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FIELD NOTE

**LESSONS IN CREATING A CDD COMMUNICATION
TRAINING VIDEO FOR HEALTH WORKERS**

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The cultural diversity and geographic inaccessibility of much of Papua New Guinea (PNG) makes it a challenging environment for the delivery of primary health care services. In spite of this, PNG is almost unique among developing nations in its outreach of health services to the rural population. Every 1,200 people in rural PNG are served by a health facility. The population of approximately 3.5 million people is served by 20 provincial hospitals, more than 20 urban clinics, approximately 450 health centers and subcenters, and more than 2,000 aid posts.¹ These aid posts are constructed by the local communities, which generally provide land for the post and a house and garden for the aid post orderly.

The backbone of the rural primary health care system are the aid post orderlies (APOs) who are trained for two years in common illnesses and treatments, preventable conditions, and environmental management (including water supply, sanitation, nutrition, and hygiene). In 1987 the APO training program was revised. Graduates from this more comprehensive training are called community health workers (CHWs); they will slowly replace APOs in the health system.

CONTROL OF DIARRHEAL DISEASE

One of the major preventable childhood conditions which confronts the health worker in PNG is diarrheal dehydration. Although diarrheal disease appears to have a lower incidence among children in PNG than in many developing nations, it is still the second leading cause of death among children one to five years of age and the third leading cause of deaths among infants. Moreover, in this country it is particularly difficult to determine the actual severity of the situation. According to the National Health Plan for 1985-1990, only a little over ten percent of deaths take place in institutional settings.² Approximately 65 percent of infants and children who die before the age of five do so at home. It is likely that a substantial percentage of unreported infant and children mortality is related to diarrheal disease.

The authors would like to thank the following individuals for their help in creating and evaluating "Making Things Clear": Byron Geniembo, Officer in Charge, Health Education Unit, Department of Health; Megea Kivali, Audio/Visual Technician, Health Education Unit, Department of Health; Dale Rustein, Director, FirstTake Productions; Chris Wiley, Managing Director, Human Resources Development (HRD); Cecilia Verzosa, HEALTHCOM/Washington; and John Elder, San Diego State University.

Since the formation of the National Committee on the Control of Diarrheal Disease (CDD) in 1979, the PNG Department of Health has undertaken a variety of activities to combat the problem. The most notable of these are:

- legislation to prohibit the sale of infant feeding bottles, except on prescription;
- the introduction of oral rehydration salts (ORS), supplied largely by UNICEF since 1985;
- the establishment of an outpatient department for the management of diarrhea and an inpatient ward at the National Hospital in Port Moresby;
- the creation of health worker training modules on CDD;
- the completion of a number of health worker supervisor training workshops.

Training under this program is conducted by the National Training Support Unit (NTSU), a part of the Department of Health responsible for preservice training, inservice training, and the design and sponsorship of regular supervisor training and other support.

In 1984, the DOH drafted ORS training modules for aid post orderlies and nurses. In the following year materials were pretested and training-of-trainer courses were initiated. In addition, the DOH developed a supervisor's CDD checklist for use in all health institutions as well as ancillary materials such as tape/slide presentations. A national workshop that year for pediatricians provided an important forum for examining the program and making recommendations for future directions. (In PNG, private physicians are supportive of the national ORT policy and consensus building within the medical community regarding appropriate technologies is not the challenge that it commonly is in many developing nations.)

Despite these efforts, problems remain. In 1987 the Department of Health, in collaboration with the World Health Organization, issued a Comprehensive Review of the Control of Diarrheal Disease Program in four provinces which identified several key areas for improvement. Among these were:

- correct and adequate use of ORS, particularly at the village level;
- early recognition and adequate treatment of diarrheal disease in the home and village, with referral as appropriate;
- an appropriate program of health education about CDD, especially in villages and urban settlements;
- increased coverage of measles immunization.

