrated by the crowded conditions at the health centers, were irritated with what they termed "patient irresponsibility" (loss of clinic card, not following instructions, etc.), felt that patients were "difficult to educate", and complained that some patients

get angry and are abusive. Problems between staff members include criticism of each other in front of patients, lack of positive feedback from colleagues and superiors, the feeling that workloads and pay are inequitable, and lack of clarity in role definition. Some of these problems are complex, but most can be addressed, at least partially, in human relations workshops.

In the MOH there is some confusion over who is or should be responsible for developing and conducting human relations training. A commission of the members of different units (at different levels) within the MOH and from different disciplines has been appointed. Among the appointees, interest in and experience with this subject vary considerably.

There is also some territoriality among different units in the MOH and this has led to disagreements over who will be responsible for human relations training. The consultants' visit served as a catalyst to free the people who were interested to come together to work on this topic and to take some initial steps towards organizing themselves and the training activities and networks. These initial steps need to be followed up and supported so that the momentum will not be lost.

### Recommendations

Recommendations were made in three areas: structures for human relations training; training content; and selection of personnel to carry out training. In sum, it is recommended that a structure be set up to organize and supervise training from the national level down to each health center and that training be guided primarily by experiences and not rely on the presentation of didactic material. The desirable characteristics of individual trainers are also indicated.

## **I. INTRODUCTION AND BACKGROUND**

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### Purposes of the Assignment

The purposes of this two-week assignment in Panama were to identify problems in the delivery of family planning services that are influenced by poor attitudes and procedures of clinic personnel; to work with Ministry of Health (MOH) personnel in designing a short-term training program to improve human relations in the delivery of family planning services; to test and evaluate the program that was designed; and to prepare a checklist for clinic personnel involved in the delivery of family planning services.

In 1979, AID and the Government of Panama agreed on the Population II project, which is funded by a grant of up to \$3,250,000, the money to be spent over five years. The grant funds are intended to be used for population-related activities, including baseline studies of demographic trends and of contraceptive prevalence, improvements in family planning services within the MOH program, programs such as sex education with the local International Planned Parenthood Federation (IPPF) affiliate, the APLAFA, and projects with the National Program of Sex Education.

One of the projects with the Panamanian MOH is designed to improve human relations skills in health centers. Staff-patient relationships are of particular concern. MOH and local AID mission staff feel that women are not returning to health centers for contraception, in part because of poor communication between staff and patients. In particular, it was felt that staff attitudes often discouraged potential or actual contraceptive users.

Staff in the Maternal and Child Division of the MOH (which is directly involved with the AID population grant) and local AID mission staff agreed on the need to try to improve human relations in the health centers. As of June 1980, three alternatives had been proposed.

1. A private firm in Panama offered to conduct human relations training at a limited number of centers for \$12,000.
2. The same firm also offered to train staff at a fewer number of centers for \$7,000.
3. A health educator in the MOH offered to run weekend training sessions at many different health centers over a three-year period for \$3,000.

The staff at the local AID mission had reservations about each of these alternatives. They felt that the private firm was expensive, would reach relatively few centers, and might not be responsive to the particular needs of the health sector. Furthermore, the training would not be replicable, except at the same high cost. Staff appreciated the health educator's offer, but thought that it would be difficult for someone to spend so much of his weekend time working, that the task was too much for one person to manage alone, and that an outside assessment of this person's capabilities would be useful.

The two consultants were asked to travel to Panama to assess the situation and to make and test recommendations for human relations training in health centers in Panama. One of the consultants, Susan Scrimshaw, is an anthropologist with extensive experience in Latin America, particularly in family planning and maternal and child health. She has addressed the issue of staff-patient interaction and respectful treatment of patients in both research reports and reports on program development and evaluation. The other consultant, Patricia Engle, is a developmental psychologist with experience in Guatemala and in Brazil in programs related to women, child care, and child development. She has worked with a variety of behavioral modification and human relations training techniques.

### Itinerary

The two consultants arrived in Panama on July 20, 1980, and departed on August 3, 1980. While based in Panama City for the entire stay, they made field trips to health centers on July 22, 23, and 24. They attended workshops in the town of Chorrera on July 30 and 31.

### Country Profile Data\*

#### A. Demographic Features

Panama's population was estimated to be 1,075,541 in 1978. The birth rate has decreased from 38.9/1,000 in 1968 to 28.4/1,000 in 1977. The Project Paper attributes this to education, urbanization, and "widespread adoption of modern means of contraception" (1979:1). The paper estimates that approximately one-half (47 percent) of women between 15 and 49 in a "stable" sexual union now use contraception. More than 20 percent of women of fertile age in Panama have adopted voluntary surgical contraception. Of those who now practice contraception, 70 percent receive family planning services through the public sector.

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\*Based on "Population II" (Project Paper), AID/Panama, 1979.

Despite the reduction of the crude birth rate, Panama is still experiencing a high annual rate of population growth: 2.4 percent. This continued high rate of growth in the face of declining fertility is due to a similar decline in mortality, particularly infant mortality.

Because of high fertility and lower mortality in the 1960s, the proportion of young people in the population is high. Forty-three percent of Panamanians are under 15 years of age. The number of women at risk of pregnancy (i.e., women between 15 and 49) is expected to increase from 321,000 to 517,000 between 1970 and 1985 (Population Project Paper, 1979:3). Since 1970, the proportion of all births in Panama to women between 15 and 19 years of age has been rising.

## B. Sociology

Panama's population is an amalgam of many ethnic groups (Spanish, French, African, Chinese and Japanese, some East Indian, and others) that have immigrated to Panama since the discovery of the New World. There are also three Indian groups of pre-Colombian origin that have retained their language and much of their culture. These are the Guayami (approximately 45,000 people in 1970), the Cuna (approximately 25,000 people in 1970), and the Choco (approximately 6,000 in 1970). The national language is Spanish.

According to estimates for 1977, the population is almost evenly divided between the rural and urban areas. World Fertility Survey data indicate that the ideal number of children is higher for rural areas (4.9 as opposed to 3.7 for urban areas) and that the proportion of women of reproductive age contracepting at this time is lower for rural areas (50 percent as opposed to 70 percent). However, the World Fertility Survey did not collect information on women under 20, who are less likely than older women to use contraception (Harrison, 1978:7). This is even more significant given the fact that the common age at which to initiate legal or de facto unions is 15. In Harrison's study of a rural population, only 17.7 percent of women age 15 and older declared themselves single (Harrison, 1978:8).

The health care delivery system combines two once independent agencies: the Ministry of Health and Social Security Systems. It is a traditional system in that much of it is clinic-based, although there is a home-visit program. The Panama Project Paper points out a number of weaknesses in the existing system, including "the clinic-only approach," administrative problems such as poor communication with rural health centers, and problems with staff-patient relationships (Panama Project Paper, 1979:8-10).

## **II. OBSERVATIONS AND FINDINGS**

## II. OBSERVATIONS AND FINDINGS

### Methods for Assessing Problem

#### A. Clinics Visited and Data Collected

Four centers were visited in order to determine whether there were "human relations" problems among staff members and between staff members and patients that would or could affect patients' continuation rates. One of these centers was located in the metropolitan region of Panama City; three were in marginal areas. These visits were made on Tuesday, Wednesday, and Thursday of the first week. The observers were interested not only in identifying human relations problems that might present barriers to patients' continued use of family planning services, but also in observing other characteristics of center procedures which might cause difficulties for patients. Systematic observations were also made of use of space and crowding, flow of patients, staff treatment of patients, and adequacy of examining rooms in terms of patient modesty, privacy, etc.

In interviews with staff members, the consultants addressed the following areas of major concern:

1. Staff members' perceptions of their specific tasks or roles.
2. Motivations for choosing the particular career (e.g., nurse, secretary) and the current position in the health center (e.g., convenience, opportunity, money, dedication to serving people).
3. Staff perceptions of sources of reward and satisfaction in their work and sources of positive feedback.
4. Staff perceptions of patient attitudes and complaints about service at health centers.

Patients at the centers were interviewed to determine:

1. Satisfaction and dissatisfaction with clinic treatment and service.
2. Family planning history and current usage of family planning methods.

3. Perceptions of potential sources of family planning information (all personnel, only one nurse, etc.).
4. Reason for current visit and degree of satisfaction with visit.
5. Age, sex, number of children, employment status, how child care and work were arranged so that patients could visit the center.
6. Length of waiting time and distance traveled to the center.

The interviewees were told that the interviews were confidential and that the results would be used by the Ministry of Health to try to improve the health centers. All interviews were open-ended. Patients were selected at random. Staff members were selected on the basis of availability. The consultants attempted to interview staff members at each level, but no medical doctors other than psychiatrists and clinic directors were interviewed. In all, 28 patients and 23 staff members were interviewed.

#### Differences in Populations Served in Four Centers

The four centers differed in important ways, and these differences underscored the need to examine each specific situation. Two of the centers were in rapidly expanding marginal areas of the city, less than an hour away from the city. These marginal areas are often the first step in the transition from rural to urban living. The centers were extremely crowded; very long waiting times were common (at least five hours in many instances). A related study indicated that residents of the marginal areas tend, on the average, to be less well off than city dwellers in equally impoverished conditions (Bernbaum, 1979). The other two centers were in more established areas, one in an urban squatter slum and one in a more distant, somewhat rural area. Neither of the two centers was under the same intense pressure to serve patients. The problems associated with a rural migrant's adjustment to urban living were also less pressing in the latter two centers.

