1 Why and How to organize training; overview; concepts and history

1.1 Foreword

This manual presents the iCARE-Haaland training model. iCARE refers to the main components of the model, i.e. intelligent Communication, Awareness (and Action), Reflection and Emotions. Within Reflection is included Observation – In Action, and On Action. The name was suggested by professor Mike English in Nairobi during a training course for nurses in June 2019 – and really says what the model aims to do: ***To give providers a better chance to show how much they care. Thank you, Mike!***

Health professionals who understand and manage their own emotions communicate better with patients and colleagues, and take better care of themselves. When they also recognize and appreciate patients' emotions, they are able to provide care with the necessary empathy to be heard and understood. In addition, health professionals who are emotionally competent in addition to medically competent handle stress better and are less likely to burn out and to get into conflicts.

The manual provides practical advice and training on how to build a safe and trusting relationship between the health care professional and the patient, and how to build and maintain good relationships with colleagues. It gives examples of how powerful these skills are and how important they are for providing quality care, and for communicating and working well in medical teams.


Our experience with developing this model over more than a decade together with more than 350 health care professionals in nine countries (Here: Lithuania, left, and Kenya, right) has shown that communication and emotional competence skills are essential. And – that there is no quick fix.

Change takes time. But, the investment is worth it, and sometimes – all it takes to stimulate motivation to learn more is that one moment of an **"AHA-experience",** when the course participant really feels the change and sees the impact. The many examples of how communicating with empathy changes the relationship between care giver and patient have inspired us to write this manual while we continue carrying out the training.

When presenting results from our training at national and international meetings and conferences, the response has been overall enthusiastic and positive, and participants have been curious: yes, these skills and results are what we need – please give the model to us!
Well, here it is – a manual shaped by the needs and frustrations and questions from health professionals in widely different cultures, describing a training programme they say has changed their practice and their way of relating to and interacting with patients, colleagues, supervisors and themselves. Many say it has also changed the way they relate to their families.

The author, drawn by Jeyaniroshan Jeyapalan, at the University of Oslo

1.2 Abbreviations

ABC	Attitude and Behaviour Change (From E. Rogers: Diffusion of Innovations)
ACP	Aware Communication Provider (or professional)
ARCP	Annual review of competency progression
BMJ	British Medical Journal
CHEP	Community Health Education Programme (NGO in Ndola, Zambia)
CME	Continuing Medical Education
EI or EC	Emotional Intelligence or Emotional Competence
F1, F2	Foundation doctor year 1 and 2 (UK)
FEAST	Study: Fluid Expansion as a Support Therapy
GCP	Good clinical practice – international standards for conducting clinical research.
GP	General Practice (medical doctors)
HIV	Human Immunodeficiency virus
HP/HCP/HW, HCW	Health care provider/professional (physician, nurse, councillor, physiotherapist, orthopedic technician, pharmacist); health worker, health care worker
iCARE	intelligent Communication, Awareness, Action, Reflection (including observation) and Emotions: the core features of the iCARE-Haaland model
KEMRI	Kenya Medical Research Institute
LHL	Norwegian Heart and Lung Patients' Organization
LVCT	Liverpool VCT Care and Treatment (NGO, Nairobi, Kenya)
NHS	National Health Service (UK)
NVC	Non-verbal communication
PCC	Patient-centred Care
PI	Principal Investigator
RCC	Relationship Centred Care
TB	Tuberculosis
WHO	World Health Organization

1.3 Use of gender, professional roles and model name

The decision of which gender to use in the writing must be made on some basis. To use him/her or herself/himself consistently is cumbersome for the reader as well as the writer.
Our target group of course consists of both genders, among policy makers/managers as well as among trainers and researchers. Among participants in the training courses, a majority will often be women. We have therefore decided to use "her" and "him" quite randomly in the text.
Doctors, nurses and other health and research professionals working in clinical care, research and supervision have participated in the courses. We use "health provider" or "health professional" (HP)

or just "provider" to refer to all personnel working in clinical care and/or research. When needed, the research roles are identified. We use "provider" and "participant" interchangeably in the text, assuming it will be clear when we talk about people who have been involved in the course.
In the manual, we use either "the iCARE model" or "the iCARE-Haaland model" to refer to the training model we describe.

