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**AFRICA CHILD SURVIVAL INITIATIVE
COMBATING CHILDHOOD COMMUNICABLE DISEASES
(ACSI-CCCD)**

CHALLENGING HEALTH WORKERS TO DEVELOP A PARTICIPATORY APPROACH TO PATIENT EDUCATION



UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
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Working Paper:

**Challenging Health Workers
to Develop a Participatory Approach
to Patient Education**

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ABSTRACT

This paper describes learning activities used to encourage health workers in Africa to develop their own participatory approach to patient education. In a structured learning experience, continuing education tutors and health education officers in Plateau and Niger States, Nigeria, were asked to consider selected concepts and ideas used in adult education and communication. They designed step-by-step processes for working interactively with individual clients and with groups, developed a plan to test them in nearby health facilities, and revised the learning activities for use with other health workers. Participants subsequently reported positive experiences with their participatory style of patient education.

Several challenges remain as these health workers strive to improve patient education. They will need to share the approach with their colleagues, address problems caused by the length of time required to interact with clients, strengthen their understanding of client perspectives and beliefs, extend their activities into the community, and develop evaluation techniques that will promote continued learning.

INTRODUCTION

Community participation is a cornerstone of primary health care. Various methods have been used to increase participation in health care in developing countries since 1970.¹⁻³ There are variations in the philosophy, approach, and methods of community participation described in the development literature in general and more specifically in adult education and health literature.⁴ This paper describes an effort to apply community participation principles to the process of patient education in health care facilities through the use of interactive, participatory methods.

In 1991, facility needs assessment results in Plateau and Niger States, Nigeria, indicated a need to strengthen patient education skills among health workers.⁵⁻⁷ For example, the assessment found that workers used sterile needles and syringes and gave the correct dose of vaccine at the correct site, in more than 95% of cases, yet warned clients about possible side effects and advised how to treat them in less than 60% of cases. Clients interviewed as they left the facilities knew when to return for subsequent immunization less than 40% of the time. This observation gave state-level ministry of health leaders an opportunity to explore the usefulness of shifting from an "advice giving" style of patient education to one of participatory dialogue. As noted in other countries,⁸ health workers in Nigeria were accustomed to didactic teaching methods and were strongly influenced by a medical perspective with an authoritative style. There was a need, therefore, to reassess their relationships with clients and to reconsider patient education goals.

As a first step, learning activities were designed to familiarize health workers with concepts and methods used successfully to promote community participation. Of particular use were lessons learned in Liberia, where leaders of community organizations met periodically with a health worker to discuss pressing health problems, then identified their own practical, technically sound, culturally appropriate solutions and ways to communicate their new understandings in their communities.* The approach is aligned with the "education for growth" strategy⁹ that encourages individuals to learn and grow through a group process of identifying, analyzing, and solving problems.

* Christian Health Association of Liberia (CHAL), unpublished reports of the health and church program Kolahun and Foya Districts of Lofa County, 1983-88.

PROBLEMS AFFECTING PATIENT EDUCATION

There are several barriers to health workers' rapid adoption of interactive, participatory communication approaches, among them barriers created during basic or preservice training. For example, health workers are commonly trained to "think medical," in the western medical paradigm. As a result of training, they are effectively, if unconsciously, inducted into a "medical culture," complete with its own language, belief system, social hierarchy, customs, and style of dress.¹⁰

Most health workers are trained in curative-oriented programs where lecture is the primary teaching method and the material is fact to be learned, not a point of departure for discussion. Training prepares health workers to function in the medical care system, and fosters a spirit of doing *to* and *for* clients rather than working *with* them to solve health problems. Professionalism, decision-making by professionals, monopoly of health knowledge, inflexibility, and reluctance to try different ways of doing things are often hidden in the curricula and modeled by trainers.¹¹

In addition to medical attitudes and practices, health education approaches taught to most health workers are developed in industrial societies, with cultures and circumstances different from those of developing countries. Trainers were themselves trained by those from industrial societies and the majority of textbooks and journals originate from such societies.^{12,13} To develop effective, culturally appropriate approaches to communication, health workers require stimulation, support, and encouragement.