#### B. Discussions with Ministry of Health Personnel

Discussions were held with appropriate MOH personnel throughout the consultancy, beginning with a briefing on Monday, July 21, with Dr. Humberto Naar, head of MCH, and Lic. Ezequiel Urrutia, health educator, and ending with a debriefing on Friday, August 1, with the same two men and most of the MOH staff involved in the human relations workshops (see Appendix A). Other meetings with MOH personnel ranged from "diagnostic meetings" with health educators, social workers, and others assigned to

work on the "human relations problem" to many working sessions with the individuals who participated in the development and trial of two human relations workshops (see "Actions Taken"). Two meetings were held with Dr. Armijo, the director of the Panama-San Blas Health Region, which includes the Chorrera health area, site of the two trial workshops.

#### C. Discussions with AID Local Mission Staff

Several meetings were held over the two-week period with John Coury, Population Officer, and Angela Mata, Mr. Coury's assistant. These ranged from a briefing and a debriefing to useful and thought-provoking discussions on the best strategy to assist the Panamanian professionals in developing a human relations training program. Both a briefing and a debriefing were held with John Champagne, Acting Chief, Human Resources Division.

#### D. Review of Existing Documents

Some time was also devoted to a review of existing documents on population, family planning, and health in Panama. These are cited in the bibliography. The Panama Project Paper ("Population II") and Polly Harrison's report on female productive life in Panama were particularly valuable.

### Findings Related to Family Planning and Human Relations

#### A. Health Center Level

##### 1. Summary of Observations of Four Health Centers

##### a. The Patient's Perspective on Problems

1. Waiting Time: Waiting time varies from center to center, but patients complained about long waiting times at all the centers the consultants visited. Patients gather early, between 5 a.m. and 6 a.m., in order to have a good place in line when the center opens, usually at 7:00 a.m. However, in some centers early arrival is no guarantee that a patient will be seen earlier than others who arrive later. At these centers the waiting time is the longest. The time between arrival at the center and departure is usually

several hours, the average being 4 to 5 hours. People often wait several times during one visit; waiting is common at each stage of the clinic visit (registration, seeing nurse, seeing doctor, injection clinic, pharmacy, lab). Many situations leading to long waits are amenable to change by staff, who could be motivated to improve conditions through human relations training and through increased flexibility and positive feedback from their superiors.

2. Crowding: Most clinics are crowded and have inadequate seating. Crowding presents particular difficulties for patients at the reception window (where patients have to shout out which contraceptive method they wish so that the receptionist--and everyone else--can hear), in the examining rooms (where one patient may be on an examining table with her feet in stirrups while another is talking with the doctor at a nearby desk), and at the cashier's, where, in addition to long waits, discussions of one's ability to pay for services are overheard. Another problem is that basic prices for services may vary from center to center.
  
3. Being Turned Away: Despite MOH norms that state that all patients requesting services must be seen that day, patients in several centers complained of being turned away because there were already too many patients. This happened, they said, even when acutely ill children were brought in. Patients seeking preventive care, such as family planning, experienced the same problem. Patients were particularly upset when they were turned away after a long wait or when they lived far away (one woman walked for an hour carrying her sick child, took a bus that took another half hour, and then was turned away from the health center because the allotted spaces had all been taken by 8:30 a.m. She had taken the earliest bus available to her).
  
4. Not Hearing Name Called: In several of the centers visited, patients were called by name when it was their turn to be seen. If they did not hear their names, they had to wait until everyone else was seen before their names were called again. This aggravated the crowding and confusion, because people tended to cluster around the door to the doctor's or nurse's office to hear their names when called. One clinic

avoided this problem completely: Staff simply make it a point to locate each patient when it is his or her turn. Patients know this and wait more quietly wherever seating is available.

5. Medical Care: There were few criticisms of the quality of medical care (most felt it was good). However, some people felt they were rushed through an appointment with a doctor or nurse and that they had neither been examined thoroughly nor listened to. Complaints related to family planning included doubt about the effectiveness of the oral pill and of tubal ligation. Several women complained that it was too hard to get a tubal ligation. For example, a 30-year-old woman with two children aged 5 and 11 had been denied sterilization because she did not have three children. She cannot use the oral pill because she has high blood pressure; she does not want an IUD. At the time of the interview, she had been waiting four hours to see a "new" gynecologist and to plead with him to authorize the surgery.
6. Abrupt Treatment by Staff: Although patients made it clear that staff are often kind and helpful, they also said that some staff members (in all categories--nurse, doctor, nurse-aide, and clerk) are rude and abrupt. Instances of this were observed. For example, staff would ask patients to sit on a bench in the order in which they were to be called and would rearrange patients with children and packages using abrupt words and gestures. In several instances, staff members shouted at patients to keep their children still and quiet--this after both parents and children had sat in a room with more people than seats available. Patients and some staff members complained of swearing (groserias) by doctors.
7. Lateness or Absence of Doctors: Both staff and patients complained that doctors do not show up or show up late. This is particularly true for obstetrician-gynecologists, who usually only work part time at MOH health centers and who may be delayed by deliveries or by surgery performed elsewhere. This problem is aggravated when patients are not informed that the doctor will be late or unable to appear.

8. Not Enough Doctors: Patients complained that there are not enough doctors and that doctors are not assigned to the center for a sufficient number of hours a week. They also complained that obstetrician-gynecologists are rotated frequently; just as they begin to feel comfortable discussing contraception or other embarrassing matters with one physician, they must face another.
- b. The Observers' Perspective on Additional Patient Problems
1. Paternalism: Many instances of paternalism towards patients were observed. Staff would talk to patients as though they were children; they would scold them for forgetting lab tests or papers, using a paternalistic tone of voice and being quick to give advice rather than listen to and try to help resolve the patient's problem.
  2. Too Many Visits Required: In the case of family planning, too many visits and procedures are required. For example, the norms specify medical examination and return visits for all methods, including the condom and the various vaginal methods. In some clinics, revisits for pills are required after one month and then every three months.
  3. Lack of Privacy: Again focusing on family planning patients, in many examining rooms there is no place for a woman to change (women are told to wear dresses and simply remove their underwear) and examining tables are not sufficiently protected from public view. In one room, the examining table was flanked by two uncurtained windows. In several instances, patients were asked to define their family planning needs publicly, either at the registration desk or within earshot of other patients waiting just outside, or even inside, the examining room.
- c. Staff Perspective on Problems with Staff-Patient Relationships
1. Crowding: Staff complained of crowding and of what they called "disorder." The area near the reception

desk is particularly chaotic. Secretaries have to search for each patient's file (even when the appointment has been scheduled) while all the patients wait. (The secretaries suggested that they could look for files the day before, during the middle of the day, when it is slow in their part of the center.)

2. Patients Lose Things: Patients who lose clinic cards, vaccination certificates, slips for lab tests, and other such papers are another source of irritation. As one staff member said, "They don't understand how difficult it is to locate their file and we don't have their clinic number."
3. Education: Many staff believe that patients are "difficult to educate"--that they do not "comply," in the strictest sense of the word. There are, of course, patients who do not comply with instructions for a variety of reasons; in some cases, the instructions are too cryptic to make sense to the patient, or the patient did not understand the reason for the instructions and so did not take them seriously enough, or the instructions were impossible to carry out. For example, the instruction for giving a baby a bath included using cotton balls, castile soap, two basins of distilled water, and other items that would not be found in a poor household.
4. Noncompliance: Staff felt that, in some instances, patients understood their instructions but refused to follow them.
5. Mentality: Some staff said that patients do not have the "mentality" to improve their health. By "mentality," it appeared that staff meant not just "intelligence" but also "will." Some staff have the impression that patients do not care whether or not their house has a latrine, or is clean, or has any number of other characteristics considered "civilized." On the other hand, staff in one health center serving an urban slum felt that they and the community had made considerable progress over the last several years in improving living conditions.

6. Patient Abuse of Staff: Some patients were described as bravos (angry, cross), abusivos (rude, abusive) or groseros (used swear words or foul language).

d. Staff Perspective on Problems with Staff-Staff Relationships

1. Criticism: Staff complained that staff are criticized by colleagues or superiors in front of other colleagues or, worse, in front of patients.
2. Feedback: It was felt that feedback from colleagues and superiors is predominantly negative and that positive reinforcement is rare or even non-existent.
3. Doctors: Many staff, sometimes even physicians, had several criticisms of physicians. One concern is the late arrival or non-arrival of physicians; other staff are left with restless and angry patients and then forced to rush patients through when the doctor does arrive. Rudeness to both patients and non-physician staff was also cited. A third area of concern is variation in the amount of responsibility delegated to non-physicians. Some centers and some doctors allow nurses and auxiliary nurses considerable latitude with patients; others do not. Staff said it is difficult to work, given such inconsistencies, and difficult not to do the work for which they had been trained, particularly when the doctor is late or does not arrive at all.
4. Auxiliary Nurses: Auxiliary nurses felt that there are inequities between them and the nurses in their responsibilities, workload, and pay. They felt their workload is greater, their responsibilities similar, and their pay lower than that of nurses.
5. Staff Meetings: Many staff felt there are not enough staff meetings (some centers almost never have staff meetings). They noted that at the meetings that are held, people are reprimanded rather than given information and assisted in solving problems.