1.4 Concepts used in the manual

Concept/idea/skill	Explanation
Action research	Action research can be research initiated to solve an immediate problem, and involves actively participating in a situation, to affect change: The purpose is to solve problems and produce guidelines for effective practices. Action research can also be a a reflective process of progressive problem solving over time.
Antennae 	Visual concept of cartoon-face with antennae – used to visualize awareness and the need to pay attention. This is the "mascot" for the course, as it visualizes the most important skills aim for the participant to develop. Drawn by the artist Bosco Kahindi in Kilifi, Kenya.
Appreciation	To value what another person has done or said and express it to the person. Does not mean that one has to agree with what the person says or does.
Attention span	The time period a student/person is usually keeping focus and listening, e.g. during lecturing/presentation of a new topic. Typically, the attention span of an adult is 10-15 minutes. After this, the person's attention is often diverted and the contents presented from the lecturer is often lost.
Authenticity, or being genuine	Being true to yourself – and when you are, you will (usually) also be experienced as being true, and trustworthy, by others. It means you are being real, and not pretending to be something or someone you are not. People who are being genuine can usually engage and connect easily with others, as it feels good, and safe, to relate to a person who is being authentic.
Automatic reaction	An automatic response, usually emotional, to something another person says or does. Usually cannot be controlled (until you learn how). Often leads to misunderstandings, and sometimes to conflict.
Being present	To keep full attention on the person(s) you speak with, or the action you perform; not letting your mind wander onto other things when you are in conversation with another. This skill helps you connect with the other person. Feels good, calm, to the person who is being present and to the person(s) he is interacting with. Very important skill for a trainer/facilitator.
Burnout	A set of symptoms normally occurring from overwork, over time, without the necessary skills or ability to identify or prevent it: Emotional exhaustion, depersonalization/categorization, and lack of job satisfaction. Burnout is a severe problem in the health professions
Communication, with awareness	To communicate while paying attention to what you say and do, to whom – "using antennae". Usually includes being aware of the effect of what you say and do, on the other person. Can enable you have a good quality dialogue, and also to discover miscommunication, take a step back, and create clarity.
Communication, mechanistic	To use the skills of e.g. listening, by following the "rules" of what you should do, but without awareness, and without paying attention to the effect of what you do and say, on the other person.

Communication, relational	Communication in the context of an interaction with another person. This includes recognising the effect of emotions on how you communicate.
Critical thinking	The ability to think in a self-guided, self-disciplined way and try to reason in a fair-minded way (rather than being egocentric). People who have this skill will often try to live rationally and reasonably and use empathy.
Emotional Competence	Emotional competence refers to the essential social skills to recognize, interpret, and respond constructively to emotions in yourself and others. The term is used interchangeably with Emotional Intelligence, and also implies being at ease with other people.
Emotional Intelligence (EI) and Emotional Competence	There are many definitions. We use the following[1]: A set of four central skills: Recognizing emotions (your own, and those of your communication partner(s)); Integrating emotion with cognition; Analysing causes and consequences of the emotion(s); Taking informed action, based on your analysis. Emotional Competence is broadly used as similar to EI.
Emotions and feelings	**Emotions precede feelings, are physical, and instinctual** *Emotions play out in the theatre of the body.* **A feeling is a mental portrayal of what is going on in your body when you have an emotion and is the by-product of your brain perceiving and assigning meaning to the emotion. Feelings are the next thing that happens after having an emotion, involve cognitive input, usually subconscious, and cannot be measured precisely.** *Feelings play out in the theatre of the mind.* From www.thebestbrainpossible.com/whats-the-difference-between-feelings-and-emotions/
Emotional labour	The act or skill involved in the caring role, in recognising the emotions of others and managing our own
Empathy	The capacity to understand or feel what another person is experiencing, from the perspective of the other person, i.e. the capacity to "put oneself in the other person's shoes". There is cognitive empathy, and affective empathy.
Empowerment	Here: The active role for participants to take power over their own learning. They decide if, how, when and where to learn, and what to do about the insights they gain from their discoveries. Empowerment has a number of different meanings, depending on roles and context (e.g. patient empowerment).
Experiential learning	Learning where participants' experiences are used as starting points for understanding reasons why things happen as they do, share experiences with others, and learn skills on how to improve. Link learning to theory.
Fun/humour	Humour helps us learn better and remember better. It stimulates the curiosity, which is where learning begins. It stimulates motivation to learn.
Humanistic medicine	Emphasizes the relationship between health provider and patient. The approach includes establishing a collaboration with the patients, based on trust, and showing the patient respect, dignity and empathy.
Hidden curriculum	A collection of values, norms, traditions and beliefs which is transferred (unconsciously) to students or younger professionals from older professionals, many of whom are hardened by years of tough work and limited support. The transfer is commonly unacknowledged, often not spoken about, it "just happens". Often blamed for "killing" young

