Module 3c:

How do we change attitudes and behavior? And – why doesn't the patient do what I tell him?

Attitude and Behavior Change in theory and practice

By Ane Haaland, with Mwanamvua Boga

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Background for trainer

Understanding how people change can make a big difference to how efficiently you work with patients and colleagues, and this knowledge can save you many frustrations. If you advise a patient to change behavior, and he/she decides not to follow your advice, a natural (automatic, emotional) reaction is to get angry and/or disappointed. The natural initial reaction is to blame the patient for not appreciating (or taking action on) the advice – ***when you know that the advice for a different behavior is "for his/her own best".***

The alternative is to practice emotional competence: You recognize your own irritation (and the irritation of the patient?), think, take a step back, and start asking questions: What are the reason(s) the patient prefers to keep his old behavior? When you learn more about ***why*** the patient responds like he does, you can choose another reaction – based on respect and understanding.

The fact is – people give each other suggestions for how to change very often, and only very little of this advice ever results in change of behavior.

There are always good reasons (from the other person's perspective) for why people "don't do as you say" – and in this module you should guide participants through the steps to discover how and why people change, and why they don't. The key here is to start with participants' own behavior change, and analyze this, to make them realize that they "fit" into the Attitude and Behavior Change Model (and theory) themselves. To be able to do this well, you should read this background and the examples, and try out the method on yourself and on some colleagues before using it in the training session. Reflecting on the outcome of this activity is a good start on developing your own awareness of how this model functions, and on why it is important and necessary to step back from your own automatic reactions (e.g. to judge a patient as stupid or ungrateful when not following your advice to change – which is a very common reaction). An important skill to practice is to step back – showing respect for the patient's right to decide if and when to change behavior

The Attitude and Behavior Change Model we use has 5 stages: Awareness, Interest, Trial, Evaluation and Adoption/Rejection. It is ***The Diffusion of Innovations-model*** by E. Rogers, and it shows how an individual changes behavior. There are several other theoretical models you can choose to learn from, or to expand your knowledge. Common to the models is that change happens in stages, and is influenced by other people, media, and/or events. Rogers' model is chosen for this course because it

is easy to understand, and it functions well to explain the kinds of changes providers are often challenged to deal with. There are several articles on how the model functions, on the net.

Essentially, the model functions like this – using "Alex stops smoking" as an example:
Alex is a worker in his late 40s, living with his family in a simple flat, on the outskirts of a town. He has been smoking since he was in his teens.
The first two stages in a behavior change – **Awareness** and **Interest** – are "Cognitive stages". This means they are driven by *rational thought*: Alex is aware that smoking is bad for him – there is a lot of info showing the bad effects of smoking, and it says on the cigarette pack "smoking kills". Alex is ***aware (1),*** he KNOWS smoking is very bad for him, but this does not make him stop. He likes his cigarettes. All the messages are "for others", he convinces himself that nothing bad can happen to him.
The last year, however, he has noticed that his cough is getting worse, and it comes more often, especially in the cold season. He has noticed that he is short of breath more often than before and has to rest more often when he walks to his workplace. He knows this is because of his smoking and is *thinking* it would be good if he could stop. It would also save him some money. He develops an ***interest (2) to stop,*** cognitively.

Then, something bad happens, and we enter the next three stages of the behavior change model:
Alex's good friend Ed, also a heavy smoker since many years, becomes ill with lung cancer. Alex is spending much time by his friend's side for several months, until Ed dies a painful death. Ed tells Alex he wished he had stopped smoking long ago.
This is called "***an emotional event***", where the potential consequences of a behavior feel relevant and personal to the one having the behavior. Often, *strong emotions* and strong reactions are involved. Alex lost his friend. The hard facts have sunk in, and it has become a reality that it could also happen to Alex. He feels vulnerable (*probably without quite recognizing this feeling or identifying it as vulnerability)* and fearful of his own health. Could he also die of cancer, like Ed?

The next three stages are the affective, or the emotional. Stages: Alex decides to stop smoking, and on the day of Ed's funeral, he smokes his last cigarette: This corresponds to "***Trial" (3)*** in the behavior change model. Alex ***Tries*** a new behavior.
(He could also have been influenced to stop by a person he respects, admires and/or identifies with, or by someone close, in his family. One of these influences – people you respect, or an emotional event, is usually the main "trigger" of trying a new behavior.)

The next stage – ***"Evaluation" (4)*** - is the stage where Alex checks out how his new behavior works for him in his life. He still wants to smoke, but – the pain of losing Ed is still there, and his decision is strong. He wants to live, and knows he needs to take care of his family. He continues not to smoke for a few weeks, and starts experiencing that he has more breath, he can walk to work without feeling exhausted. His wife is relieved, and also comments that they now have more money for food. His friend tells him that it is very pleasant that he does not smell so much of smoke anymore, and that he looks better. Alex listens, feels, thinks – this is all part of the evaluation period. He notices positive effects on his health, and he gets positive feedback on his new behavior from people around him – people he respects and/or are close to, like his wife and his friend. This motivates him to keep his new behavior, although he still misses his cigarettes.

After some months of resisting a number of temptations, he decided to ***Adopt (5)*** the new behavior of not smoking. At least for now… (*NOTE: Stopping to smoke is difficult, many smokers go through the starting and stopping process several times before they finally stop*. *Each time, they pass through the same stages in the behavior change model. These people would* ***Reject (5)*** *the new behavior at stage 5 (instead of adopting it). They would go back to the cognitive stages (1 and 2), where they know smoking is bad for them, but they still decide to keep the behavior).*

The decision to adopt the new behavior is also influenced by people he respects and/or are close to.

This concludes the 5 stages of behavior change.

Cognitive stages – 1 and 2: The first two stages are called the ***Cognitive*** ones, which means they are about how we *think* about the behavior. These two stages are easily influenced by media, books, people (anybody) – we are not very critical when assessing new ideas in these stages. A person is often thinking about changing for months and years before actually **doing** something about it (which is go to ***trial*** stage, see below).

Affective or emotional stages – 3, 4 and 5: The next set of stages – from Trial through Evaluation to Adoption (or Rejection), are called the ***Affective stages***, or the ***emotional stages***. Here, emotions are involved in and are influencing the decision-making: First, some kind of emotional event is often happening to make the person decide that NOW, I will start implementing the change I have been thinking about for so long (*trial*). Someone close to him/her, of someone he/she respects or admires and/or can identify with, is often involved to influence this vital decision (e.g. a family member, or a close friend). Then, he/she progresses to the *evaluation stage*: If the person feels that he is better off with the new behavior, and is getting feedback and comments from friends and family that he/she looks better, or smells better, or … - then there are higher chances he might stay with the decision to use the new behavior: the behavior is *adopted*.