6. Staff-Staff Communication: Staff complained that colleagues will go to a superior with a complaint about another coworker rather than attempt to discuss the problem with the coworker.

e. The Observers' Perspective on Staff-Staff Problems

1. Authority: Staff members, especially those with administrative or supervisory responsibilities, sometimes have difficulty exercising authority. Some feel a person must be strict and domineering when exercising authority; others try to be everyone's friend so that they will be liked and respected. Some feel it is best to never hold staff meetings but to deal with all problems individually. Many people acknowledged their difficulty in handling authority and asked for help in developing their administrative and leadership skills.
2. Human Relations: There is little emphasis on human relations in the training of health care professionals, in job descriptions and job orientation, and in the evaluation of job performance. For this reason, it is hard for some staff to perceive that good human relations is part of their job, although many clearly identified a need to develop their skills in this area and to have their superiors notice and encourage good staff-staff and staff-patient relationships.
3. Nurses' Responsibilities: In some instances, nurses are not allowed to practice their skills. For example, nurses trained to do revisit-screening for oral contraceptive users must ask the woman to wait for the gynecologist because the norms specify that a doctor must see such patients.
4. Role Definitions: Many health center staff are unclear about their exact roles and responsibilities, because their clinical training was not matched with orientation and role definition after they were assigned to a health center.

f. Patient Perspectives on Positive Aspects of Health Centers

1. Quality of Care: Many patients said they felt they got good care at the MOH health centers.
2. Dedicated Staff: Patients identified a number of staff members as particularly dedicated and helpful. They cited people who were courteous (amable), who took time to listen to and help them, who helped them through obstacles in the system, and who cared about them.

g. Staff Perspectives on Positive Aspects of Staff-Patient Relationships

1. Gratitude: Patients often express their gratitude. Many staff members feel this is their only source of positive reinforcement.
2. Challenge: Patients are seen as challenging and interesting to work with. Many staff cited contact with people as a reason for choosing health-related careers.
3. Progress: Staff felt they could see the positive impact of their work. They could see how both individuals and the community improved. The chance to follow-up individuals was given as a reason for choosing work in a center instead of a hospital, where one is less likely to see a patient again.

h. Staff Perspectives on Positive Aspects of Staff-Staff Relationships

1. Getting Along with Others: Some staff perceive the human relations skills of other staff members and appreciate their colleagues.
2. Teamwork: In some centers, there is a strong sense of support among the staff, and of staff unity and teamwork.

3. Approachable Superiors: Staff mentioned superiors who were both approachable and helpful.
4. Staff Meetings: Many said that staff meetings are helpful and important.
5. Good Superiors: Many staff said they both respected and admired their superiors.

1. Other Positive Features of the Health Centers

1. Staff Attitudes Towards Patients: Many staff seem to have a real "calling" to work with people. They enjoy it and are very good at it.
2. Support Services: The health centers observed in Panama employ several types of staff not always found in health centers who provide important support to the basic health services. Among them are psychiatrists, psychologists, and social workers. These professionals appear to be making important contributions to both staff and patients, and their presence and level of involvement are impressive.
3. Community Support: The practice of forming community committees that help raise money for the health center and that help with the center's community relations and activities is valuable.
4. Teamwork: Despite the self-criticism of center staff, who acknowledge the need to improve human relations, the sense of teamwork and of unity in many of the centers is strong.
5. Sources of Support: Center directors can and do appeal to local political representatives for financial and other support. In many other countries, such support is not available to health care providers.
6. Awareness of Human Relations: Health center staff interest in and awareness of human relations issues are remarkable.

## 2. The Human Relations Problem

It is quite clear that there is a lack of support for staff in most centers, a lack of clear definition, and a lack of appreciation of all of the activities and skills that the respective jobs require. For instance, the secretaries at the front desk, who initially receive patients, may do a lot of counseling which is neither recognized nor rewarded. Auxiliary nurses may play an important role in bringing certain needy patients to a doctor's attention, only to incur the doctor's anger. Salaries are low, the patient load is heavy, many of the patients are mystifying to the staff, and good work is rarely recognized. Morale among many of the staff who were interviewed appeared to be low. It is, however, remarkable that many staff work very hard to provide better care for the patients. For many of these dedicated workers, reward appears to come through the patient, from seeing that (s)he is treated better or receives proper care. Thus, patient care is for many one of the few sources of satisfaction.

It is also clear that there are certain skills which are lacking at all levels, from administration to manual labor. Most staff said they were never oriented or trained in "human relations," although a small number had taken some of the Ministry's courses, several of which stress interpersonal skills. Specifically, the deficiencies are:

1. Lack of skills in the administration of personnel (e.g., how to define lines of communication, how to give orders constructively, how to share decisionmaking in the group, and how to establish positive incentive systems).
2. Lack of skills to help patients to become responsible for their own health care decisions and to be more responsible family planners.

It is important to note that these problems are not unique to these health centers; they are common problems even in health facilities in the U.S. The most frequent mode with patients seems to be to tell them what to do or to give them advice rather than help them decide what the best course of action might be.

Not only are certain problems widely recognized by staff, but a considerable amount of interest in "human relations" training is being expressed at all levels of the Ministry and at the level of individual health centers. The term means different things to different people; to some it may mean that everyone else should take on a larger portion of work or that other people should change (doctors should come on time, patients should be more compliant to medical requests). Others would like to feel better about their work and to develop new and different ways of handling complex

situations, because they clearly see that the existing methods are not working well. The general level of interest is a reflection of the relatively high level of center development. People are less likely to be concerned with human relations when their energies are concentrated on needs for survival or safety.

Thus, there are some deficiencies in the present system, a lack of specific skills in personnel, and considerable interest in "human relations," however one defines the term. One might ask how important these needs are to adequate patient care, given the observed organizational and physical barriers. It appears that such problems as long waiting times exacerbate the human relations problems between patients and staff and among staff. They may, furthermore, reflect some of these problems. Both areas need attention. One way to confront these physical barriers is to have staff work through possible solutions to some of the operational problems, making a joint decision and putting their conclusions into action.<sup>1</sup>

The term "human relations" should be defined or, at the least, limited. To avoid direct interpersonal confrontation, this is critical for programs that aim to improve patient care or working conditions, but not to alter personality patterns, and in which participants are required to attend, and not volunteer. Open discussions about why person x is upset with person y may spark a confrontation which only a group leader with specialized training can manage and which is difficult for many participants to handle. Since soul-searing encounters are not necessary in order to help people improve their skills in communication and interaction, they are best avoided. (This issue will be considered again in the section on recommendations.)

## B. Regional Level

Panama is divided into nine health regions. Each has a director who is responsible directly to the Vice Minister, who, in turn, is responsible to the Minister of Health. The various programmatic areas, such as Maternal and Child Health, must work through the Vice Minister or the regional director (usually the latter). Figure 1, Appendix B, is a diagram of the organization of the MOH.

The consultants met several times with the director of the Panama-San Blas region, Dr. Armijo. The two workshops conducted during the consultants' stay were both carried out in that region at his invitation. Dr. Armijo, a psychiatrist, is particularly interested in human relations, and he is familiar with many human relations skills and the techniques for transmitting

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<sup>1</sup>For examples, see the account of the human relations workshop for health center staff.

them. Because the other eight regional directors were not interviewed, it is difficult to know whether the same degree of knowledge and support exists among the other directors. On the basis of conversations with others directors in other regions, it appears that both awareness of the role of human relations in the delivery of health service and interest in the topic vary.

Frequently, center directors expressed a desire for more support, communication, and positive criticism from their regional directors. Just as health center staff felt they only heard from their superiors when they did something wrong, center directors, too, felt they received predominantly negative criticism from their superiors. To add to the frustration, there is no economic incentive to take on the extra burden of running a center (center directors are paid exactly the same as other physicians in their specialty), and seeing patients is still considered to be one of their primary responsibilities.

Another problem that emerged during discussions at the regional level is staff transfers. According to health center directors, staff are not selected personally but assigned to them by the regional office (this may also be true at the national level, although it has not been clarified). This means that a center director and center staff may work hard to build a unified, concerned staff only to have individuals transferred. Center directors in particular felt that transfer policies discourage work towards staff unity.

Resources, patient load, community support, staff satisfaction, and patient satisfaction vary considerably from center to center. These differences could be a basis for program improvements since the different centers could be evaluated to determine what makes them successful and why they are accepted by patients. Also, individuals who have applied successful innovations in one center could share their experience with their colleagues from other centers. At this time, there is no organized effort to do this. Scheduling regular (annual or biannual) meetings at which people could present projects, ideas, and problems and discuss techniques for solving problems would encourage exchange, give people an incentive to develop and share their innovations, and help create a feeling of cohesion among health workers in a region.

### C. National Level

The impetus for the consultants' visit was an agreement between the Department of Maternal and Child Health in the MOH and AID that part of the money from an AID grant would be used to improve staff-patient interaction at health centers in order to make services more acceptable to family planning patients in particular. Because of this agreement and because of the presence on the MCH staff of a professional trained and interested in

human relations, the MCH division is a target of major interest and expertise in this area.