The recommended improvements thus focused largely on the practices of caretakers themselves, and secondarily those of APOs--especially in their role as educators.

As part of its response to this review, the DOH invited A.I.D.'s HEALTHCOM Project to assist in introducing a systematic communication program to strengthen PNG's health education system, with special emphasis on diarrheal disease control. Communication skills per se have never been part of the regular preservice or inservice training programs provided to APOs. Moreover, health education has traditionally received little focus. In 1982 the Health Education Unit of the DOH was reduced to a skeletal staff of two health educators responsible for coordinating all health education efforts throughout the country. Other national and provincial health education officers were transferred elsewhere within the DOH (usually becoming primary health care officers or inservice training coordinators). At the provincial level, most health education responsibilities were addressed indirectly; every health worker was considered to be a health educator. Without proper training and support, however, this approach was ineffective. The Health Education Unit had essentially no budget until 1988 when concern about AIDS focused attention upon the unit and plans were made to raise it to the level of a division.

PREPARING FOR A PILOT PROGRAM

The HEALTHCOM Project resident advisor began working with Department of Health in 1988 in collaboration with the officer in charge of the Health Education Unit and assistance from the audio/visual technician. With virtually no other professional staff and a very small operating budget, the PNG project has been the smallest-scale HEALTHCOM site. This has meant that both priorities and methods have been scaled

accordingly, and difficult trade-offs among short- and long-term goals, between speed of production and thoroughness of technical review, and between effective use of limited funds vs. "institutionalization" of capacities within the DOH have been everyday realities. The PNG project therefore provides some interesting insights into how and to what extent "corners can be cut" in order to initiate successful communication activities within the health delivery system, and what aspects of the HEALTHCOM methodology are essential to assuring the usefulness of strategies and products. It also demonstrates the importance of seeking resources and expertise outside the immediate circle of collaborators, particularly in the private sector.

Background Research

The Central Province, including the National Capital District (NCD), was selected as the site for a pilot program in the area of CDD. We began with an extensive review of existing research and determined that important background information on the knowledge, attitudes, and practices (KAP) of the target population within the Central Province was lacking. Because staff, expertise, and other resources were not available within the DOH to undertake such a study, we contracted with a local research firm, MarketSearch, to conduct a KAP survey consisting of 500 interviews with urban and rural mothers (250 from five locations in the Central Province and 250 from the NCD). This quantitative data was supplemented by information gathered through six focus group discussions (three each with urban and rural mothers) conducted by MarketSearch simultaneously with the KAP survey. The focus groups investigated what mothers know and do about diarrhea among their young children.

Among other findings, the survey indicated that diarrhea is not considered serious in its early stages. However, when mothers do seek advice, health workers are their leading source of treatment and information. The research also indicated that there are widespread beliefs regarding spiritual causes of diarrhea, as well as for other diseases. Mothers were more willing to discuss these beliefs during focus groups than in one-on-one interviews.

CDD Treatment Norms and Realities

At the time of this survey, CDD policy was in the midst of being revised by the National Committee for CDD. New norms were approved in late 1989. Recommendations include early home treatment of the child with available fluids

(coconut water, fruit juices, etc.), continued breastfeeding, and assistance from the health center or APO, especially in administering ORS in case of signs of dehydration. The guidelines state that in most situations ORS packets should not be given to mothers for use in the home. Under special circumstances (such as a mother living a long distance from the aid post) the health worker can give out packets but is then responsible for insuring the mother understands proper mixing procedures.

In fact, informal interviews conducted by the resident advisor with APOs and community health workers revealed that 31 out of 34 (of a total of approximately 80 health care workers in the Central Province) gave out packets to most mothers who came to them when a child had diarrhea. Health workers were thus often in the position of providing more training to the mother than was officially recognized. Yet informal observations in aid posts showed that APOs spend the majority of their time in providing treatment for ill children and practically no time communicating with or providing instructions to the patient or parent. These observations were supported by a PNG Rural Health Services Cost Study³ that found that health workers at health centers and subcenters allocated less than 15 percent of their time to preventive health care activities.