Change takes time: It is common for a behavior change to take several years, from the person starts thinking about it as relevant to her (awareness stage), to developing an interest in changing (interest stage), to actually deciding to change (trial stage), evaluating the new behavior (evaluation stage), and finally deciding to adopt or reject it (adoption/rejection).

How can providers use this model?

Understanding and discussing the implications of this model is crucial for the providers: The trainer's task is to help participants see how change happens in their own life, and then reflect on what it means for their work with patients (and colleagues). The trainer should facilitate a discussion that results in insights and conclusions of the following kind:

- Providers are most likely able to influence the patient to ***be aware of and interested in*** the new behavior (i.e. stages 1 and 2) – unless it is a behavior (change) the patient has been thinking of him/herself already;
- If the provider can be a person the patient can respect and trust, the patient is more likely to use the advice to change behavior;
- Knowing how long time behavior change usually takes, the provider should be patient, and not expect instant changes.

When the provider understands this model, she/he is "armed" with a good reason to practice emotional competence and critical thinking around attitude and behavior change: The provider needs to become aware and learn to recognize her own emotional reactions when a patient is rejecting a suggested behavior change or showing lack of willingness to change. She needs to step back from her own automatic reactions, and to start asking open questions to understand the patient's reasons for his actions. The provider can then take action based on respect for and understanding of the patient's reasons, and by using emotional competence in this situation – she will be practicing patient centered care.

An example of a health provider changing

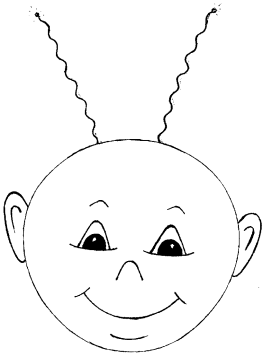
A provider in her mid-30s, Prudence, believes she is a good professional, even though she knows patients are often afraid of her. When observing and reflecting on her listening patterns, she gets some surprises.

Awareness: Prudence is observing how she listens today: She was taking history from a client and listened to her complaints. The patient was not saying much, and Prudence asked her to continue giving information, and then asked some direct questions. Prudence suddenly noticed the impatience in her voice, and that she was critical of the patient's reluctance to give open information. She saw the patient looked almost afraid.

The same happened with several other patients: Prudence always thought she was listening well but when she really paid attention, she noticed that she often did not get much information from the patient, and therefore sometimes had to make guesses about the treatment. She continued to observe her listening throughout the week, and saw that in the morning, when she was fresh, she often listened better and asked questions that invited the patients to open up. The patients then seemed to trust her and be more open, and it was easier to practice empathy and build a relationship with the patient when she listened well.
Interest: Prudence reflected on her observations and started to think she needed to do something: She was maybe not as good a listener as she thought. She started to question if her listening – or rather lack of patient listening – could influence her giving quality care to her patients. But, she thought – wouldn't it take too long time if she listened more? She was definitely interested to do a good job, she always was, and took pride in being a good professional.

Trial: She decided to watch how one of her experienced communication skills trainers (Gladys) listened to patients. Prudence respected her senior colleague very much and asked Gladys for permission to observe her. She saw how Gladys was very attentive to the patient, and listened with "big, open ears", as Prudence liked to describe it. She was empathetic with the patient. The patient gave information very freely, the dialogue between them flowed easily, and they quickly came to the points. It did not seem to take a long time.

Prudence talked with Gladys afterwards, and asked her how she managed to listen so well. Gladys explained she had also struggled in the beginning, but that when she greeted the patient warmly, and introduced herself in a friendly way, the patient seemed to relax. This helped her focus on the patient and stay present with her. Gladys said she had also started to become aware when her voice changed, and she became critical – and then stopped herself, stepped back, smiled, and got back on track. She said she learnt gradually, over time, and the good responses from the patients motivated her to continue learning and to practice good listening skills. Gladys felt this enabled her to give better professional and patient centered care. She also felt better about her job



Prudence decided to try out "listening more patiently, and be present", as she called it to herself.

Evaluation: Prudence started to listen, with more awareness. She greeted the patient and introduced herself in a friendly manner and found that this prepared her better for patient listening. The patients seemed to develop trust in her, and they could develop a relationship. She experienced patients being more open with her, and that she could also recognize when her impatience sneaked in sometimes, and step back in time. Sometimes, the dialogue took longer time, but sometimes, she used less time than she used to before she tried to listen with more patience. She also felt less irritated than she used to, and felt she was giving more patient centered care. One of her colleagues commented that she seemed to be in a better mood, so what had happened? Prudence told her

about listening with patience, and the effect she had observed on herself and on the patient, and the colleague was very interested. The colleague commented that Prudence seemed to listen well to her as well, and that this made her feel good, and motivated.
She decided to observe Prudence during her interaction with patients, if the opportunity arose.
Adoption: Prudence reflected on the effects of listening with more patience – both on the patients, and on herself, and liked the results. She decided to continue using this skill, and also to learn more: She would discuss with Gladys and ask her if she could come and observe how she worked, and then give her feedback. Prudence knows that slipping back to "the old way" of being impatient is very common and wants to prevent this.

The provider's (automatic) emotional reaction: A psychological perspective

Providers often give advice to patients about what they should do, and how they should change behavior. The advice about a new behavior is often well founded, from a medical perspective – but it may not be feasible, or understandable, or preferable for the patient to adapt this new behavior for the time being. The patient's reasons may be not clear or not acceptable to the provider.

An example: A mother is in the ward with her three year old son, who is being investigated for meningitis. The child was in critical condition when he came in but is now stable. The providers who have been dealing with the mother, have found it difficult to talk with her. Now, a provider is asking her consent to take a lumbar puncture from the child, but the mother refuses.

It is common for a provider to take the patient's (or parent's) refusal personally, and react by "punishing" the patient, verbally or non-verbally (and categorizing him/her as "difficult"). Emotionally, the provider feels "rejected" *(or not appreciated*), by his/her (good) advice for a necessary medical procedure being rejected, and this can result in a strong emotional reaction: Being rejected is a very bad feeling. Providers may ***not know*** this is going on, as the reactions are all subconscious: All they know is – they are feeling bad, and they are "taking it out" on the patient.
The alternative is to use emotional competence – recognizing her own emotions, think, taking a step back and put the emotions aside (i.e. taking it professionally, not personally), and then ask questions to find out the reasons for the patient's emotions, and why she does not want to follow the advice.

NOTE: This is the behavior which is likely to be used when providers understand the Attitude and Behavior Change (ABC) Model: They start to question their old behavior and learn to use emotional competence in combination with understanding the ABC model.