There is an office in the MOH which is in charge of all aspects of health education. This office is directly under the Vice Minister and the Minister (see organizational chart, Appendix B). There is some feeling among the staff that any human relations training efforts in the MOH should be undertaken and supervised by that office. In addition, the Comite Nacional de Docencia was formally appointed in August 1980 to deal with education and training. This committee is made up of members from various divisions in the MOH (not only MCH and Education). These individuals represent a variety of disciplines and their experience and interest in human relations training for health personnel vary. At this time, there seems to be some confusion about who has responsibility and authority to initiate and supervise human relations training in the MOH. In addition, there is some competition between individuals and divisions which could continue if those who will indeed act are not given the responsibility and authority to do so. In the consultants' judgment, it would be inadvisable to place responsibility for human relations training with the committee, because of its size and because of the diversity of the members. It would be better to appoint one person (or, at most, three) to be the executor or administrator of a human relations training program, with the committee serving in an advisory capacity.

### Actions Taken

#### A. Network Development

The Population II grant and the visit of the two consultants served as a catalyst to free MOH staff interested in human relations training to work on the topic intensively for two weeks. The visit also provided an excuse to convene (for the first time) the provisional National Education and Training Committee, which had been formally appointed and established within the MOH before the consultancy ended.

During the meeting of the National Education and Training Committee, there was much discussion on the establishment of a human relations training program in the MOH. It was clear that there was disagreement about what human relations training is, whether it is of any value, what background is needed to be a trainer, and what the content of human relations training should be. None of these questions had been resolved by the end of the meeting. It was felt that the experience of developing, testing, and evaluating two human relations workshops with the consultants would provide the basis for further discussion.

In developing and testing the workshops, it was possible to identify MOH staff who had interest, training, and ability in this area. During the consultancy, everyone in the Ministry who was said to be interested or involved in this topic was contacted. Two "sample" workshops were planned and conducted. The participants had an opportunity to demonstrate their interest and abilities and to work on this topic with others in the MOH.

## B. Development of Human Relations Workshops in Conjunction with MOH Staff

It was decided that two different workshops, one for directors of centers and one for the staff of one center in the Chorrera health area, would be held. The center course was planned at the MOH on Monday, July 28; the directors' course was planned on Tuesday, July 29.

### 1. Planning the Center Course

The following persons from the MOH were present at the Monday planning session:

- Elida Rodriguez, National Chief of Social Workers
- Ricardo Aguilar, National Chief of Sanitary Inspectors
- Theresa de Rodriguez, Nurse, Coordinator of Nursing for Maternal and Child Health (on loan from position as Head Nurse, Metropolitan Region)
- Flor de Vasquez, Obstetrical Nurse, Member of Teaching Committee (on loan from position as Obstetrical Nurse in the Metropolitan Region until end of December 1980 to teach a course for Maternal and Child Health)
- Carlos Harris, Health Educator, Chief of Health Educators, and Chairman, National Committee for Teaching, MOH
- Franklin Degracia, Health and Sanitation Inspector (in charge of information courses in sanitation)
- Ezequiel Urrutia, Health Educator (on loan to Maternal and Child Health to design mass media and communications materials in family planning)

This group met Monday morning to plan the course. A list was made of all possible human relations skills (the word was chosen with care) that staff members would need to learn. No attempt was made to make each of the items mutually exclusive; nor were terms carefully defined. The list was considered to be a general list, not a specific guide to the Thursday session in the center.

List of Skills in Human Relations

1. How to use positive reinforcement
2. Ability to listen
3. How to give and receive help
4. How to live the experience of the patient, how to put oneself in the patient's shoes (take the patient's perspective)
5. How to help someone solve his problems
6. How to avoid projecting emotions onto someone
7. How to acknowledge one's successes
8. How to increase self-understanding
9. How to accept that the other person may be right; how to compromise in order to win
10. Defining the roles of each member of the group (of workers)
11. How to define whom a problem belongs to (owning one's problems)
12. How to learn about the community, about how people think and feel
13. How to give and receive orders
14. How to ask for help from a fellow worker
15. Recognizing the importance of giving attention with sympathy
16. Giving and receiving feedback

17. How to accept an individual as he is
18. Strategies for running meetings
19. How to leave one's problems at home and vice versa
20. How to learn people's names
21. The importance of one's name or title (how used as a sign of closeness)
22. How to give incentives
23. Body language: the importance of bringing together the verbal and non-verbal
24. Perception: how to avoid projections and how to note variation in what is seen
25. Communication
26. Sense of being part of a team
27. Increasing empathy
28. How to break the ice
29. Body language
30. Difference between kinds of relationships
31. Work motivations
32. Understanding Transactional Analysis (parent, adult, and child models)

(It will be noted that this list included suggestions from everyone present and draws from a number of different psychological models.)

For the center workshop, a decision was made to concentrate on four main areas:

1. Giving members of the health center the sense of being part of a team;
2. Sensitizing staff members to the patient's perspective;

3. Teaching staff members one specific skill (how to listen to help someone solve a problem); and
4. How to use positive reinforcement.

Given the time constraints on the center staff (who had to take time from their regular daily work to care for patients), the consultants planned to use only one day, from 8:00 a.m. to 3:00 p.m. (the normal working day is 7:00 a.m. to 3:00 p.m.), and to serve lunch, which the local AID mission provided.

In brief, the outline for the day was as follows:

| <u>Time</u> | <u>Exercise</u>  | <u>Person In Charge</u> |
|-------------|--|-------------------------|
| 8:00        | Introduction   | Urrutia                 |
|             | Development of Group:  |                         |
|             | ● Greeting without speaking  | Engle                   |
|             | ● Back-to-back and front-to-front paired communication   | Urrutia                 |
|             | ● Finding significant events in one's life, sharing events with a paired person, and introducing paired partner to others in the group | de Vasquez              |
|             | ● Memorizing names   | Aguilar                 |
|             | ● Barriers to communication (how rumors are passed; nonverbal communication)   | Urrutia                 |
|             | ● Perception exercises (figures that change)   | Urrutia                 |
|             | ● Listening skills (referential communication)   |                         |
|             | ● Brief introduction to Transactional Analysis   | Degracia                |
|             | ● Active listening   | Engle                   |
| 12:00       | Lunch Break  |                         |
| 12:30       | Taking the Patient's Perspective:  |                         |
|             | ● Sociodrama of nurse ordering people on benches, talking to secretaries through windows   | Scrimshaw               |

| <u>Time</u> | <u>Exercise</u>   | <u>Person In Charge</u> |
|-------------|---|-------------------------|
|             | Taking the Patient's Perspective (continued)  |                         |
|             | <ul style="list-style-type: none"><li>● Exercise of talking to someone who is writing (while not looking); done in pairs</li><li>● Making a list of all similar problems for patients, discussing what can be done about them</li></ul> |                         |
| 2:00        | Positive Reinforcement:   |                         |
|             | <ul style="list-style-type: none"><li>● How to restate a request in a positive way</li><li>● Generating positive concepts about a person</li><li>● Self-acknowledgment exercise</li></ul>   | Ermila Munoz            |
|             | Empathic Circle   | Urrutia                 |
| 2:30        | Evaluation:   |                         |
|             | <ul style="list-style-type: none"><li>● Graphic evaluation</li><li>● Verbal comments</li></ul>  | Urrutia<br>Aguilar      |
| 3:00        | Termination of Workshop   |                         |

There are several examples of descriptions of exercises (or of "modules") in Appendix C. These modules include specific instructions and activities and the goal of the exercise. The reader should note that these exercises are derived from several different group methodologies. The entire group was involved in planning and conducting the exercises.

## 2. Developing Directors' Workshop with MOH Staff

On Tuesday, July 29, a group met to plan the details of the Wednesday meeting with the directors of the Chorrera centers. Dr. Armijo, director of the Panama-San Blas region, which included the Chorrera area, had informed the center directors that there was to be a meeting on Wednesday morning, July 30. The consultants had planned to meet with the directors for four hours, from 11:00 a.m. to 3:00 p.m., the end of their working day.

The Tuesday group included Ezequiel Urrutia, Flor de Vasquez, and Ricardo Aguilar; Franklin Degracia, Carlos Harris, and Elida Rodriguez, from the previous day; and the two consultants. The other persons present were Ermila Munoz, a health educator in the Panama-San Blas region, and Rolando Solis, a health educator in the Darien region. Others who stopped in for part of the session were Dr. Narr, head of Maternal and Child Health; Dr. Donas, PAHO, an advisor to the education committee within the MOH; and Olgalina Rodriguez, a social worker in the Colon area who was preparing a human relations workshop for the following week in Colon.

The goals for the directors' workshop were developed in the same way that the skills list had been developed the previous day. A list was made of all possible objectives and then the specific goals for the four-hour workshop were selected. The general goals were:

1. To improve medical attention to the public.
2. To improve relations among staff members and between staff and the public.
3. To help the directors develop better methods for administering personnel (e.g., identifying staff problems and finding alternative ways of giving orders).
4. To make the directors capable of identifying the current system of positive reinforcement.
5. To help center directors to identify potential sources of reward among their staff.
6. To improve directors' capacity to put into practice changes in working conditions in their own centers.