RESPONDING TO A TRAINING OPPORTUNITY

All of these findings confirmed the need for educational programs aimed at both mothers and at health workers in order to improve treatment in the home and to strengthen both case management and transfer of knowledge from APO to mother at the clinic level. The HEALTHCOM Project made one of its chief targets the quality of interaction between health worker and mother.

A major opportunity to integrate health communication skills into the regular training program arose from February through May of 1988 when both the Central Province and the National Capital District planned a series of inservice training workshops for APOs. The training covered a variety of child survival and other primary health care issues. HEALTHCOM was invited to assist in developing a module within the CDD portion of training. Given the lack of emphasis upon communication in the overall curriculum, we decided to design a module to provide APOs with education skills that they could transfer to any health issue involving the training or motivation of the target audience.

We chose to design the training module around a video, which could be used in an interactive manner and in conjunction with print materials and exercises emphasizing individual practice and role playing. The video medium offered a standardized behavior modeling tool which could be adopted in different training settings. Given the absence of a cadre of trainers or of a standard training hierarchy (common in many developing countries) the video would allow consistent messages to be provided to various groups under different circumstances. Video is an increasingly popular medium in PNG and we anticipated it would have great potential as a teaching device with our target group, among whom the medium is still quite novel. We knew electricity was available at our workshop sites and we had our own equipment to bring along. (Since that time, WHO and UNICEF have donated video equipment to each of the provincial health departments in PNG.)

We planned as the theme of the video and of all training materials to emphasize that mothers are capable of learning important health skills, given adequate instruction and feedback. The video would attempt to counter occasional negative attitudes among APOs about the care-giving abilities of mothers. It would focus on two-way communication and counseling, emphasizing the importance of both listening and making oneself understood.

DESIGNING THE TRAINING VIDEO

Given our time, staffing, and resource constraints, the production of our video was very much a "no muss no fuss" activity. Because we decided to make a video only one month before the first workshop was to take place, the entire process was by necessity streamlined. The creation of the video took place in eight stages. Briefly these were: 1) selection of basic content and format; 2) contracting of producers; 3) writing of script; 4) first technical review; 5) selection/contracting of actors; 6) production; 7) pilot test in workshop setting; 8) second technical review; 9) revision and translation.

Pressures of time and local budget were in some ways a help and in some ways a hindrance to producing an effective, appropriate, and quality video. Our chief challenges were with respect to timely technical review and institutionalization of the learning process within the Department of Health bureaucracy. The remainder of this field note describes this process in detail and reflects on the lessons learned in the creation of "Making Things Clear."

The Concept and the Content

In seeking models and principles upon which to design the video, we turned to two resources: Talking with Mothers About Diarrhea⁴ and Promoting Health and Well Being in the Community⁵. Both of these focus on elements of two-way communication and counseling. The first guide leads participants through scripted interactions (both good and bad) between a mother and her physician. It provides instructions analyzing elements of a conversation and exercises in recognizing and practicing productive communication skills such as listening, asking "checking" questions, using examples and demonstrations, and providing support. The second publication is a manual for training local leaders to motivate and teach positive health practices among community groups. The focus is on participatory learning methods.

We decided to present a simple dramatization of interaction between a mother whose child has diarrhea, and the APO she goes to for treatment. A narrator would help the viewer analyze good and bad aspects of the interaction. The small number of characters working in a natural setting would help reduce costs and also provide the appropriate models for role playing exercises (including the "observer/critic.")

On the basis of this plan, the project provided informal creative briefings to four video production houses in Port Moresby and solicited bids. We selected FirstTake Productions, a full service marketing firm and the one able to complete the work within the short time available. FirstTake has produced a wide range of videos for public and private sector organizations, and has also been working on a documentary for the USAID-sponsored Radio Science Project. We were confident in their ability to understand our target audience and our objectives. As part of their "package," FirstTake also gave us the services (partly volunteered) of a market researcher from the parent company, Human Resources Development (HRD). Our creative team thus consisted of four people: the officer in charge of the DOH Health Education Unit, the HEALTHCOM resident advisor, a production specialist from FirstTake, and a market researcher. [yes?]