SUPPORT FOR DEVELOPING A PARTICIPATORY APPROACH

To address problems affecting patient education, a 1-week workshop, *Communicating About Health*, was organized for selected Nigerian health workers in February 1992, under the auspices of the African Child Survival Initiative-Combating Childhood Communicable Diseases (ACSI-CCCD) project. The workshop provided a structure for considering and applying concepts and ideas used by adult educators and communicators. Seven trainers from Continuing Education Units (CEUs) and two senior staff from Health Education Units (HEUs) in Plateau and Niger States, who were responsible for improving patient education, became active participants in the workshop and initiators of subsequent activities.

The workshop was designed to promote reflection among the participants and to encourage them to develop personal, culturally appropriate, interactive styles of patient education. Given time and opportunity, it was hoped they might also apply these new approaches to community education. The use of a participatory approach provided workshop participants with an excellent opportunity to work with district health staff in improving patient education and community involvement in health.

DEFINING THE PROBLEM

At the beginning of the workshop, participants observed educational activities in nearby health facilities. This involved listening to general health talks and “tagging on” to patients throughout their visits—from the registration station, through consultation and treatment, to a final call at the exit table, where patients were interviewed about their understanding of instructions. At the exit table, advice given earlier to clients on what to do at home, which danger signs to watch for, and when to return for further care, were reinforced. Participants were also asked to critique one of many health education posters in the facilities.

Observations, experiences, and perspectives that focused particularly on missed opportunities for learning were shared when participants reconvened at the workshop site. After sharing experiences, the workshop participants concluded that communication with clients was alarmingly minimal in the facilities observed. Even when information was provided, participants felt the communication methods were poor.¹⁴

Health education posters examined during the exercise were found to be seriously inadequate in design, quality, language, in the way they were used, and in the usefulness of the information they were meant to convey. Reflecting on the way health workers often rushed to obtain posters when they are being distributed, participants concluded that posters were most useful only for wall decorations, since clinic walls looked bare without them.*

These observations led to a clear definition of the problem and served as the point of departure for discussion in the sessions that followed. Dissatisfied with what they had seen, participants were ready to share their experiences, perceptions and understandings, and to develop alternative approaches to patient education.

Since the aim of the workshop was to encourage the participants to reflect on aspects of communication and culture in developing their own approach to communicating with clients in health facilities, activities were designed in a way that required action by (and interaction among) the participants. From the outset, they were encouraged to keep in mind that discussion questions had no “right” answers, but were opportunities to reflect on their experience and to develop ideas and understandings.

CONCEPTS AND ISSUES IN PATIENT EDUCATION

In a series of sessions, participants were asked to consider issues and concepts that may influence health workers’ attitudes and approach to patient education, such as:

- a choice between doing *for* and *with* people (the issue of self-reliance);
- the question of “whose problem is it?” (considering ownership of problems and their solutions);
- cultural barriers created for health workers by their training;
- the usefulness of focusing on problems rather than wants or needs;
- the common practice of overloading patients with information;
- basic principles of adult learning; and
- the importance of reasoning with clients (rather than simply advising them).

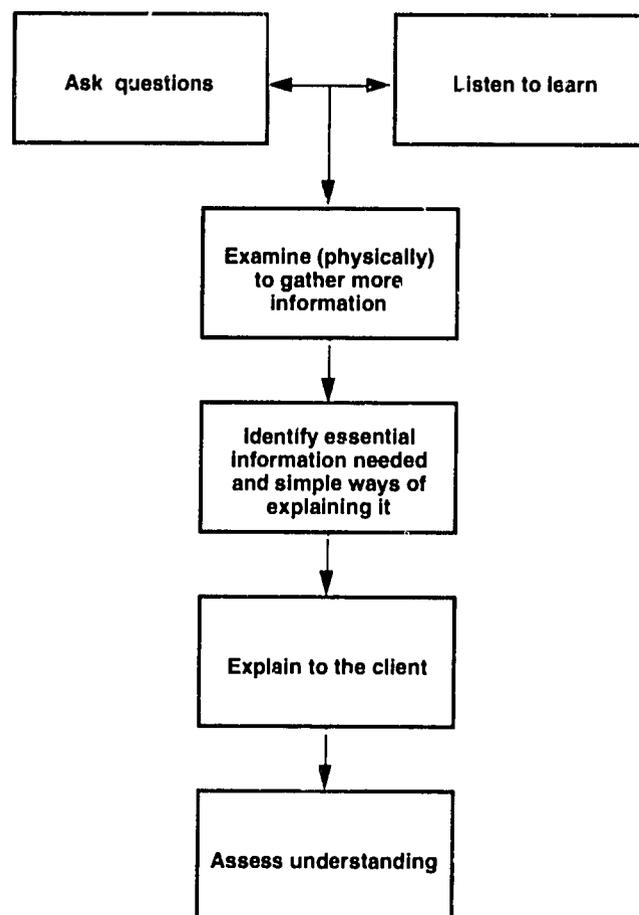
*Berney KT. (Consultant, Technical Support Division, International Health Program Office, Centers for Disease Control and Prevention [CDC]). Trip report (appendix B), April 1992.