The content of the workshop was as follows:

| <u>Time</u> | <u>Exercise</u>                              | <u>Person Responsible</u> |
|-------------|--|---------------------------|
| 11:00       | Introduction                                 | Munoz                     |
| 11:10       | Expectations for Directors and Centers       | Aguilar                   |
| 11:30       | Leadership Styles:                           |                           |
|             | • Identification of actual styles used       | Urrutia                   |
|             | • How directors could improve the style used |                           |

| <u>Time</u> | <u>Exercise</u>   | <u>Person Responsible</u> |
|-------------|---|---------------------------|
| 2:00        | Development of Specific Skills:   |                           |
|             | ● Introduction to Transactional Analysis  | Munoz                     |
|             | ● Referential communication exercise  | Urrutia                   |
|             | ● Getting away from the need to be right (exercise in compromising)                               | Munoz                     |
|             | ● Identification of positive incentives for directors and staff; how to improve incentive systems |                           |
|             | ● Strategies for running successful staff meetings  | Scrimshaw                 |
| 2:45        | Verbal Evaluation   | Munoz                     |

Fewer group leaders attended the directors' meeting (the meeting at Chorrera was larger) because the number of participants was quite small (eight or nine was the maximum); only five people could participate as session leaders. Again, Urrutia's willingness to include all interested and potential leaders in the program was a definite asset.

### C. Administration and Evaluation of Directors' Workshop

The group of leaders arrived at the hospital where the session was to be held at 11:00 a.m. Initially, only two directors were present. Seven more arrived at 11:30. There had been a failure in communication. The directors expected a one-hour session with the region director, not a four-hour session on human relations. The group of leaders considered giving up the session altogether, but decided instead to do one small part of the planned day with the group of directors. There was not time for the very important exercise of defining one's own expectations for the session. Instead, an introduction was given tying the human relations effort to the failure of family planning patients to return for continuation visits. The session then moved directly to the exercise on leadership styles. Urrutia conducted the session.

For the exercise in leadership styles, each participant was asked to fill out a questionnaire indicating his or her relative valuation of productivity or individual satisfaction with work. The scores were summarized and placed on a grid indicating the preferences for the two values, and the kinds of leadership that each emphasized were described. The participants

were then asked to answer either-or questions on a variety of attitudes toward their staff members, such as the extent to which they were willing to trust the natural capacity of their staff members to work hard on their own. The directors' opinions of subordinates were discussed and compared with their styles of leadership.

The questionnaire on their opinions of subordinates was a much discussed subject that led directly to a comparison of the directors' own and their subordinates' sources of reward. Lists were made of the directors' own sources of reward and then of the sources of reward of their staff members. It became clear that the two lists overlapped considerably. The level of interest in these exercises was very high, and discussions continued until 1:15 p.m. The directors were very interested and requested that the session continue after a short break for lunch. All but one of the directors canceled plans for the rest of the afternoon in order to continue with the workshop.

In the afternoon, three activities/exercises were presented. For the first the directors used the lists of sources of satisfaction to develop lists of current situations that could serve as incentives; they also discussed various plans for improving incentives. They noted that one of the most important sources of satisfaction for their subordinates was praise from the director. An exercise developed by S. Scrimshaw and presented by E. Munoz illustrated how complaints or commands could be rephrased so that the listener would not be on the defensive and how problems could be solved through more democratic and less administrative channels.

Several specific skills were taught during this exercise: how to "own" your own emotions, how to overcome the need to always be right, and how to develop group problem-solving capacities. Heated debate about an example in which a patient returned for treatment without having complied with the previous recommendation illustrated the need for more understanding of patients' difficulties in complying and for developing ways to help both doctor and patient share the responsibility for continuing treatment.

The final exercise was a direct extension of previous discussions. It consisted of a discussion of the benefits of staff meetings and of the strategies for constructive sessions. Several objections were raised immediately to the idea of staff meetings; lack of a common time to meet and not wanting to criticize an individual in front of others were cited. The comments revealed that a constructive, problem-solving or educational staff meeting to resolve problems related to the lack of time might be valuable but that time was needed to develop the concept. Directors will need to realize that criticism need not be the only administrative strategy available to them.

The directors evaluated staff meetings and noted the following:

1. Absence of prior training in human relations for administration and need for such training.

2. The need to share information with other doctors.
3. The need to share strategies with other staff (one person acknowledged the value of a similar course).
4. General feelings of satisfaction and well-being during the session.
5. The value of an opportunity to examine ideas.
6. The sense that the session was too rushed.
7. A clear desire for following sessions.

Many of these issues should be explored further, as there are many misconceptions that should be corrected. One director, for instance, has been holding regular "therapy" sessions. He feels that they are successful. However, therapy generally involves deeper levels of personality exploration and change than can be reached during human relations workshops and requires a level of openness and trust which is neither likely nor appropriate in a weekly or monthly staff meeting at one's place of business. It is very important that the directors do not become "overnight" therapists for their staff. Psychiatry practiced by a non-expert can have disastrous consequences.

The consultants' evaluations of the session were generally positive. Some of the leaders occasionally faltered in timing exercises, were too pointed in discussions, or were too abrupt when responding to participants. There were times when leaders were unable to resist the temptation to "lecture" rather than draw out the group itself. The leaders themselves pointed out these problems during the evaluation session held at the MOH on Friday, August 1. The most effective messages were related to identifying sources of satisfaction for directors and staff, developing ways to improve situations, differentiating between the various types of people in the leadership styles exercise, and learning how to phrase requests or opinions so that the listeners will not become defensive. (For evaluations of each leader's training and skills, see Chapter III.)

At the suggestion of some members of the staff of the Centro de Salud of Chorrera, a meeting was held on the second floor of a large restaurant. The space was donated by the restaurant. Unfortunately, although the room was cool and breezy, it was extremely noisy, as it was open and fronted on a busy highway and near an automobile repair shop and junk yard. The noise was difficult to deal with; for instance, in the middle of an exercise, a truck would begin to accelerate up the hill in front of the meeting room, necessitating a halt in the conversation for several moments. In spite of these conditions, response was positive, interest was high, and there was a definite commitment to continuing the effort.

The workshop was led by seven different people: Urrutia, Munoz, de Vasquez, Degracia, Aguilar, and the two consultants, Engle and Scrimshaw. Rolando Solis, who volunteered to direct a certain part of the program, did not appear; he offered no excuses later. Dr. Donas of PAHO and John Coury and Angela de Mata of the local AID mission were present as observers or participants, depending on their preferences.

The meeting began at 8:28; 37 members of the Chorrera center were present. About 20 remained in the center because they had to care for patients or because they did not wish to participate. Doctors were noticeably absent; only one medical doctor was present in the morning. Three dentists also participated. The 37 persons represented all of the other staff positions, including the director of the laboratory, manual laborers, drivers, secretaries (receptionists), auxiliary nurses, and nurses.

The director of the center, who had been at the session on the previous day, introduced the workshop with much enthusiasm, indicating that it had been very valuable for him. His introduction confirmed the feeling that it is important to introduce the directors to the idea of a human relations workshop before a session is held with the entire center.

The plan, as outlined previously, was followed more or less. The format was a combination of a short information session, an exercise, an opportunity for the participants to express their feelings about the exercise, and some additional interpretations by the person in charge of the session. (See Appendix C.)

In one of the exercises, the entire group was asked to identify situations which might cause problems for patients. The group's list and some of the suggestions for dealing with the problems illustrate the potential benefit of using center expertise to increase the quality of patient care. The group cited the following problems:

- doctors do not come when patients have appointments;
- doctors come late;
- there are no job descriptions;
- patients have to wait with everyone else even when they have very sick children (no triaging);
- patients are refused care for lack of time or lack of money;
- patients must wait until their files are located (files could be located the previous afternoon to save time);
- staff members may have personal conversations while a patient is waiting;

- the tendency is to attend first to one's friends and to treat one's friends and other professionals differently from the way one treats campesinos (this comment was greeted with applause from the group!);
- explanations to patients are too complex and words that patients cannot understand are used;
- receptionists have to leave a patient to answer the telephone and to search for the staff member being called;
- all staff will leave a patient when an official visitor (e.g., a consultant) arrives; and
- some feel that staff show a lack of understanding of patients' lives.

Some situations which the consultants had identified as problems for patients were not mentioned. When asked what could be done to remedy these situations, the staff made some good suggestions. For instance, it was suggested that although staff could do little to ensure that medical doctors arrive on time, they could at least inform patients that the doctors would be late and that they could be expected at a certain time (if known).

Two kinds of evaluations were made: one by the workshop participants and one by the group leaders the following day. The workshop participants evaluated the experience graphically and verbally. For graphic evaluation, the participants divided into four groups and drew pictures that represented their opinions. Their picture-responses included opened eyes, a smile because of happiness, and a circle for the group. One picture depicted "reception, listening, a large heart, on a firm base." The verbal evaluation included a request for a repetition every month, a feeling of more confidence and closeness within the group, and a desire for "therapy" for members of the center who could not attend. It is important to underscore the difference between "human relations workshops" and "therapy"; some participants were still confused about this at the end of the session.

The group appointed a committee to continue the activities in the center. The committee seemed to consist of people who had emerged as leaders during the workshop. One (a dentist) had just joined the center the week before. The leader of the committee said that the committee would "help us identify our faults." It is obvious that it will take some effort to convince people that "human relations workshops" are not designed to blame individuals for their failings.

The group of leaders met the following day to evaluate their efforts. Their general conclusions were that a location is important and should be checked out before a session is held; attendance should be taken in the

morning and afternoon to discourage partial attendance; the group needed more practice in working together to clarify interrelationships between leaders; lecturing should be reduced even more; more positive reinforcement should be given to participants; and the ways in which assistants can or should participate should be clarified. The general feeling was that the meeting had been remarkably successful, given the circumstances.