The team quickly settled on a "tone" for the video: simple, straightforward, but gently humorous, in order to grab the attention of listeners. The market researcher emphasized that humor has been found to be effective in PNG for marketing a variety of products.

We established our key communication issues as the following:

- listening
- asking questions
- examining the patient
- speaking simply and clearly
- looking at the patient/caretaker
- showing concern.

In addition, however, the video would focus on a number of technical issues involving CDD policy. The extent to which our video could combine a focus on interpersonal skills with a valid presentation of CDD norms was problematic. Our difficulties were compounded by the state of flux in CDD policy at that time, specifically with regard to home treatment of diarrhea and investigation of an appropriate home measuring device. We decided that our video should focus on the general diagnosis of dehydration, and on one component of treatment--namely the mixing of ORS--which required actual education of the mother by the APO. Packet distribution to mothers being a relatively minor component of CDD norms from a policy viewpoint, it was not surprising that ORS mixing received minimal emphasis in the clinical training of APOs. We decided to concentrate on this issue.

Another major area for discussion--and some debate--among the creative team was how best to demonstrate these skills in a short video. The chief question was whether to show a single good demonstration or to compare good and bad examples of health worker/mother interaction. Although we knew there was some danger a negative example might be misinterpreted as a correct one, we finally agreed to use contrasting scenarios. Two dramatizations would require more time but we felt this approach would sharpen viewers' discrimination between effective and ineffective communication, would encourage interactive use of the video (which could be stopped at designated times and discussed) and would provide an obvious opportunity for some humor. Our hope was the audience would feel safe in criticizing the slightly exaggerated behavior of a fictional colleague and would find the video more memorable than a one-dimensional didactic presentation. We decided that a video under 15 minutes could present the issues effectively and still keep participants' attention.

Script Writing and Review

We wrote the script in the space of one week. The writing itself was a group process, with FirstTake Production taking the lead. We wrote the original script in

English because health workers in the Central Province/NCD area receive their training in English. Our title, "Making Things Clear," was also our own guiding creative principle. The narrator speaks simply but familiarly and with animation. He focuses immediately on the crowded, sometimes chaotic everyday environment of the APO and speaks directly to his colleagues:

You may know everything there is to know about taking care of people when they get sick, but if you do not know how to make things clear to your patients, then all your training is not very effective, because the message doesn't get through.

He then introduces the first "episode" in which it becomes quite clear that "communication means much more than talking to people." A mother comes to the APO with her small child who has been having diarrhea for several days. The woman is obviously worried. The APO takes a quick look at the child and rapidly tells the mother what to do. He makes a number of obvious communication blunders--ignoring the mother's questions and confusion, seemingly blaming her for the child's condition, and finally dismissing her with a supercilious wave. The APO is satisfied with the encounter; the mother is not. (See Annex for complete video script.)

The narrator then returns to help us analyze what has and has not happened. As the scene is replayed the narrator speaks in the background, pointing out each major error that APO makes. Among these are:

- He used many words which the patient did not understand.
- He never looked at the child's mother to see if she could understand him.
- He spoke too fast for her.
- He never listened to her questions.
- He never asked her if she had any questions.
- He didn't really care about her problem.

According to the narrator, "These six mistakes are the most common communication problems."

We next see the same scene played between a sensitive and solicitous APO. He sits down with the mother and first looks at her baby's health card. He then

congratulates the woman on the fact that the child's vaccinations are complete. Then he asks her what the child's problem is. He expresses concern, makes eye contact, asks questions, and makes sure the mother understands the importance of giving liquids, food, and ORS. The mother leaves the aid post not only understanding how to mix ORS but feeling confident and encouraged about her ability to take care of her child. Once again, the narrator goes back over the scene and points out the behaviors which add up to effective communication. [Photos: six video stills with principle beneath each one and also shot of narrator.]