Bad habits common in hierarchies: Kicking downwards: Another common way of "punishing the patient" is to transfer anger (i.e. feeling hurt), to the patient: A provider (Caro) has been badly criticized and put down by her supervisor (Baya), in front of her other colleagues, for not managing to get consent from a mother to take a blood sample from her child. Caro listens to Baya, and says nothing – because she fears the supervisor, and does not have the skills or confidence to speak up against him. She feels hurt and really bad and covers it up by being angry. The next patient who refuses to give blood, gets the full blast: "*You just don't know what is good for your child! You are being difficult and ignorant! How do you expect us to treat your child if you don't cooperate! You think we are magicians who can just know what is wrong with your child by looking at him?"*

The balance is restored. Caro let out her "steam": "I fixed that patient well!" she might say, being proud on the surface. ***But underneath, she knows this is not right.***
And the problem remains: Abusive supervisors will continue to frighten the providers, who will swallow the criticism, and take it out on the next (un)suitable patient. The quality of care suffers: There is no empathy, and no patient centered care. The providers also suffer: The danger of medical mistakes, conflict and burnout increase.

Let us say the provider, Caro, has learnt emotional competence. When being confronted and criticized by supervisor Baya, in front of her colleagues, she calmly puts up a hand and says "Excuse me, Mr Baya, can we talk about this in your office?" She recognizes her own fear, but is able to think, take a step back and ask respectfully to talk about the situation in his office. Most likely, when approached respectfully, he will agree, and they can talk in peace and quiet, and understand and come to an agreement about the situation. (*We can also note that – with emotional competence, Caro would most likely have handled the mother in such a way that she would have agreed to give the blood sample, so the problem may not have occurred at all*.)

Understanding the attitude and behavior change model, and the emotions caused in this encounter, can help show providers how to break this vicious cycle of automatic emotional reactions to fear. Learning emotional competence is vital to be able for providers to recognize their own as well as the patients' (and supervisors') emotions, and to take a step back to question and understand them – before taking action on the issue. With emotional competence and the ABC model, the provider is well "armed" to guide patients and their behavior change in a more professional and effective way. They will also be better equipped to handle supervisors who are acting automatically.

There are six sections in this module. An overview:

1. **Introduce the topic and establish relevance:** raise the question about how people change, and link it to their experiences with patients (slides 1-4)
2. **Using participants' examples to explain the Attitude and Behavior Change Model:** These examples and the analysis of them, and then linking each to the ABC model, will provide a reference point for participants to remember how the ABC model works. The section also focuses on who they are influenced by, to change (slides 5-8);
3. **Applying the Attitude and Behavior Change Model to understanding their own role:** Using the model in practice will deepen the understanding of how it works, and how they can apply the principles learnt to their own relationship with and strategies for working effectively with patients (slides 9-15)
4. **Challenging old beliefs with ABC facts:** The "True, or False?" exercise will enable them to debate old perceptions of how people change, with new insights from the ABC theory (slides 16-20)
5. **Applying ABC to their own practice:** Role-play (slide 21)
6. **Summing up learning, linking to their own need to change practice:** Creating awareness, trying new practice and keeping it – these stages are influenced from different players. Conclusion of module is – the providers are the ones who need to change (slide 22-23)

Further background about purpose and contents of the sections

1. Introduce the topic and establish relevance

The purpose of this first section is to introduce the participants to the idea that behavior change needs to be understood by reflecting on how they themselves have changed behavior, and then linking these experiences to theory. Many will realize that they have tried to make people change and have been frustrated at their lack of success. AND – that they have blamed the other(s) for their lack of willingness to follow good advice. By understanding their own slow process of change, they get useful perspectives on the unrealistic expectations they have placed on others.
It is these experiences and perceptions we will discuss and reflect on in this module. We will aim for the insight that – we cannot make others change, we can only change ourselves.

2. Using participants' examples to explain the ABC Model

The ABC model is relatively easy to understand when linked to real examples of how participants change, and it is this link which makes participants remember the main points of the model – and be able to use it in their work. It is important that the trainer learns how to do this – by e.g. practicing on other trainers before running this module. The examples will provide a reference point for discussing the model further and see how they fit into the theoretical model.
Understanding who can influence them to change, and why this is so, is another important learning in this section: the points on the slide can be related back to their examples, to further link the theory to the reality. Respect is a key element here.
NB – explaining the model without linking it to their own examples, will likely result in them not learning it, and not being able to apply the knowledge to their practice.

3. Applying the ABC Model to understanding their own role

The deeper understanding of this model will lead to an ability to apply it to their own practice: Firstly, they use the question of the patient coughing, to identify to whom he would listen, for advice. This will enable them to question their own role, and to see the problem from the point of view of the patient: He would only listen to someone he trusts.

The exercise tempts participants to (automatically) judge the mother for her actions to seek traditional care, and then to question their own reaction. This (emotional) reaction often also delays the provider from focusing on the need to treat the child first. Participants are encouraged to reflect on the mother's intention or motive – which is to help her child, and to conclude that the provider and the mother have **the same goal**: Focusing on this will open the possibility for a respectful dialogue that can lead to adherence to treatment, and – possibly – to a behavior change in the future. Through this discussion, they also realize that blaming the mother defeats the purpose – both of (possibly) helping the child, and of influencing her to change behavior in the future. The provider who blames the mother is shortsighted: She does not understand how people change behavior – and how she as a health professional can best help to facilitate this process.

These insights are further deepened by linking them to the stages of crisis, where participants reflect on patients' abilities to receive and act on information in the different stages. By again looking at situations in their own practice, and reflect on crisis with patients they have known, they can apply these insights and question the wisdom of their "old" practice. Encourage such discussions!

4. Challenging old beliefs with ABC facts

The cartoon portrays a situation many providers recognize: Blaming the patients. The "True, or False?" exercise is designed to make participants take a hard look at their own perceptions of how people change (*which are often not conscious – as many people do not really think about this, and do not know the theory*), and look at them in the light of new knowledge from the ABC theory. Bringing up some of the points for debate will make the learning go deeper. By asking them to pick out the points that are unclear, or that they don't agree with, you can clarify to them what the theory says about these topics.

5. Applying ABC to their own practice

The role-play is designed to enable them to use their communication skills to apply the ABC knowledge to a practical situation in their work. Using the analogy from the model: The points above (slides 1-20) address the cognitive stages (***awareness and interest***), while the role-play addresses the ***trial*** stage (of practicing the new skills).

6. Summing up learning, linking to their own need to change practice

The last slide sums up the main ways to use this model, to facilitate change of practice – with awareness and knowledge of how change usually happens in individual people.

Trainer's story of change: Like a lizard

Indeed the communication or the health workers communication training is such a powerful tool and when I think in my mind, I liken the transformation that takes place when you undergo this training like what happens to a lizard when a lizard grows old. It grows some scale okay, but then when it feels that it is time to change it has to make a decision, and this decision involves scrapping off that old scale and it takes off that scale and it becomes a new and it feels young again and it begins a new life okay. And that is the kind of transformation that the communication skills training brings in someone. You feel you need to change, you make that decision and you put yourself in that process and eventually you feel you are newer again. That's what I can say.