The consultants had some additional observations: They noted that several of the leaders need considerably more practice in leading this kind of group activity and that some tended to make judgments, to lecture, to cut off participants, or not to support participation. The goals of an exercise must be kept clearly in mind.

Participation as a group leader is an essential part of the training of a workshop leader. The level of interest expressed by several of the most inexperienced leaders was quite high, and the level of expertise demonstrated by Urrutia was impressive.

### **III. RECOMMENDATIONS**

### III. RECOMMENDATIONS

#### Structures for Human Relations Training

##### A. Ministry of Health (National Level)

A small group of individuals (one to three) at the national level needs to be appointed to organize the training system; to select people at national and regional levels who will be trained as trainers (or facilitators); to acquire additional training and human relations skills; to train other key people in these skills; to develop a manual containing a series of modules for improving human relations; to administer human relations workshops with clinic directors, possibly with doctors, and with staffs of health centers; to delegate many workshops to the individuals they have trained; to supervise the training system; and to help evaluate the training system and its impact (see Figure 2, Appendix B).

There are several ways to organize this group. One alternative is to request that the Training and Education Commission appoint the group. This may take a long time and may result in the appointment of people who are not committed to the effort or who are already overcommitted and not free to accept other responsibilities. A second alternative is for the MCH to appoint the group (or individual), with the understanding that it will coordinate with but not be dependent on the national commission. In other words, the human relations efforts would be initiated in the MCH division. This second alternative is recommended at this time. It is possible that a modest effort coordinated through the MCH could become a pilot project for the development of a larger system.

The person or persons in charge of organizing and carrying out the human relations training at the national level (whether for the entire MOH or through the MCH) must be relieved of some current responsibilities in order to carry out the effort properly. The effort cannot be assumed as an additional task.

During her visit, Dr. Scrimshaw suggested that a consultant should visit Panama to prepare and conduct baseline studies in the pilot area by interviewing and observing staff and patients in health centers and by interviewing members of the community at large.

##### B. Regional Level

A core group of individuals responsible for conducting and supervising human relations training should be identified for each region. These groups should include people with relevant training, such as psychiatry, social work, and health education. The national core group would be responsible for any additional necessary training and for supervision. To avoid taxing existing resources unduly, a group could be selected from existing health center staff and one day a week of their time could be allocated to work with different health centers throughout the region. Small workshops could be held and health center human relations leaders could introduce human relations training modules at their staff meetings.

### C. Health Center Level

Individuals who are interested in human relations and who are respected and trusted by their fellow workers should be identified at the level of the health center. These persons should be encouraged to work with the regional staff in both long (one to two days) and short (part of a staff meeting) human relations exercises.

It is suggested that initial efforts to set up a structure for and to conduct human relations workshops be directed at one area within a health region (e.g., La Chorrera, where work has already begun and where the area director is behind the project) which would serve as a pilot area.

### Content of Human Relations Training

#### A. General Recommendations

Human relations workshops must be primarily guided experiences, not presentations of didactic material. This view is shared by a number of Ministry of Health people interested in human relations workshops.

Because there is a common tendency to be concerned with the identification of faults and errors rather than with the development of positive incentive systems at all levels in the Ministry, human relations activities need to be developed at both the local and administrative levels, and the focus on sources of positive reinforcement must be maintained. Workshop activities during which some individuals or groups are labeled "better," "more adequate," or "deficient" should be avoided.

Distinctions between human relations workshops and therapy, sensitivity training, and encounter groups must be clear. Human relations workshops involve the development of communication strategies, interpersonal skills, self-awareness, and sensitivity to patient needs through self-evaluation rather than confrontation. Although some MOH staff talk about the distinction, it has not been made clear enough in the plans for human relations activities. The distinction needs to be discussed further. Clear agreement should be reached on what activities and approaches are not appropriate for human relations workshops for health personnel.

In place of the requested check-list for appropriate staff behavior, a manual containing a series of training modules or specific workshop activities that could be done with some regularity at the local level is recommended. A check-list could well be one of the products to emerge from an exercise in which local clinic staff generate ideas about good communication.

The theoretical base for the workshops should probably remain eclectic for two reasons. One, there are a number of different psychological theories which can be applied effectively at these workshops. Two, there are individuals in the MOH who have received different kinds of training and who could effectively design and direct workshops. Acceptance of a variety of methodologies promotes the creativity of the designers, helps them develop the best possible program for a specific situation, and prevents the human relations workshop from becoming the "property" of a small number of people.

Specific skills that should be included in a human relations program and examples of specific exercises are given below.

#### B. Development of Manual with Discrete Modules

It is recommended that a capacity for human relations training be developed at all levels of the Ministry to increase coverage of centers and to ensure the continuity of the effort. To facilitate widespread distribution, development of a booklet or manual which would be continuously updated and which would contain sufficient information on the various units or modules is recommended. Each module would contain an exercise so that a facilitator at a local center could use one or more modules in a regular weekly staff meeting to upgrade a specific skill which was touched on in the first all-day (or day-and-a-half) workshop. Each module might contain the following information:

- a. Goals for each exercise, skills that are being developed
- b. Number of people who can be present
- c. Approximate length of time needed
- d. Specific instructions to group, including ideas on how to vary the instructions to accommodate the situation
- e. Description of the exercises
- f. Discussion of possible reactions to exercise, what to look for in group
- g. Questions to ask participants after the exercise is completed
- h. Patterns that may emerge during the exercise that could be brought out in a discussion
- i. Person who developed module.

Unless a facilitator has had considerable training and experience, he should probably first assist at a meeting using a particular module. The meeting should be led by a more experienced supervisor. Ideally, several trainers or facilitators would be present at each meeting to offer to the group leader feedback on technique.

### C. Specific Skills

The list of skills which follows is suggestive, not exhaustive. Each module, which would contain both information and exercises, would be designed to develop one or more of these skills or areas of understanding. Some examples of modules are given.

1. Communication Skills: Verbal and nonverbal behavior and what it communicates; behavioral strategies for making contact.

Example: Nonverbal communication. Two people spend a minute or two looking into each other's eyes without speaking. Each then looks beyond the eyes (over the left ear) of the partner. Differences in the kinds of communication and ease in performing the two activities are explored.

Example: Mirror exercise. Two people stand face to face, palms together (Person A's palms are pressed against Person B's palms). In the first half of the exercise, Person A is the leader, Person B the "mirror." Person A moves his hands in a random fashion, and Person B follows, keeping palms together. After a period of time, the roles are reversed, with Person B leading and Person A following. After the exercise, the leader helps people relate their reactions to their own preferences for leading or following.

2. Perception: Subjectivity of perception; mechanisms of projection; effects of attitudes on perception.

Example: Variations in perception among individuals. A brief role play (sociodrama) is staged with volunteers (a game with lots of action). All of the observers are asked to record what they saw in specific terms (who said what, what happened first, etc.). All of the different observations are recorded on a large sheet of paper. This activity demonstrates how differently people perceive things.

Example: Effects of attitudes on perceptions. All members of the group circulate freely, shaking hands, not speaking. After everyone sits down, each person is asked to think about his reactions to the different people he encountered (without responding publicly). Each is asked to identify the kinds of people that he found less acceptable, the persons he decided to "write-off," the persons to whom he responded positively (again, the participants need not respond publicly, but only to themselves). The leader asks the participants to identify the characteristics of each of the two groups. (What specific physical attributes did the people who were avoided share? What general characteristics did they share?) The leader may simply suggest general groups--according to sex, age, race, and "fitness"--to which the people who were less acceptable may have belonged. The exercise is designed to help people isolate their own personal systems of prejudices. At no point is anyone asked to "confess" that he is prejudiced; however, if people wish to tell others their reaction, they may do so. The exercise also helps people perceive how they communicate--by reaching out as opposed to waiting for others to come to them.

3. Problem-solving Skills: How to identify a person to whom a problem belongs and how to help a person with a problem so that he makes his own decision (e.g., for a patient to take responsibility for his own treatment); how to resolve conflicts without needing to be right; using no-lose methods to resolve differences of opinions.

Example: Use of "I-messages" when a problem is shared by both members of a pair (how to use a different format to express a concern or complaint). A list of examples of statements commonly made by health workers to patients or by administrators to subordinates is given in the common "you didn't . . ." or "you did . . ." form. Participants try to rephrase the statement so that the listener does not appear to be wrong. They use statements that reflect the speaker's reactions (e.g., "I feel. . .").

Example: Active listening. When the problem belongs to the speaker only (e.g., a patient coming to see the nurse about a problem), and when it is not a simple request for information, the workers are taught "active listening" strategies. The leader presents to the entire group a question that a patient might ask (e.g., "I want to use a family planning method, but my husband doesn't want me to." The problem is the patient's; it will not be resolved simply by providing information.) Each person records his responses to the question; then, barriers to helping the person solve the problem are described (specifically, giving advice, giving warnings, telling the person what to do). A more appropriate method is then described and illustrated using a volunteer. (S)he role-plays the patient presenting the problem. Two different counseling methods are used. One, the patient is given advice and, two, she is helped to think through the

problem. The volunteer is asked to identify the preferred method. (All prefer the second!) After this demonstration, the individuals break into small groups to practice the strategies using real problems of their own. One person takes the role of the person who needs help, another is the helper. The observers help redirect the helper if he begins to give advice, moralize, warn, etc.