After finishing the script, we reviewed it carefully with the officer in charge of the Health Education Unit to make sure the details of diagnosis and treatment conformed to the current CDD norms. Although the video was not meant to be a diagnosis/treatment example but rather an illustration of communication skills, we wanted to make sure our script supported current treatment policy.

Production

FirstTake screened and selected four actors from the National Theatre Group (three adults and a child, who has no lines) and a few days of rehearsals were begun. We taped the episodes in two components. The "good" and "bad" skits were taped in a single day on location at a small health facility in a village just outside of Port Moresby. The narrator was taped in Port Moresby a few days later. Editing of "Making Things Clear" required another week. The video was then used almost immediately in the workshop setting. From conception through production, the process had taken only about five weeks. However, the phases which followed proved to be equally important.

MONITORING THE PILOT VIDEO

We presented the video at district level workshops in the Central Province (Abau District) and in the National Capital District. The videos were part of a three-hour training session conducted by the chief health officer of the Health Education Unit on the role of the aid post in community development and the importance and nature of effective communication between health workers and their patients. In both instances, the video was followed by lively discussion about the "good" and "bad" behaviors demonstrated by the actors. We then led the groups through role playing sessions (of "good" communication practices) and followed these with further discussion. Audience appreciation of our video was confirmed during the evening sessions. Participants had

been scheduled to see several foreign videos but asked first to see "Making Things Clear" again, and watched it twice. They found the bad example particularly funny and enjoyed discussing the APO's different interactions with the mother. Although our "bad" APO was not in any sense farcical, we speculated that his behavior was so true to life and at the same time so unhelpful from the mother's perspective that our participants were able to appreciate (perhaps for the first time) the absurdity of this fairly typical interaction.

Behavioral Observation

Several weeks later we conducted follow-up studies to test the effect of the video on participants' actual behavior in the clinic setting. We set up a small study to contrast behaviors of 14 health workers who had received the communication skills training (and had seen the video) with the behaviors of 28 health workers who had not. Of the 14 health workers who saw the video, seven were observed less than one month after viewing it and the other seven were observed more than three months afterwards. We held the observations at district health centers on pay Fridays. This assured that we could interview a maximum number of APOs. It also assured us of sites with electricity. After the conversation/role plays we invited our participants to view the video. The study thus also became a training experience for those who had not been in the original workshops.

The "research team" consisted of a local woman--who acted as a mother of a sick child--and a male observer. We invited APOs to meet individually with the team in a private setting and to "role play" with the mother who had reportedly come for help with a child who had diarrhea. The mother was purposely somewhat passive and noncommunicative, requiring the APO to strive to use the skills presented in the video. She had a fixed set of responses for the various signs and symptoms the APO might ask about. The observer watched and listened, and recorded activities observed and questions asked on a checklist.

We designed the checklist to evaluate the health workers according to behaviors recommended by the World Health Organization and adopted under PNG's CDD policy. WHO outlines an "ask, look, feel" method for assessing a child's condition. We added other elements to the checklist in order to evaluate treatments recommended by the APO to the mother, explanations given, and extent of personal interaction--including whether the APO showed the mother how to administer ORS and whether the mother learned the steps. The results of the study are given in Table 1.⁶

Table 1

Observations of APO Interactions

<u>Group</u>	<u>N</u>	<u>Aver. No. of Assessments</u>
Didn't see video	28	5
Saw 1 week ago	7	10
Saw 3 months ago	7	9

Health workers who viewed the video were more likely, even after a period of three months, to conduct a more thorough assessment of the child and to ask the mother more questions than were those who had not seen the video.