Francis Kombe, senior trainer

A special note by Robert Chambers: The Importance of attitudes

Robert Chambers developed the participatory research methods with community members and colleagues in India in the 1980s. During the next 30 years, he has continued his work to question authorities' and professionals' use (and abuse) of power over the people they are supposed to assist. He concludes that it is US, the people in power, who need to change. One of his quotes:

*"Personal behaviour and attitudes are fundamental for true participation. It is **our** attitudes - the professionals - which have to change.*

This critical finding, and its implications, are still only recognised, let alone acted on, by a minority of development professionals. Most donor agencies, Governments, universities, training institutes, and NGOs continue to promote and practice business-as-usual with top-down blueprints, packages, targets and teaching. Only the language has changed.
Many adopt the new rhetoric of participation; few change what they do.

At the same time, on a vast and increasing scale, donors and Governments demand and require participation and that PRA be used, more and more universities and training institutes seek to teach PRA in the classroom; many NGOs assume that NGO status alone enables them to be good PRA practitioners; and consultants coopt the label without the substance or the spirit.

The result is abuse and malpractice on a massive scale."

Time needed: 2 ½ hours

Preparation (important!): The day before the presentation, ask participants to think about their own change process, as a preparation for understanding the theory and understanding how other people change. Ask them to think about the following questions:

- Identify a behavior which you have changed during the last 5 years
- What, or who inspired you to change?
- How long time did it take?

Emphasize: Attitude and behavior change is a very personal issue. You will be invited to share your reflections, on a voluntary basis. The most important is however, that you think through for yourself what has happened with you, and why: This will make it easier to understand the theory and to be able to use it in your work.

NOTE: The trainers should prepare for this by doing the exercise themselves, and by analyzing it with each other. See an example of how a trainer changed behavior, at the end of the module.

Materials needed: Flipchart, marker pens different colors (including red)

Facilitator/assistant facilitator roles: The assistant should be prepared to volunteer his/her own example of change, if participants are reluctant to come out with their own examples initially. Furthermore, the assistant should write on the flipchart, and sit in on some of the group discussion (without participating – the assistant should just be listening).

Presentation slides: Comments, questions, main points to bring out

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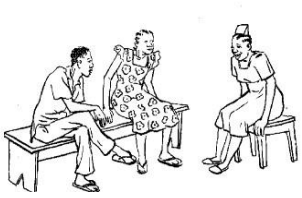
How do we change attitudes and behavior?



And – why doesn't the patient do what I tell him?

Ane Haaland and Ayub Mpoya Mwanamvua Boga

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Introduce the topic in your own way – e.g. -
Ask: How do people change? What are your experiences?
Have you ever been in a situation where you have asked yourself that question – why do they (not) change, when I ask them to?
What do you think could be the reason(s)?

(*I usually ask in a humorous and personal way – "has anyone here tried to make someone else change, and failed?" And I put up my own hand… and usually – everybody puts up their hand… This brings a lot of laughter, and is a good starter.)*

Main Points:
If patients are not respected, they will not change (ADD….)
Conclude: We will look at how and why people change, and why they don't, and how you as providers can work more effectively – when you know this model and how it works.

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Referencing and acknowledging the iCARE-Haaland model

- *Please feel free to use and adapt the material in this presentation, and the model it is built on, by referring to the model, and the authors:*
- This presentation is adapted from ***«How do we change attitudes and behavior?»,*** which is part of the learning materials in the iCARE-Haaland model.
- **To reference this content please use the following**: Haaland A, with Boga M, 2020. Communicating with awareness and emotional competence: introducing the iCARE-Haaland model for health professionals across cultures. With contributions from training teams, Vicki Marsh and Sassy Molyneux. https://connect.tghn.org/training/icare-haaland-model/
- The authors' names should remain on the presentation, with a by line recognizing the person who (has adapted and) is presenting the presentation

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Please reference the materials you use from this module and the presentation in the way specified on the slide.

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Objectives

Understand:
- How attitudes and behavior change
- The role of emotions in ABC
- Your own role in influencing ABC

Practice:
- Using your understanding to deal with a patient appropriately

Reflect on
- Implications of your understanding, on your work

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Read out the objectives

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What makes people change? 	**Purpose:** Make them question the "Transmission of information"-model (Module 2c) **Ask:** What is happening here? **Main points:** The "Educator" is giving info forcefully The woman has not asked for it. Not needing it? She is not pleased. The educator is not aware of this. Focus: on self No emotional competence. **Ask:** Do we know people who believe in this way of giving info? Have you ever tried this? Why does this method not work? ➔ Educator believes he has all answers
Examples from participants • *"The knowledge has helped me to appreciate patients and value their beliefs. Personally i used to feel bad when children wear charms around their waist, hands and wrist (NOTE: from traditional healer) but nowadays I value them because I understand people are doing whatever they are doing to ensure their relative/children recover. Before the learning I used to tell them to remove the charms but nowadays I leave them."* • *"A habit/attitude is built for a long time so it can't go or stop in one day. It requires one's strong desire/interest and determination to change."*	**Read** out the examples
The task:* How did YOU change?** ***Yesterday we asked: • Think about a behavior which has changed over the last 5 years • Who, or what, influenced you to change? • How long time did it take? • ***What are your examples?*** 	**Exercise 1** **Remind** them of the task you asked them to do yesterday: *We wanted you to think about what has changed in your life over the last few years. We hope you have had time to think?* **Ask** for examples/people who will contribute. Have a backup prepared: One of the trainers can give his/her example, to get started. **Procedure: (See at end of module)**
Stages of behavior change (1) • Awareness • Interest *Cognitive* • Trial • Evaluation *Emotional* • Adoption/Rejection 	**Get the stories first.** **Then - draw** this model on the flipchart, piece by piece. See procedure for how to discuss

Influence on behavior change?

Stages

- Awareness
- Interest *Cognitive*
- Trial
- *Emotional*
- Evaluation
- Adoption/Rejection

Who/what influences?

- Media, books, people: Anybody, anything
- Emotional event; People you respect

Ask: What and who can influence you in the different stages of change?
Main points:
In the cognitive stages, you can be influenced by anybody, or anything: We are bombarded with several hundred new ideas every day – but we take action to change behavior on very few of them

In the emotional stages, we are influenced mainly by people we respect, admire and/or can identify with, OR by an emotional event.

Whom do you listen to and respect?

Who can influence you? Someone -

- With authority and experience
- You respect
- You can identify with
- Who follows same rules and norms

Barriers:

- Age, gender, profession, nationality, ethnicity

Ask them to talk at the table to identify people close to them, whom they think could influence them to change – and be their role models.
Main points:
These people will often be a family member: grandparents, a wise uncle/aunt, a family friend; or someone from work: a supervisor, a trusted colleague, or a teacher.
Relate comments to their examples of ABC
Ask – what makes them respect and admire those people (pick an example), to strengthen awareness about who our role models are, and what makes these people be good role models.