4. Use of Feedback: How to give feedback appropriately; how to receive it without defensiveness.
5. Analysis: Analyzing the specific roles and jobs of each person in the health center; acknowledging activities; developing team consciousness and work relationships; exploring group dynamics.

Example: The resources available to the MOH--the experience and expertise of Urrutia, Solis, and Munoz--are particularly appropriate here. Lic. Urrutia has a compilation of a whole series of exercises developed by the National Training Laboratory, many of which are appropriate here. In one, for instance, the advantages of having clear and specific goals are illustrated by an exercise in which the performance of a task by two groups--one with a clear goal, the other with a vague goal--is compared. The two groups try to perform the required task; several observers watch the interaction. The exercise illustrates the debilitating effects of unclear goals and directions on task performance.

Example: Expansion of role definition. All of the specific tasks for a certain position, such as head nurse, are listed by the entire group. Efforts should be made to define these various tasks in terms of behavior; subjective terms (e.g., listens well) should not be used. Tasks which are appropriate, which should be added or subtracted, or which are not possible for the person to perform should be noted. The exercise is designed to support people who are doing good but unrecognized work (socio-emotional support of the patient is particularly stressed) and to identify sources of role conflict, situations in which people are expected to perform two conflicting kinds of activities.

6. Taking the Patient's Perspective: Gathering more information about beliefs, attitudes, and stresses in the lives of the patients.

Example: Role-playing a patient-staff interview. The group is divided into pairs; one member of the pair plays the doctor, the other the patient. The patient explains his problem to the staff member who is

busily writing and not looking at the patient at all. The patient is telling the staff member about some significant event that recently happened and gave him satisfaction. The roles are reversed. When the exercise is over, the group reunites to discuss their reactions to the experience and to suggest ways of making the patient feel the staff person is listening. These observations and recommendations are recorded on a large sheet of paper in front of the group.

7. Self-exploration, Self-understanding, Self-acknowledgment.

Example: Lic. Urrutia has some good exercises. For example, in "planning for living" (planear para vivir), participants list 10 ways that they define themselves (e.g., "I am a mother.") and then consider the implications of those definitions for their work.

8. Identification and Development of Positive Reinforcement Systems: Improving Incentives for work.

Example: Defining sources of reward for each worker. The group attempts to list personal sources of reward and the sources of reward of one category of workers (e.g., secretaries). Distinctions and similarities between the two groups' lists are discussed.

9. Theoretical Orientations and Presentations: Principles of behavior modification, Transactional Analysis, group dynamics from the National Training Laboratory, Gestalt, Parent and Administrator Effectiveness Training, etc.

Training and Selection of Personnel for Human Relations Training

A. Recommended Approach to Training

In order to clarify the roles in this new area, specific descriptions of the positions to be filled, including capabilities, experience, and methodologies mastered, need to be developed at the MOH level.

Different levels of expertise would be established; the methodologies mastered at each level should be specified. One suggestion is to name as trainers people who could teach and supervise others; as assistant trainers those who would be in the process of learning; and as facilitators at each local center those who would have some training and experience but who

could call on the trainers and assistant trainers for assistance in local sessions.

The training of trainers, assistant trainers, and facilitators should be continuous and conducted in the field. One approach might be to have a trainer, assistant trainer, and facilitator jointly lead each human relations workshop. Participation as a leader in each workshop would be part of the training. All three people would design and plan the workshop and evaluate the course after the workshop is completed. These skills cannot be learned without supervised practice. Theoretical training is also needed. The training sessions would probably be more fruitful and more efficient if they were relatively short and interspersed with the person's regular work. In other words, a single seven-week course given to a group in the city would not be the most efficient or effective training method.

The "intermittent" approach to human relations training suggests that someone should be brought to Panama to work with a defined leadership group at the national level of the MOH in an intensive session. The consultant would assist members of the group in developing and directing a workshop as part of their education.

## B. Selection of Personnel for Training

### 1. Criteria

Potential trainers should probably be selected on the basis of personal interest and desire to learn the techniques. Again, the value of supervised practice is obvious, as it helps the trainer to identify, early in the process, before large investments in training have been made, people who have the capacity and interest to direct groups.

### 2. Existing Resources in the MOH

There are people in the MOH who have considerable knowledge, expertise, and experience in running human relations workshops. Lic. Urrutia is an especially valuable resource. He would profit from the opportunity to develop his skills in programs other than that offered by the National Training Laboratory. Another resource may be the psychiatrist at the Curundu Health Center. Two other individuals who have been identified as potential "trainers" are Ermila Munoz and Rolando Solis. Both are health educators. Solis failed to appear for the training and offered no excuses, thus suggesting that he may not wish to be involved. Munoz is interested, overcommitted (apparently), and definitely in need of more training. Two others who appear to be very interested and who perhaps could be quite

capable trainers if they receive more training are Flor de Vasquez, an obstetrical nurse, and Franklin Degracia, a health inspector. De Vasquez is on loan to the national-level Comite of Docencia until December of 1980, at which time she must return to her regional post.

The MOH personnel who appear to offer the most promise as workshop leaders or trainers are listed below. Their current level of training\* is indicated.

| <u>Name</u>        | <u>Previous Training</u>  | <u>Training Needs</u>  |
|--------------------|---|--|
| Ezequiel Urrutia   | 14 years experience as group leader; several courses with National Training Laboratory in Puerto Rico                             | Quite capable; skills well developed; could profit from exposure to different techniques**   |
| Ermila Munoz       | Two-month training course with National Training Laboratory   | Shows interest in learning; manner is brusque, didactic; may need considerably more practice to switch from teaching to group leadership |
| Rolando Solis      | Two months of training with National Training Laboratory  | Unable to assess level of interest   |
| Flor de Vasquez    | Has participated in several intense group experiences; no formal training   | Potentially excellent; good ideals; creative; needs training   |
| Franklin Degracia  | Has taken course in Transactional Analysis; no formal training or experience in group dynamics                                    | Much interest; responds well to suggestions; could be good; needs training   |
| Olgalina Rodriguez | ? group dynamics course in social work school? could be a useful trainee; no opportunity to observe her                           | Is currently running groups in Colon area  |
| Ricardo Aguilar    | No previous training interest; physical limitations (very heavy) may prevent him from being as effective as he might be otherwise | Shows considerable interest  |

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\*May not cover all of individual's training.

\*\*Suggestions as to where Mr. Urrutia might receive further training would be appreciated.

### 3. Other Human Relations Resources Available in Panama

In the short period of time available, it was impossible to make an exhaustive search for potential human relations resources in Panama. It appears that some individuals have been trained in specific methodologies, such as Transactional Analysis, in the private sector, but they do not appear to be committed to training other leaders. However, it might be possible to use these resources for different aspects of training.

In the Ministry of Health, the potential sources of support are the psychiatrist at the center at Curundu (she has experience in group leadership in her center) and Dr. Bethancourt, a director of a center in Colon who has shown an interest in human relations. The consultants could not evaluate Dr. Bethancourt's expertise in the time available.

Other potential resources are two employees of AID, Pedro Martiz and Angela de Mata.

E. Urrutia has a manual developed by the National Training Laboratory which contains many useful exercises. Although directed to business, portions of the manual could be adapted for use at the health centers.

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## **APPENDICES**

**Appendix A**  
**PRINCIPAL CONTACTS**

Appendix A  
PRINCIPAL CONTACTS

Ricardo Aguilar  
National Chief of Sanitary Inspectors

Dr. Armijo  
Director, Panama-San Blas Health Region

Dr. Bethancourt  
Director of a health center in Colon

John Champagne  
AID/Panama

John Coury  
Population Officer, AID/Panama

Franklin Degracia  
Health and Sanitation Inspector  
(in charge of information courses in sanitation)

Dr. Donas  
PAHO Advisor to the MOH and to the Education Committee

Carlos Harris  
Health Educator; Chief of health Educators;  
Chairman, National Committee for Teaching,  
Ministry of Health

Pedro Martiz  
AID

Angela De Mata  
AID

Ermila Munoz  
Health Educator, Panama-San Blas Region

Dr. Humberto Narr  
Head, Maternal and Child Health

Elida Rodriguez  
National Chief of Social Workers

Olgalina Rodriguez  
Social worker in the Colon area  
(prepared a Human Relations Workshop in Colon)

Theresa de Rodriguez  
Nurse; Coordinator of Nursing, Maternal and Child Health  
(on loan from position as Head Nurse, Metropolitan Region)

Flor de Vasquez  
Obstetrical Nurse; Member, Teaching Committee  
(on loan from position as obstetrical nurse in Metropolitan Region  
until end of December 1980, to teach course for Maternal and Child  
Health)

Rolando Solis  
Health Educator, Panama-San Blas Region

Lic. Ezequiel Urrutia  
Health Educator (on loan to Maternal and Child Health to design  
mass media and communications materials in family planning)