Additional Technical Review

Simultaneous with our pretest of the video during the workshops, we submitted "Making Things Clear" to several additional technical experts for their review and input. These experts included the WHO Western Pacific Regional CDD Officer and the chief pediatrician at the Port Moresby General Hospital. The HEALTHCOM Project office in Washington, DC, also reviewed the video at this time.

The reviewers made several recommendations regarding the clinical aspects of the dramatizations. One dealt with the APO's diagnosis of the child and the other regarded mixing of ORS. Specifically, the reviewers suggested that the fictional child not have symptoms of dysentery (as the mother indicates) but only exhibit symptoms of mild dehydration. This allows the APO to concentrate on standard ORT treatment. Secondly, the DOH finalized its recommendation regarding the common one-liter measuring device found in PNG homes and it was necessary to change the cup selected by the mother for mixing ORS. Both of these factors necessitated a reshooting of the "slice-of-life" portions of the video. Given this opportunity, we made a few other changes as well. In the opening scene of the revised version, the narrator stresses that the video is not

meant to serve as a complete diagnosis/treatment illustration, but only as a dramatization of communication skills. In the "good" scenario, the APO stresses the importance of continuing to give the child liquids and foods--a message which we thought had not been passed to mothers effectively enough during our behavior observations.

During the technical review we received widespread feedback that the video addressed an area which has been very much overlooked by traditional DOH trainings. The Health Education Unit decided it would be appropriate to translate the video in Tok Pisin so it could be made available to health services or facilities throughout the country. With nationwide distribution of "Making Things Clear," we hope to conduct a more complete evaluation of its impact on communication skills.

Within a year of producing "Making Things Clear" 600 copies of the video were distributed throughout PNG. The WHO regional office in Manila also responded to requests for the video from Laos, China, and Vietnam. Health officials in Laos are dubbing a Lantian soundtrack onto "Making Things Clear" and plan to produce a completely Lao version in the future.

LESSONS FOR THE FUTURE

No effective behavior-modeling training tool can be made without technical "content." Although we tried to focus our video on a small aspect of CDD case management, our dramatization inevitably overlapped with many other aspects of CDD policy. We learned the difficulty of designing communication materials when medical norms are in a state of ambiguity or transition, and we learned the hazards of putting off thorough technical review until changes become difficult or costly. Moreover, we realized our method of pretesting was a potentially dangerous one. Since we were using the pretest as simultaneously a training event, our mistakes could have done some harm.

However, by using a "finished" video in our pretest setting, we gained a number of advantages. Although it is possible (and common) to test storyboards with a target audience, testing at some midpoint in the creative process leaves much to the imagination of the viewer. We also benefited from the behavioral follow-up test, which indicated that our video was successful in a true training setting. We were fortunate that time constraints obviated the all-too-common hold-ups of a comprehensive bureaucratic screening. Given the opportunity to do this job again, however, the team would have looked for some happy medium in reviewing the script. Ideally, a small committee consisting of one or two technical experts, one or two health educators, and

one creative professional would be asked to review the script once, make comments, and have input into a single revision.

Institutionalization of methods and skills within a local institution is challenging even when staff and resources are readily available. The first step in this process is often demonstration of a successful health communication activity. Even the earliest step, however, must be carried out through cooperative planning and implementation with local partners. We were fortunate in PNG that experienced private sector organizations were interested in our project and could provide needed expertise at several stages and on a scale which was appropriate to our needs. Learning to work with the private sector is often a crucial step in professionalizing communication efforts within a ministry of health--no matter what its size. We hope that the successful partnerships demonstrated during these early efforts in PNG provide a model for future activities as well.