Participants were encouraged to identify factors that create an environment conducive to communication and learning. For example:

- they were introduced to the use of “discussion starters” (evoking images of problems to begin a discussion);
- they evaluated words for appropriateness and simplicity;
- they explored the use of questions and practiced listening as tools for learning and understanding their clients’ beliefs, experiences and circumstances;
- they began the process of identifying appropriate information to share with clients, on the basis of that learning; and
- they discussed ways of assessing the client’s learning or understanding.

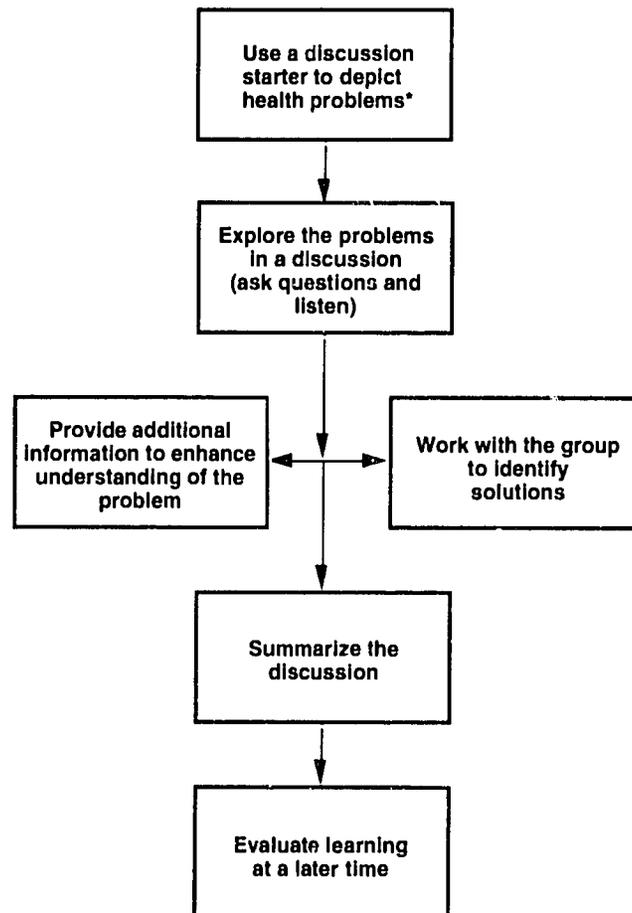
After considering these ideas and issues, participants accepted the challenge to design their own approach to communicating with individual clients in the health facility setting. They defined their goal for individual client education as *the client being able to manage patient care at home*. To encourage them to think about the steps required, small groups focused on specific medical problems, then identified the steps in providing both care and education. Role plays provided opportunities to try the process and make adjustments. **Figure 1** shows the steps the participants identified for communicating with individuals.

FIGURE 1: COMMUNICATING WITH INDIVIDUALS



While participants were comfortable in identifying steps with their clients on a one-to-one basis, they were less confident about designing steps to educate groups of clients in health facilities. Goals identified for group education included *creating an awareness of problems*, *promoting an understanding of their cause*, and *discussing solutions or methods of prevention*. **Figure 2** shows the steps identified by the participants for communicating with groups. Again, the group approach was tested through role play. While some participants led the discussion, others played the role of clients with a variety of perspectives and dispositions.

FIGURE 2: COMMUNICATING WITH GROUPS



* Participants began by identifying and creating discussion starters depicting health problems they frequently noted at facilities, with the intention of soliciting more problems (from the participants) at the end of each discussion.

Since assessment of these new approaches could only be made through practice, participants were asked to write plans for trying these approaches in health facilities. Participants were encouraged to keep a written record of effective questions and discussion starters, as well as problems experienced, and what they learned about beliefs and practices to use and share with colleagues. A follow-up meeting was scheduled to share experiences and learning.