**Appendix B**

**FIGURES 1 AND 2:  
ORGANIZATION AND SAMPLE NATIONAL NETWORK**

FIGURE 1

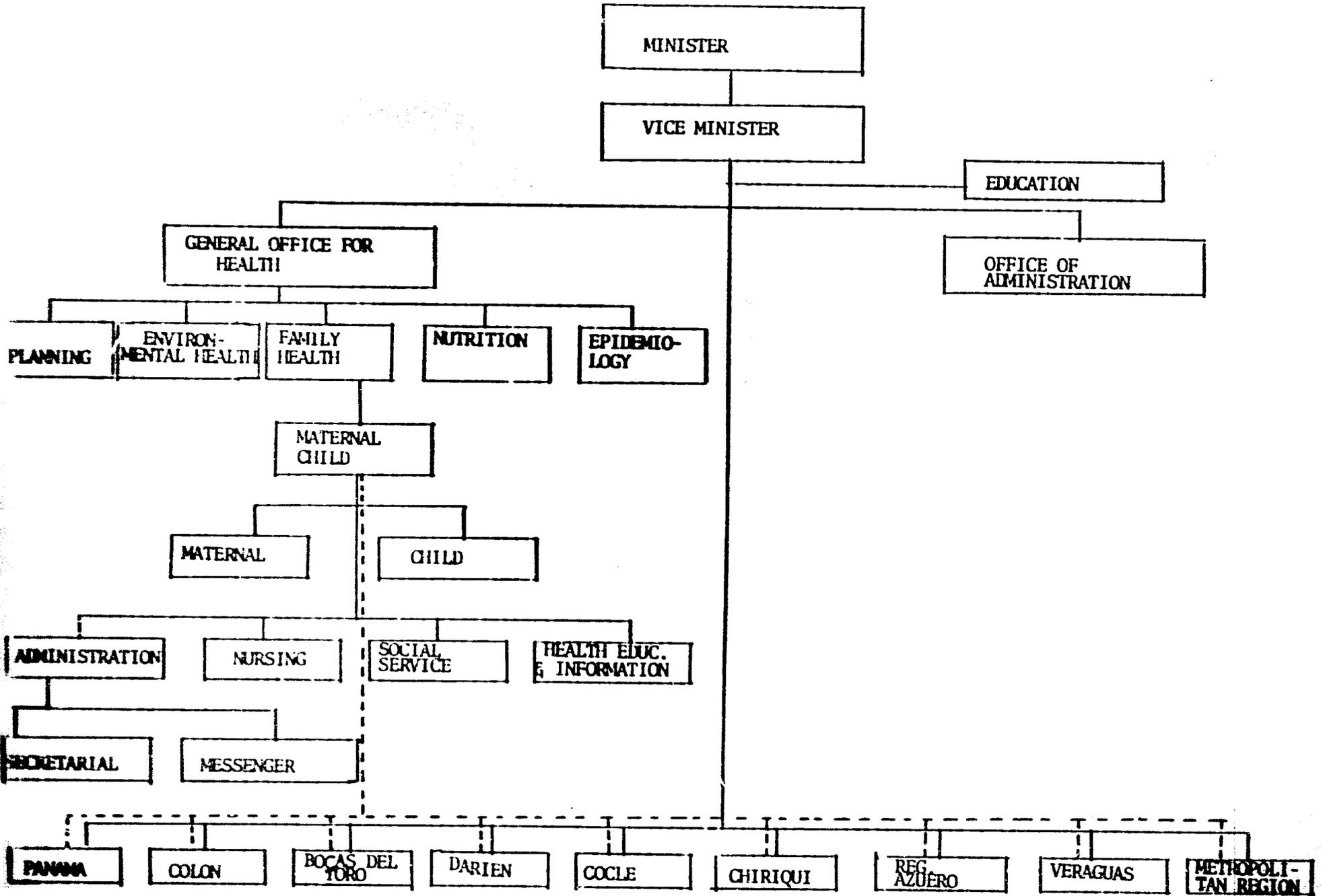
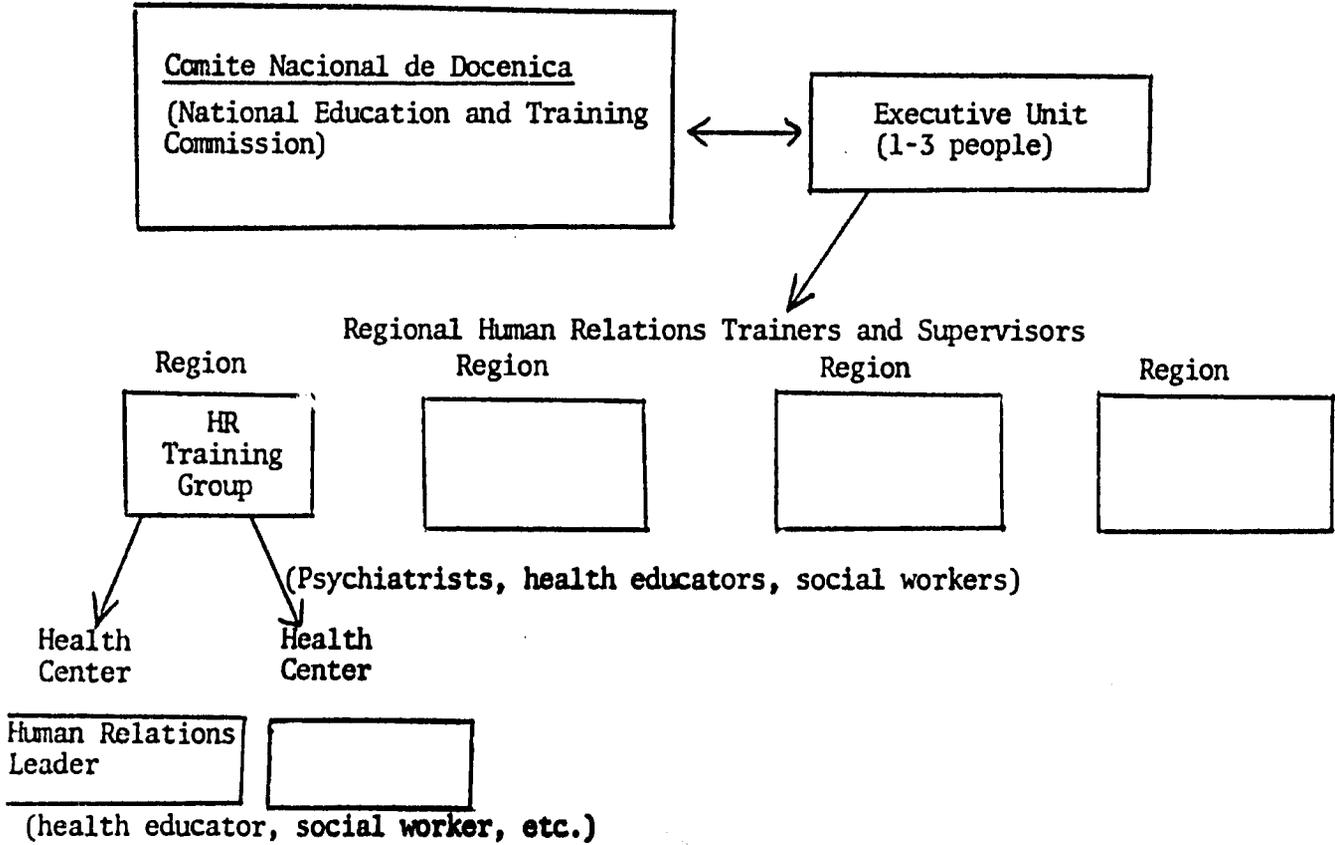


FIGURE 2

Example of a National Network for Human Relations Training



**Appendix C**

**SAMPLE HUMAN RELATIONS SKILLS EXERCISES**

## Appendix C

### SAMPLE HUMAN RELATIONS SKILLS EXERCISES

Module: Greetings without words (Developed by P. Engle)

Goals: Opportunity to contact large number of people (ice-breaker); practice in non-verbal communication (looking in eyes; making contact through touch); opportunity to take safe risks in reaching out for relative strangers and to become aware of individual pattern of reaching out.

Number of People: No limit

Length of Time: Approximately 10 minutes

Materials: None

Instructions: "Today we are going to practice greetings without words. First, let me show you an example of greeting in which no communication has occurred. May I have a volunteer? (Demonstrates loose handshake, not looking in eyes, etc., with same volunteer.) Fine. Now, here is another greeting. (Demonstrates good handshake, looking straight into eyes, long look.) Good. (Ask volunteer.) Which did you prefer? (If he preferred the first, you may not have exaggerated the difference enough. Perhaps try again with the demonstration.) Now I would like you to greet each other without words. I am going to ask you all to stand up, and move around the room, greeting each other with a handshake and looking into the eyes, without saying anything. Any questions? Good. You can all stand up now."

Description of the Exercise: Everyone should stand up and turn to someone to begin the greeting. People will then move about the room, greeting and passing each other. This may continue for five minutes or more, depending on the size of the group.

Reactions to Look For: Some people find it very hard not to talk, and they may be whispering or giggling. You may want to discourage talking with a gesture. Some people will reach out, circulate freely, greeting a lot of people; others will be very shy, will hold back, or will not even leave their chairs. Some will look directly into the eyes of others, whereas others will avoid a direct gaze and prefer very quick contacts.

Questions: Ask how people felt about the exercise; encourage reports of experience rather than beliefs.

Analysis: You may want to express an overall reaction, depending on the behavior you saw. You may also want to point out that some people have an easy time reaching out to others, whereas others tend to be shy and hold back. Ask people how they felt when someone looked into their eyes and how it felt to have someone avoid the direct gaze. If you felt that people had a lot of difficulty with this, you might want to move into the groups of pairs exercises in which participants have to gaze for a minute or two without talking.