NOTES

1. 1985 Handbook on Health Statistics, Department of Health, Port Moresby, Papua New Guinea.
2. Ibid.
3. PNG Rural Health Services Cost Study. (M. Mitchell, D. Donaldson, J. Tomason--1988)
4. Talking with Mothers about Diarrhea. W. Smith, C. Verzosa, P. Whitesell, and R. Northrup. etc. [I have.]
5. Promoting Health and Well Being in the Community. W. Hoff and K. Galowa. Environmental Health, Department of Health, PNG. 1988.
6. In contrived situations such as this one, we expect an "overreaction" by the participants. Knowing they are being observed, they will try to demonstrate how much they know and not necessarily what they actually do at the aid post. However, we can be fairly certain that what they don't ask or do during this observation will also not be done at the aid post.

ANNEX

MAKING THINGS CLEAR — VIDEO SCRIPT

(Music with title supered over exterior shots of a health clinic.)

NARRATOR ON CAMERA:

You may know everything there is to know about taking care of people when they get sick, but if you do not know how to make things clear to your patients, then all your training is not very effective, because the message doesn't get through.

The purpose of this video is to help you learn about the best way to make things clear to the people who come to you for help.

Many times you are in a big hurry, and maybe you don't take the time to make sure your patients understand the things which are very new to them, but quite common to health workers. We want you to understand that even though you might be speaking the same language, communication means much more than talking to people, it means making sure that the information is clear and that the patient can follow the instructions.

You are going to see an example of an aid post orderly explaining oral rehydration therapy to a mother whose baby is quite sick. This fellow will be talking but not communicating and his patient will go away confused instead of getting the correct information. This is not supposed to be a complete treatment of diarrhoea, just a bit of drama to show you what we are talking about. Now, watch closely, and try to see where the health worker is not doing a good job of making things clear.

(The scene is an examining room in an aid post)--WIDE SHOT EXAMINING ROOM

APO: Come in, come in...hurry.

(A nervous and frightened village lady comes in and takes a seat.)

APO: (MED. 2 SHOT.) (Talking quickly, never looking at the patient) Where is your book? What is wrong with your baby?

WOMAN: Diarrhoea. (She hands the book to the APO.)

(He reads it quickly. He gives the baby a very quick examination, checking the tongue, the top of the baby's head.)

APO: Now listen good (picking up an ORS packet) because this medicine is important since you let your baby get severely dehydrated due to acute diarrhoea.

(CU. Cutaway to a close up of the patient with a blank expression on her face.)

APO: (CU SHOT.) You must put the powder in this packet into one liter of clean water, stir up the mixture thoroughly, then administer to the baby throughout the day until the mixture is gone, and make sure the mixture stays covered when not in use.

(CU patient, over last two lines, her confused face darting back and forth from the APO to the packet and back.)

APO: (MED. 2 SHOT.) OK? (Handing her the packets) Good. (Shouting) NEXT!! Bring your baby book!

PATIENT: Sori, taubada...

(The APO ignores her question. CU cutaway to the patient's face looking closely at the packet, then looking to camera baffled.)

NARRATOR ON CAMERA:

How much did that lady understand? What are the chances that she will prepare the medicine correctly? Unfortunately, this is what happens to many patients when they come to the aid post. The health worker gave all the correct information, he was never rude, but he made some very serious mistakes. Even though he did all the things he was taught to do, he really failed to do his job because he did not make his words clear to her. Let's take a closer look at his mistakes.

(Replay of video from last scene without sound for each mistake.)

1. He used many words which the patient did not understand.
2. He never looked at his patient to see if she could understand him.
3. He spoke too fast for her.
4. He never listened to her question.
5. He never asked her if she had any questions.
6. He didn't really care about her problem.

These six mistakes are the most common communication problems. To be good care givers, communicate clearly with patients. Remember communication means much more than just talking to people.

Now let's watch the same scene with the APO showing the right way to give instructions.

(Same scene as before. The village woman comes in with the same feeling of nervousness)--WIDE SHOT EXAMINING ROOM

APO: Hello. Have a seat. You have your baby book? (He reads.) Good, your baby got all his shots. What about your other children, have they been immunized?

WOMAN: Yes, I think so.

APO: Very good. OK, what is wrong with the baby?

WOMAN: Diarrhoea.