RESULTING ACTIVITIES

During the following week, the participants reviewed learning activities they experienced in the workshop and prepared a facilitator's guide to use for training others. They made the guide specific to their situation and rewrote activities found to be problematic during their learning experience. They also worked on an aspect of the approach they found particularly difficult, choosing specific information about problems and determining the best way to share them. To tackle this difficulty, groups of participants worked to apply their communication approaches to specific health problems. They decided to begin keeping a written record of stimulating questions, effective discussion starters, and specific ways of explaining health information to groups and individuals.

As the work progressed, the participants realized they needed more information on local beliefs and the way people conceptualize specific problems, because most of their own current beliefs and knowledge were derived from their training. For example, when they attempted to create a discussion starter to present the problem of tuberculosis in a child to a group of mothers (who probably have not seen a child with tuberculosis), they were faced with several dilemmas. What could they present that would enable the mothers to recognize the problem of tuberculosis? How would mothers identify tuberculosis? How could tuberculosis be related to the importance of immunizations for their children? The gap in perceptions between clients and those of health workers gained increased significance. To bridge this gap, the participants recognized that clients and community elders are valuable resources for learning about local perceptions of illness and disease.

After two weeks of work, the participants indicated a sense of ownership of the approach they developed. They felt it offered a means of improving people's understanding of health, and therefore their practices. However, the participants realized that further development of this approach would require their continuing time and effort.

FEEDBACK

In response to follow-up questions about their practical experience, participants indicated their enthusiasm after trying this participatory approach in health facilities. Everyone who responded showed an interest in continuing to use the approach and in sharing it with their co-workers.

Participants reported that they were particularly impressed by the response of individual clients to their new approach. They shared their perceptions, including “[he] feels he is being treated specially. . .”; “[they] felt they were given attention. . .”; or “[they] felt free with me and asked questions that were bothering them. . .” All participants who responded believed their approach was effective. One participant said, “the new approach is quite rewarding since in the long run, the client is made to be self-reliant.” Another found the approach made the clients “. . . realize or identify a health problem as theirs, instead of the health worker's problem.”



Experiences with groups included enthusiastic participation by clients, both in discussing problems and in formulating solutions. Health workers in the facilities where participants practiced also expressed an interest in learning about this participatory approach. One participant reported responding to a request to share the concepts and ideas with health workers under his supervision.

The major drawback noted by the participants in the participatory approach to patient education was time; they found that dialogue takes more time than giving advice, particularly when working with individual clients. In a busy facility, this approach was definitely a problem.

DISCUSSION

The workshop and subsequent activities were a first step in helping a group of health workers learn to communicate more effectively with their clients. Participants gained a fresh perspective on how patient education should be conducted and on their roles as facilitators of learning. They realized the importance of interactive learning, recognizing that until they understand what their clients believe and perceive, they will have difficulty communicating health information effectively. They strengthened and improved the communication and decision making that are important for health workers in primary health care, and became more aware of their need to continue to learn—to become educated—throughout their working life.¹⁴

REMAINING CHALLENGES

FURTHER DEVELOPMENT

Challenges still remain if the participants are to further develop their approach and improve health communications. Perhaps the first of these challenges is to integrate the approach into the routine provision of care in health facilities. To that end, CEU and HEU staff at Plateau and Niger State have planned a workshop to facilitate a learning process (similar to the one they experienced) for facility-based health workers. Once the second group of participants design their own communication approach and use it on a daily basis, its usefulness may be better assessed.

As the initial group of participants found, the time required for this style of communication is potentially problematic. A realistic appraisal of the way time is used in the health facilities, together with observation and timing of client-health worker interactions, can help health workers understand how they actually spend their time, and should provide useful information that will help them solve the problem. Health workers will need to try their ideas, share what they learned, and work together to solve problems and improve their skills. Other problems requiring appraisal and solution will undoubtedly arise in the future.

Another challenge is to design a system for documenting and sharing among health workers learning related to relevant beliefs, practices, perceptions, and to ways health workers have successfully explained ideas. Sharing new learning minimizes “reinventing the wheel” and may motivate health workers to actively learn more. Publications are available on information related to beliefs and concepts in specific cultures. For example, an approach to explaining nutrition, based on local concepts in one part of Nigeria, is available and useful.¹⁵

TOUCH-POINTS

“Touch-points” are bits of information that help people build a bridge between their current experience and scientific information, such as interventions an individual or group might use for developing effective solutions to problems. For example, in exploring the problem of dehydration in small children, community leaders in another country* described the classical signs of dehydration but were primarily concerned about the sunken fontanelle. A discussion of the importance of water in life, and what happens when water is absent, helped them to see the connection between the loss of water they had observed in diarrhea and vomiting and sunken fontanelle. This allowed them to conclude that giving fluids was imperative to maintaining hydration. Subsequent experience with rehydration led to the realization that when fluids were given, the fontanelle did not sink. “Touch-points” allow people in traditional cultures to make sense of medical information and use it to fashion effective solutions. Health workers can learn from and teach each other about such information.