Changing cough behavior

Discuss:

- **How will you get him to cover his mouth when coughing**
- **Whom will he listen to?**
- **Why?**
- **How should you behave to make him want to follow your advice?**

✓ ***Show how you would do it***

Exercise no. 2
Purpose: Apply the ABC model to a work task.
Procedure: Ask them to discuss in groups how they would influence this patient to cover his mouth when coughing, plus other questions on slide.
Ask volunteers to act out the solution in front of the group.

Main points to bring out (see at end of module):
*Recognize emotions – be present
*Being a provider he can trust,+ communicate with
*Respectful advice
*Explain why he should follow advice
*Remember behavior change takes time
*Give positive reinforcing feedback

Behavior change: Key factors 1

- ***Being aware*** of a problem does not make people change
- ***Having knowledge*** about a problem does not make people change
- People must **WANT** to change
- Must ***be influenced by***
  - someone they respect and trust, and/or
  - by ***emotional event***

Summarize the points made so far.
Bring in points on emotional competence, if appropriate.
Ask for comments and questions

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Examples

- *"I realized that it's necessary to give people time to change after talking to them because change is not instant"*
- *"Nobody likes that somebody points out one's faults, hints one's bad habits or condemns one's lifestyle. We can't change someone's behavior only with words, sooner we can make him angry and have bad cooperation".*

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Read out the examples (or get someone to read)
Ask – can you recognize this? Is this true for you as well?
Invite experiences with trying to get someone to change behavior. For each example, get participants to analyze why it worked/did not work for the other person to change.
Bring in the emotional aspects, where relevant.

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Introduce this in your own way, e.g. by asking if this is a situation they can recognize/if they have had patients like this. (Read the mother's words).

Ask: What do you think about the mother's behavior? Is she rational?
There will probably be many opinions – flip to next slide and let them discuss the questions.

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Will she follow your advice?

Discuss in groups: *Looking at the mother – and what she has done for her child:*

- What should you **focus** on first? Why?
- How do you need to **behave** for her to
  - *follow your advice, and*
  - *change her behavior?*
- How long time do you think it will take for her to change?

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Exercise no. 3
Ask them to discuss the questions in groups.
Main points for discussion (see below):
*The mother handled rationally, from her own perspective and understanding: Her interest is to do the best for her child.
*HP must recognize and acknowledge this before giving other advice. He must recognize her fear, and meet this with understanding and empathy.
*The focus should be to diagnose + find treatment for the child first, thereby taking care of her fear
*HP must act respectfully, invite trust, and develop a professional relationship
*If she trusts him, they can discuss behavior – after having diagnosed and treated the child
*It may take weeks and months for her to change. Change must be her own decision.
*If the HP judges the mother for being irrational and wrong, he will have lost the opportunity to help her and influence her to change. HP must recognize his own emotions, and step back from them – to help the mother and child.

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Stages of crisis • **Shock** – fear, pain, bodily reaction, intellectual • *Take in information/advice?* • **Reaction** – strong, turbulence, confusion • *Take in information/advice?* • **Processing** – dealing with the crisis, coming to terms, emotional • *Take in information/advice?* • **New orientation** – life goes on • *Take in information/advice?*	**Relate** the example above, to these stages of crisis. **Ask** for each point – do they believe the parent will take in information or advice? **Main points:** *When patients feel they are in crisis, they do not take in (detailed) information (give example). *They need to be calm, and feel the crisis is dealt with, before they can relate to cognitive information. *This means – the last two stages.* *The crisis can be one over shorter time (like an acutely sick child, who becomes stable after a few hours), or longer time (e.g. a death).
Implications for your work ***Buzz in pairs:*** • Are there situations where patients perceive they are in crisis, and you as HP do not see it as a crisis, but as a «normal» medical situation that can be dealt with? Share experiences about this, and about how you handle it. **Points to reflect on:** • How do you recognize that a patient feels she is in crisis? • Is there a difference between «rejecting their crisis»/telling them they are wrong, and settling them/allaying their fears? What is the difference? • Where is the HP focus when rejecting the mother's emotions, and when allaying fear? • What is the effect on the patient? • How do you communicate in such situations? Do you give a lot of info when patients feel they are in crisis? What is the effect?	**Exercise no. 4** **Ask** participants to discuss these points in groups. **Main points for discussion:** *Perception of "crisis" is personal: a mother with a sick child experiences a crisis, and is scared: she will act, based on her emotions. *HP might not see it as a crisis (she has seen many children in this situation and knows they usually pull through), and therefore not acknowledge and accept mother's emotions. She may reject the emotions. *HP needs to respect the mother's emotions, and allay her fears *(rather than act automatically – based on her medical knowledge*) *Giving her much information when she is scared, is a waste of time: Mother's focus is on her fear *Expecting her to act on such information given, shows HP has not understood how patients learn (and when they don't learn) when stressed, or in shock. *The mother may lose out on important information she needs to care for her child. *She may not be empowered to act well for her child
Will they change?  	**Ask** a trainer to read out the text – using the voice of a HP not respecting her patients. **Ask**: Will these patients change? Why/why not? Brief discussion – as an entry to the next exercise.
True, or false? 1. You have to see something as a problem yourself before you can consider change. 2. You can only change yourself. 3. Changing behavior can be a quick process. 4. We often judge people as being stubborn or ignorant when they don't want to change.	**Exercise no. 5** **Give out** the handout, let them discuss After 5+ minutes, discuss the points in plenary, and agree on ***True or False*** on at least the first 7 points, and the last 3 **Have** a co-facilitator write T or F after each point, on the slide (on the computer)

5. If you tell people to change behavior, they will be happy to oblige you. 6. If someone refuses to change, you can push them to change their behavior if you know it is harmful to their health. 7. To change, you require time and energy to think and reflect.	**See procedure, at the end of the module** The points are shown at the end of this module, with the correct answers.
True, or false? 8. People we trust and respect can influence us to change. 9. If someone else gives you a reason to change - a reason which is good from THEIR perspective - you will change 10. Even if you don't see the behavior as a problem, you can change it, if someone else says you should. 11. You need to be ready to let go of an old idea to be able to change. 11. Being stressed is not a problem, you will be willing to change anyhow. 12. You can help people see the need to change by expanding their view.	
True, or false? 13. If a person is very busy and overworked (like a mother with 5 children, a sick husband and little money), she will be open to change behavior when you tell her to do so. 14. You have to feel safe to consider change 15. Never try to push someone to change. 16. By just giving someone information you can make them change. 17. No one has a "wrong idea". 18. When people don't want to change, even though you give them a good reason, they are stubborn+ ignorant 19. You need a good reason to change behavior. **True, or false?** 20. You can change behavior regardless of how you feel - even if you are very tired or hungry or feel burnt out, you will be open to change 21. When people are stressed (scared, overworked, undernourished, tired), they will not consider change. 22. If you tell someone else to change, they will do as you say 23. Changing behavior is easy, for others 24. Changing behavior is difficult, for you	**Go** through the last points together – these relate to important aspects of ABC