(APO begins to examine the child. Examination involves looking for general condition, sunken eyes, quantity of tears, dry tongue, skin elasticity--of the stomach, not the arms--pulse, etc.)

APO: Is he vomiting?

WOMAN: (Nods yes)

APO: How many times has he vomited?

WOMAN: Just once today.

APO: Is he very thirsty?

WOMAN: He likes to drink a lot of water.

APO: That's important. Because when the baby gets diarrhoea, his whole body can dry up and he can easily die from that. You must keep giving the baby drinks and keep feeding him. Now, how many stools is he making every day?

WOMAN: Three or four each day for the past four days.

APO: Is he making any pis pis?

WOMAN: Not very much.

APO: (CU.) (Speaking slowly and clearly, and looking straight at the woman.) I'm afraid your baby is quite sick. Now, first of all you must keep giving the baby fluids to drink and foods to eat to keep him from drying up and getting weak, this is very important. Now I want to give the baby some special medicine right away, and because you live far away from the aid post I'll show you how to mix it yourself. You mix one of these packets with one liter of clean water. (Pause) Do you know what one liter is?

WOMAN: (CU.) No.

APO: I'll show you. Do you have any of these containers at home?

(He shows her four containers: a cordial bottle, a metal tea cup, a saucepan, and a bucket. She points to a coffee cup, 250 ml.)

APO: (MCU.) (Picking up the tea cup. He pours water from a pitcher not a kettle.) OK, you must fill this cup to the top with very clean water four times to get one liter of water.

(He demonstrates. Actually he gets the woman to help him make the mixture. He pours the water and she empties the packet into the container and mixes thoroughly. [This may be too complicated due to the woman holding the baby, but we should try it because we want to show the mother actually practicing the skill.]

APO: When you have mixed up this medicine you should give it to the baby all day, and it's good if the baby can finish all of it in one day. Give the baby other drinks too like coconut water or juice, and keep giving food as well. If the baby throws up, wait for a while and then continue giving the medicine, but more slowly. Is it clear?

WOMAN: (Nodding yes) Yes.

APO: Now, let's see if you remember. What should you do right away when the baby gets diarrhoea?

WOMAN: (Embarrassed) I can't remember!

APO: It's OK, you must keep on giving him fluids and plenty of foods to eat!

WOMAN: Yes, yes. I know that.

APO: Try again. How many cups of clean water do you use with the packet?

WOMAN: (She hesitates with a shy smile.) Four. (Holding up four fingers.)

APO: Good! And what will you do if the baby throws up after giving the medicine?

WOMAN: (Still a bit shy) I should wait for a while and then keep giving the medicine more slowly.

APO: Good!

(She smiles and looks at the packets.)

APO: (WIDE SHOT.) Now, I'll give you these packets for the next few days. If the baby gets fever or doesn't drink normally you come back and see me. Don't worry, your baby will be all right.

(She gets up to leave feeling better.)

APO: Who's next!! Bring your baby book. (He goes to wash his hands.)

NARRATOR ON CAMERA:

Can you see the difference? This time the health worker really communicated his message to the patient. He diagnosed the child and then took the time to make sure she could understand how to mix the oral rehydration.

Let's go back and take a look at the things the APO did this time which helped the patient to really understand.

1. He took time to diagnose the baby.
2. He spoke clearly and slowly.
3. He did not use any big words which the woman could not understand.
4. He looked at the woman when he spoke.
5. He asked the woman if she could understand.
6. He asked her to repeat the instructions to make sure she knew what to do.
7. He showed that he cared about her problem.

In this example the patient was treated very well and she left the aid post with a clear idea about how to use the medicine. You must try to remember that communication means more than just talking to people. It means listening, asking questions, speaking clearly, and making sure that your patient knows what to do.

You should try to use good communication whenever you are helping a patient, not only when you are treating diarrhoea. We are all trying to improve the health of this nation, and knowing how to make things clear will be a big help.