SORTING INFORMATION

It is important that health workers possess basic, accurate, up-to-date information on health problems to enable them to identify “touch-points,” and to distinguish other appropriate bits of information to share in discussions. The Nigerian participants identified a need to sort through their knowledge and to identify information that would enable groups and individuals to understand the “why”; in other words, the reasons behind problems and potential solutions. Although they realized that people need accurate, basic information relating to their problems, they felt unsure of their own ability to provide it. They also discovered how easy it was to revert to telling people what to do about problems, rather than sharing information that would help clients identify their own solutions.

COMMUNITY APPLICATIONS

It should be stressed that the activities discussed so far have focused on health facility settings, where individual education usually relates to treatment and care of the sick, and group discussions focus on common problems and their solutions. Yet, many of the health problems seen in facilities are most effectively prevented by working with communities. Examples of diseases requiring community effort are schistosomiasis,^{16,17} diarrhea, and measles. Other diseases, such as tuberculosis, onchocerciasis, and neonatal tetanus can be

*Christian Health Association of Liberia (CHAL).

prevented or controlled by individual action, but are more effectively addressed through community-wide efforts. In addition, Liberian leaders informally observed that when new ideas and information were widespread in the community, people were more likely to try them.* The widespread effects of health actions taken by communities are described by Arole¹⁸ and others.

In addition, people often consult with each other, rather than with a trained health worker, about health matters. Most health problems are first dealt with by families, traditional practitioners, and other community members.¹⁹ The results of a study in Nigeria, for example, showed that elders (43.1%), friends (14.9%), and relatives (3.4%) were the main sources of information for persons wishing to treat themselves. Direct and indirect information provided by health workers was relatively small.²⁰ The great majority of people will not adopt a new behavior until they perceive it as an accepted norm.¹⁸ These findings highlight the need for health personnel to work with their communities, encouraging identification of health problems and sharing information that will both aid in the formulation and implementation of effective solutions and promote the appropriate use of health facilities.

Building on their cumulative experience with an interactive, participatory communication approach in their facilities, health workers can design and test an approach to community education they feel confident and comfortable using and sharing with others. Given the uniqueness of individual health workers and the communities they serve, it is important to develop approaches that foster participation and creativity rather than to rely on standardized styles and methods. This is particularly true in light of the difficulties experienced in many countries when government-based primary health care programs have attempted to replicate and expand successful small-scale projects.¹³

EVALUATION TECHNIQUES

Finally, the participants will need support in learning how to identify indicators for monitoring their progress and to devise simple, participatory techniques for qualitative and quantitative evaluation.¹¹ These will help them answer the question, "How will we know we have succeeded?" Being able to evaluate their own efforts, for their own benefit, is important. Standard methods of evaluation are a means of determining success or effectiveness of projects, primarily for the benefit of staff and donors. However, these are usually administered by outsiders. The primary purpose of evaluation in this participatory approach is to enable health workers to learn whether their approach and the solutions they identified and implemented are effective. Subsequently, their knowledge of evaluation techniques will be valuable in helping communities learn ways to evaluate the effectiveness of actions they take to solve health problems.²¹

*Christian Health Association of Liberia (CHAL).

CONCLUSION

A promising start has been made toward developing a new approach to patient education by CEU trainers and health educators who participated in the learning activities described in this paper. Building on concepts and principles of community participation and communication, they designed a new approach to working with clients in health facilities and identified additional information they must learn if they are to communicate effectively. After trying this participatory approach in health facilities, the health workers were enthusiastic about their experiences and expressed determination to continue using the approach and learning from their efforts. With support, they will be able to expand its use by sharing it with colleagues, to address problems created by the time required to work in this way, to strengthen their understanding of client perspectives and beliefs, and to develop appropriate evaluation techniques. Experience and understanding gained through facility-based efforts will form a basis for the development of a participatory approach to health education in communities.

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