Summary: **Changing ideas and practice** • Create ***awareness*** of new ideas and practices through mass media and information activities (posters, pamphlets) • Encourage ***trial of new practice*** through trusted source, or emotional event. • Encourage to ***keep new behavior*** through trusted source, positive reinforcement, and peer pressure 	**Summarize** the main points **Add** points from the discussion, and from their insights, and role play **Emphasize** that use of this knowledge will change their practice as providers It will reduce their frustrations of why people don't change, and make them free to collaborate with people instead – based on a realistic understanding of how people REALLY change. Patients, colleagues and family will appreciate these insights! ***In other words – it is the HP that needs to change his/her communication behavior!*** ***NOTE: Emotional competence is very important throughout this process. Bring out these points (see module 3b) whenever appropriate, and remind participants of their importance,***

Exercises

1. How do you change?

Purpose: To enable participants to discover, through analyzing their examples of change, how their change process follows the steps in the behavior change model. Furthermore, to discover that what influenced them to change was possibly a person they respected/admired and/or could identify with, and/or – an emotional event. This will give them the insight that "making someone change" is difficult/impossible, and that when patients don't change, the reason could be that the provider is not someone they respect and trust positively (but rather – someone they fear?). Furthermore, to discover that change takes time: typically, their own change – from they start thinking about it (awareness and interest), until they have changed (trial, evaluation and adoption) – can take several months, or years. They need to see when and how the BIG change – **the decision** – happens, and that this moment is usually something they will remember clearly. The overall purpose is for them to discover and reflect on the implications of understanding this model, on their work with patients and colleagues.

NOTE: The trainer will ask many questions to find out what participants did, how their change process went, and who was influencing them: This has to be done very carefully and respectfully – personal behavior change is a vulnerable subject. Be sure to appreciate participants for their examples, and their willingness to share. Also be careful not to dig too deep into sensitive subjects. The point is to ask questions to show that the person went through the different stages, and to especially illuminate the point where the decision is made to change ("*Jumping the red line to try a new behavior" – see the drawing of the model).*

Procedure:

1. **Ask for volunteers to share examples** of their change process. Inform them that you will ask for 3 examples. If no volunteers – ask your trainer (who is prepared) to share an example. This is usually enough to get other participants to contribute. If they still seem reluctant, ask them to share at the tables, and then ask to share in plenary.
2. **Let the participant tell his/her story**, without interrupting. Appreciate the contribution,

3. **Ask questions to identify *a) the different stages*** (becoming aware of the problem, and thinking about it for some time, developing an interest to change – ask for how long); ***b) the time/event/person(s) who influenced the decision to change/try a new way;*** c) ***the time after the decision*** – what happened (possibly - reinforced to keep the change by results they saw on themselves, or in relation to others, and/or influence/comments/support from friends, colleagues, family); and d) ***how the person feels now about the change.***
4. **Repeat the process with 2 more participants.** ***NOTE: Do not link to the model while asking the questions!***
5. **Draw the model:** Draw the different stages (Awareness, Interest, Trial, Evaluation, Adoption/Rejection) on the left side of the paper. Draw a red line between Interest and Trial. Draw a stick figure with the head above the red line, and the body below. (*NB just showing this on the computer is not nearly as effective as drawing it – and especially being able to emphasize "the red line". Also important to draw the figure – with the head/thinking above the red line, and the body with the heart/emotions below the red line).*
6. **Link the story to the model:** Refer the stories to the stages, one at a time: Show how the first two stages, where the participant was thinking about change – are the COGNITIVE STAGES (write on flipchart), the stages where the participant ***thinks*** about the need to change. Show how the event, or the respected person you have identified, influenced the participant to start the new behavior – to "Jump the red line" and try a new behaviour: This is connected to Emotions (WRITE – EMOTIONAL STAGES) – there were probably some feelings involved (like – becoming pregnant, starting a new education, serious illness to self or someone close..). During the evaluation stages, emotional aspects also influence: how the person feels (and thinks) about the change, and how feedback from friends, colleagues and family will strengthen the decision to stay with the new behavior. **Do this for each story**.
7. **Ask for comments and questions.** Let them discuss at the tables, and then ask questions.
8. **Ask what are possible implications of this knowledge, for us as health providers.** Let them discuss at the tables, if no immediate answer comes.
9. **Conclude:** For the rest of this module, we will be working with these questions, and see how they apply to our work, and our practice.
10. **Leave the model with the five stages up on the wall in the classroom, and refer to it during the further exercises and discussions – to reinforce the knowledge.**

Main points to bring out (on point 8 – implications):

- We are unrealistic when we expect patients to change behavior just because we tell them to. By understanding this model, we can work more realistically and effectively with patients.
- Providers are most likely able to influence the patient to be ***aware of and interested in*** the new behavior (rather than making the patient actually change) – unless it is a behavior (change) the patient has been thinking of him/herself already;
- If the provider can be a person the patient can respect and trust, the patient is more likely to use the advice to change behavior;
- Knowing how long time behavior change usually takes, the provider should be patient, and not expect instant changes.

2. Changing cough behavior

Purpose: To strengthen awareness about what kind of people patients will listen to and follow the advice of, and why this is so – by applying the ABC model to a real problem in their practice.

Procedure

1. **Ask** participants to discuss in groups how they would influence this patient to cover his mouth when coughing. Also ask them to discuss whom he would listen to, and why – linking

this to the ABC model. Ask them to reflect on how they as providers have to behave to make him want to follow their advice, again using the ABC model.

2. **Ask** volunteers to act out the solution in front of the group.

Main points to bring out

- The patient would listen to a provider he feels he can trust, someone he respects and can communicate well with. This would involve emotional competence from the provider.
- The provider should recognize the patient's emotions (and her own), and be empathetic and respectful. S/he should engage in a dialogue to explain why the patient should follow advice, and the implications of not following the advice, on staff (i.e. you), and other patients. The provider should encourage the patient to ask questions, and should give positive reinforcing feedback when the patient covers his mouth when coughing.
- If the patient is reluctant – ask questions to find out the reasons for his reluctance, and show respect for these. Negotiate, if appropriate.
- Remember behavior change takes time.

3. Will she follow your advice?

Purpose: To strengthen awareness of (potential) automatic emotional reactions of providers to parents taking children to traditional healers, and the possible consequences of such reactions, on the mother following advice and changing behavior. Furthermore, to strengthen awareness about the potential effects of using emotional competence to meet the mother with openness and respect, acknowledging that she has done the best for her child, and focusing on the common goal of provider and mother – to cure the child (effects: Mother will likely follow advice, and possibly change behavior). Finally, to place this understanding into the ABC model.

Procedure:

- Ask groups to discuss and reflect on the questions on the slide
- Discuss one question at a time in plenary
- Sum up the discussion by emphasizing the usefulness of understanding this model, to providers' quality of work.

Main points for discussion:

- The mother handled rationally, from her own perspective and understanding: Her intent is to do the best for her child.
- HP must recognize and acknowledge this before giving other advice, and empathize with her.
- The focus should be to recognize and take care of her fear first, by diagnosing and finding treatment for the child
- HP must recognize his own emotions (e.g. of judgement that she has gone to the traditional healer and tried other remedies instead of coming straight to the clinic – and take a step back from his own judgment). He must act respectfully, invite trust and build a professional relationship.
- If she trusts him, they can discuss behavior – after having diagnosed and treated the child
- If she trusts him, she is likely to follow advice, at least in the short run.
- It may take weeks and months for her to change behavior re seeking help at the clinic at an earlier stage.
- In summary – the HP must use emotional competence. He must use awareness and ability to establish a professional relationship with the mother, and thus influence positively the quality of the work and outcome for the patient.

NB: Be careful about giving the message: "*The mother should always come to the clinic first*". Coming to the clinic is expensive, and it takes time – compared to going to the traditional healer, or herbalist. There are many health problems in the community which are treated well by the local healers - the mothers know this, and they will continue to use these resources. What she needs to know (*and is more likely to take action on*) is – when should she come straight to the clinic, which symptoms should she be very aware of, and **why**? This is knowledge she is likely to act on – rather than on the automatic (from the HP): "You should always come to the clinic first."

4. Stages of crisis: Implications for your work

Purpose: To strengthen awareness of the effect of different stages in a crisis, on patients' ability to understand and process information. Furthermore, to strengthen awareness of the potentially different perceptions of "a crisis" between the person experiencing the problem/disease (*and feeling a lot of fear*), and the provider who knows how serious it is (*and thus knowing if there is a "rational" reason to worry very much*). Finally, to relate this understanding to their own work situation by reflecting on patients they have treated, who were in a crisis, and to reflect on these examples – using emotional competence.

Procedure:

- **Go through the stages of crisis by relating** the example above, to the stages: Ask for each point – do they believe the parent will take in information or advice? Why/why not?
- **Then, let them discuss in pairs** the implications of understanding this theory, on their work (NB reason for talking in pairs rather than groups is – they will each have examples, and should be able to tell one each, which is quicker in a pair – and it leads to more insights when they can all reflect on their own example)
- **Ask them to reflect** on the points on the slide
- **Get one or two examples in plenary**, and discuss the reflection points related to these examples (the examples then function as common reference points). Bring in emotional competence where relevant.

Main points to bring out in the discussion:

- When patients feel they are in crisis, they do not take in (detailed) information (they are mostly overwhelmed by the emotions). They need to be calm, and to feel the (immediate) crisis is dealt with before they can relate to cognitive information. *This means – the last two stages (Processing, and New orientation).*
- The crisis can be one over shorter time (like an acutely sick child, who becomes stable after a few hours), or longer time (e.g. a death).
- Recognizing a patient's perception of being in a crisis: When the patient (or parent) is very worried about e.g. the life of her child, this is experienced as a crisis.
- A patient experiencing a crisis is very vulnerable, and needs empathy. She should be treated with kindness, compassion and concern, to allay their fears to the best possible extent. The focus should be on the patient.
- The provider should be able to recognize his/her own emotions in situations like this, using emotional competence: It is essential to recognize and be able to step back from their own emotions, before being able to help others in the most effective way.

5. Behavior change: True, or false?

Purpose: To strengthen awareness of how the behavior change theory translates into practical issues, related to their work. The list also challenges some present practices about ABC, and makes them reflect on whether these are true – related to what they have now learnt.

Procedure:

- Give out the one page handout (without the answers, of course..)
- Let participants fill in individually, and then discuss in pairs for about 5 minutes.
- **Alternative 1:** In plenary, use the first slide, go through point by point – ask for answers, and (ask your co-trainer to) write on the slide (T, or F). Where appropriate – ask e.g. "Why is it like this?", or – "what happens if we do this", or any question to invite brief comments from their discussion, and bring home the point.

Go through the first slide like this, and take a few more points – e.g. the last 3, and any point participants want to bring out (e.g. because they have disagreed in the group, or think it is a very important point, etc.)

- **Alternative 2** (after first two point in procedure, above): Ask each pair to identify and bring out an example they want to discuss in plenary – because they are not sure whether to agree or disagree, or because they think the point is an important one for their work. Discuss these examples in plenary.

Which of these statements do you agree with?	***True***	***False***
You have to see something as a problem yourself before you can consider change.	T	
You can only change yourself.	T	
Changing behavior can be a quick process.		F
We often judge people as being stubborn or ignorant when they don't want to change.	T	
If you tell people to change behavior, they will be happy to oblige you.		F
If someone refuses to change, you can push them to change their behaviour if you know it is harmful to their health.		F
To change, you require time and energy to think and reflect.	T	
People we trust and respect can influence us to change.	T	
If someone else gives you a reason to change - a reason which is good from THEIR perspective - you will change		F
Even if you don't see the behavior as a problem, you can change it, if someone else says you should.		F
You need to be ready to let go of an old idea to be able to change.	T	
Being stressed is not a problem, you will be willing to change anyhow.		F
You can help people see the need to change by expanding their view.	T	
If a person is very busy and overworked (like a mother with 5 children, a sick husband and little money), she will be open to change behavior when you tell her to do so.		F
You have to feel safe to consider change.	T	
Never try to push someone to change.	T	

By just giving someone information you can make them change.		F
No one has a "wrong idea".	T	
When people don't want to change, even though you give them a good reason, they are stubborn and ignorant		F
You need a good reason to change behavior.	T	
You can change behavior regardless of how you feel - even if you are very tired or hungry or feel burnt out, you will be open to change		F
When people are stressed (scared, overworked, undernourished, tired), they will not consider change.	T	
If you tell someone else to change, they will do as you say		F
Changing behavior is easy, for others		F
Changing behavior is difficult, for you	T	

Further examples from participants

"It's high time that I change, I said to myself".

"I realized that the change that started in me had changed the whole community".

" The change made my work easier because the people stopped their old habits and implemented what I taught them".

An example of changing behavior, from a senior trainer

Communicating respectfully with a family:
"Compromise helps quite a lot"

Baby E (who is about a month old) had been on the wards for about 3 weeks with meningitis, and on treatment. Apparently still on treatment but he has developed hydrocephalus (*accumulation of fluid in the brain as a complication of meningitis, hence head increasing in size*) while on the ward. This is continuing to increase gradually and it is worrying us clinicians/nurses. Baby E's parents are also worried. I keep on reassuring them since there are still things that we can do to avoid further enlargement of Baby E's head. A brain ultrasound is required and I inform parents about this since it is going to guide us on whether to let Baby E undergo surgery to relieve the fluid or not. Baby E's parents are so scared about this.

When they came to the hospital, baby E had charms tied to his wrists and ankles, showing they had been to a traditional healer. They believed his condition was due to witchcraft, and they wanted to

take their baby back to the healer. I got scared, and I really wanted the baby to benefit from surgery – I knew that if they took him home to the healer, he could die.

So, with my fears (*the fear that Baby E's head is getting bigger and parents might not agree to let him undergo surgery*) but in control and wanting to create that understanding on Baby E's parents I talk to them and they agree, but they make it clear to me that they cannot afford and furthermore they are worried of the hospital bill too.

I offer much reassurance to allay their fears; then Baby E's father makes a proposal. His argument is, Baby E's head started to enlarge while on ward hence our intervention is not working. He further appreciates our efforts and concerns but requests that we take Baby E for a brain scan then after that we let Baby E go home because there is a traditional doctor at home who is perfect in fixing such heads. The parent beg me to let them try this alternative. Of course I cannot accept this from my medical point of view but looking at it on the other side they are right, something isn't right and they are desperate to have the problem solved. I appreciated their proposal and tell them since they have agreed to have Baby E have the brain scan, we shall discuss that further after the results. They agree. When the results came, we managed to get the surgeon who confirmed that he would perform the surgery. Then a tube that is to be inserted in the brain to relieve off the fluid was being sourced and it is expensive.

Then Baby E's parents ask to speak to me again, this time in the company of some members of their extended family. Six of them. Four of them elderly. I knew there was work to do here and got a bit tensed but composed myself. Thank God these days I am equipped with lots of good communication skills and practicing a lot to take care of my emotions.

I approach them with respect and appreciation, then I explain to them the situation. I could see they were tensing up and looking worried - like I was blocking them from doing something so important. So I asked them to air their views. One of the elderly ones asked if I could just let Baby E home for some time, then come back to the wards since there is a traditional doctor who is an expert in handling such problems.

I did not want Baby E to leave the ward but it seems they believe and trust this traditional healer. We were talking like partners therefore negotiating so I proposed something to them. I asked them to let this traditional doctor come to the ward and see how we can help each other to help Baby E. They were all surprised and burst into laughter and asked "Doctor are you sure you can allow this doctor here?" I said 'Yes', and added "then I can discuss with him and come to an agreement on what we (both the traditional doctor and I) can do here and then the rest can be done when Baby E is out of hospital". This lightened them. They were so mesmerized. They relaxed, too. I was glad because by this time we were feeling comfortable about each other.

Then later into our discussion another elderly said "Well, doctor, we may let Baby E stay but just before we do that let us consult with one other health worker who works in a hospital and see his views". I told them, "you are welcome. Let me know the feedback and in any case I am happy to speak to him". They were so impressed. We exchanged numbers and he even gave me this health worker's contacts.

When he arrived, they spoke to him; then I spoke to him and even let him see Baby E with their permission. Finally all of us were in agreement that Baby E stays and undergoes the surgery. I reassured them that the hospital has a waiver system and since it was one of their worries I will communicate this to the nurse-in-charge who will address the issue to the hospital matron. And about buying a shunt (the tube for draining fluid from the brain), I would speak to my senior since

there is a way my organization helps patients who can't afford some of these things that may be life saving.

Meanwhile, while all this was taking place I noted some mothers on that bay where Baby E was, were very supportive. So I asked them to constantly encourage Baby E's mother. Some even shared their experiences with children of their relatives who had suffered the same problems. There was also a nurse who had undergone the process communication training, and I frequently asked her to talk to Baby E's mother. There was a clinical officer intern and a few nursing students whom I encouraged to accompany me whenever I spoke to Baby E's people. I had to ask for their permission to let them be around and they did not mind. I wanted the students and intern to grasp the good methods I used and had a small session after that to discuss my approach. They thought I had some magic and wondered where I get the energy.

An update on Baby E (a week later)

Baby E suffered several convulsions over the last weekend. This resulted in him being transferred from the general ward to High Dependency Unit where further investigations and treatment were offered. I was not on duty when this happened. When I reported back he had already been transferred back to the general ward, and I first got the news from his mother. She was calm when she was speaking and on further enquiry I gathered she understood why Baby E had to undergo other medical tests. This made me appreciate more the value of letting patients or parents know about a disease and its complications. When I examined Baby E, he was out of danger and breast-feeding well.

Baby E's mother later informed me that they are not able to purchase a shunt for him. I had already inquired with my seniors and they had bought one for him already so I let her know about this.
Since last time we had a discussion we have been waiting for the surgeon's word. Baby E's parents have been very patient and I have been updating them on the progress. Surprisingly, they haven't insisted on going home and seeing the traditional healer before surgery. I have really enjoyed the way we communicate and the teamwork involved in caring for this baby.
The surgeon came this morning and asked us to prepare Baby E for surgery today.
As I write, Baby E is on the operating table with the surgeons and we hope everything goes on well. Am so happy!

Hiza Dayo, Clinical Officer, senior trainer

Reflections on my change process: I stopped judging

When baby E came to the hospital with a serious disease and with charms tied to his body, I got scared – I knew this baby was in danger of dying, and I knew now that I had to act with awareness and respect to negotiate well with the parents. Previously, I would have covered up my fear with anger (*not knowing that this is what I was doing*), and really judged the parents harshly, "attacking" them verbally for their actions. I used to judge parents who bring their kids to hospital with charms or who refuse treatment because they want to consult the traditional healer. I used to really create a fuss out of it instead of focusing on the sick person. I would judge and show disrespect, and parents would feel bad, shut up or walk away without any treatment.

I was aware that if I approached them the way I used to previously, I could miss the boat big time.

So, fearing that Baby Elvis will die if he doesn't go through surgery, I had to act. And this time around I had to be constructive with my approach. I recognized my emotions and took a step back – rather than acting on my fears. I applied communication skills, and it worked. Both the parents and the

family heard my honest concern for baby E (both medical and personal), and we could cooperate to save his life.

Since then I have stopped judging/criticizing/ridiculing/giving angry verbal attacks to patients who have gone to a traditional healer or who are asking to go to a traditional healer. Instead, I engage them in a constructive dialogue. It works much better!

By the way – Baby E survived the surgery. However, he has developmental delay and he is being followed up at the Neurology clinic. The mother really tries to keep his appointments. Sometimes she misses. Whenever she brings Baby E to hospital, she looks for me to say hi. This makes me feel good, and appreciated, and inspires me to continue using my skills.

Hiza Dayo, Clinical Officer, senior trainer