[1] Schneider, T & al (2013): Emotional intelligence and resilience. Personality and Individual Differences 55, 909-914

	professionals' motivation to use e.g. modern methods of communication, and for making them hide or "kill" their emotions.
Inner motivation	A motivation emerging from within the person herself, after seeing that what she does, does not work well/not according to her own values. An inner motivation can empower the person to change, for her own reasons.
Intelligent Kindness	Kindness: recognition of being of the same nature as others, being of a kind, in kinship. It implies that people are motivated by that recognition to cooperate, to treat others as members of the family, to be generous and thoughtful. It means that clinical, managerial, leadership and organisational skills and systems can be brought to bear purposively to promote compassionate care. ***Intelligent*** kindness is a binding, creative and problem-solving force; it inspires and directs the attention of people and organisations towards building relationships with patients, recognising their needs and treating them well[2].
Management of emotions	To be able to recognise emotions (your own, and those of the other person); take a step back from (automatic) reactions, and act with awareness
Self-observation and reflection task	Guided tasks to self-observe and reflect on one communication or emotion skill at a time, systematically, for one week. The aim is to discover the pattern of how you communicate, and the effects of your communication on the other person. This becomes personal evidence for initiating learning, and change
Reflection In Action	Process of reflection that takes place WHILE one is doing it: **"Think when" – and "be present" while you communicate, to be able to take notice of what is happening, while it happens.** This method enables the practitioner to recognise how she communicates, and emotions that she experiences during the situation, as well as recognising the emotions of the other person(s). The natural inclusion of emotions enables the practitioner to develop a habit of including these in the reflections on his work. It also enables her to recognise automatic (emotional) reactions and learn to stop these and take a step back and act with awareness. The method is not yet frequently used (?) in education.
Reflection On Action	Process of reflection that takes place AFTER the event: **"Think back".** If reflecting on emotions, these will be less intense than if reflecting in action, see above, and thus be less likely to have a strong impact, and/or trigger change. This method is the most frequently used in reflective practice.
Reflection, to discover	Reflection used when self-observing own practice over time, when communicating with others. The purpose is to discover own patterns of communication, and the effect(s) of these practices on the other person(s). Used in individual practice.
Reflection, interactive	Reflection in pairs or groups, typically in the workshop, on a theme that has been discovered as a learning need by several participants. (It can also be a theme introduced by the trainers, from trends or challenges the trainers discover when reading the feedback from self-observation and reflections)
Reflection, informed	Individual reflection which takes place after the workshop, when new skills have been learnt. During this phase, participants "know" what they are looking for, and are looking at how their new skills are functioning in practice (but also frequently discovering new learning needs!)

[2] Campling, P: Reforming the culture of healthcare; The case for Intelligent Kindness

Patient centred care	Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions
People centred care	Umbrella term which specifies that the patient should be considered across all levels of the health system.
Relationship centred care	RCC is an important framework for conceptualizing health care, recognizing that the nature and the quality of relationships are central to health care and the broader health care delivery system. RCC can be defined as care in which all participants appreciate the importance of their relationships with one another.
Relationship, professional	Relationship between a provider and a patient, or between providers as colleagues. Building a relationship of trust and respect is a good basis for finding the best way to relate to a patient and help him, and – to relate to colleagues. Such a relationship is a basis for good communication.
Resilience	Capacity to *withstand/cope well with stress* – involving behaviours, thoughts and actions that *can be learnt by and developed by anyone.* Resilience involves *connectedness* to physical and social environment, to family, and to a sense of inner wisdom. The *road to resilience* lies in acknowledging and working through the emotions and effects of stress and painful events – *not* to avoid them
Step back	When you learn to recognise automatic (emotional) reactions to what other people say and/or do, you become aware that you have a choice: To act on the automatic impulse, or – to stop the impulse and take a (mental) "step back" and not react. Learning to step back is an important aim in the course. The skill enables people to get control over their actions, and act with awareness.
Vulnerability	**In medicine**, vulnerability is commonly seen as "weakness", and is commonly feared and/or ignored. We add the other interpretation of vulnerability (from humanities and psychology) – it is the emotion that makes you human, that enables you to connect and engage with another person. Being aware of one's vulnerability and being able and willing to use it, e.g. to connect and engage with patients in vulnerable situations, requires that the provider has conscious boundaries. Awareness of vulnerability (one's own, and the other person's) is a requirement for practicing empathy.

1.5 Introduction: For whom, why, and how to use the manual

In these introductory sections we describe who the manual is for, what it aims to achieve, how it is organized, and how to use it. We also give an overview of the modules.
A prologue gives a brief history and describes why and how this work has been conducted.

1.5.1 Who is the manual for, and what are the aims?

There are two main groups we aim to reach with this manual:

1. Decision makers and managers in the health system, who want to strengthen patient-centred care, wellbeing of their staff, and collegial collaboration in their institution(s) through in-service training, and
2. Trainers of health care providers

The manual is not written primarily with academics in mind, although many academics have expressed interest in its contents – and many may find it a useful resource to inform themselves, and/or to initiate discussion and training.

The overall aim of this in-service (CME) training is to strengthen the motivation and ability of health providers to communicate well with patients and colleagues, to strengthen patient-centred care and strengthen collaboration in medical teams. Furthermore, it is to improve providers' awareness, and wellbeing. Providers develop motivation to learn through becoming aware of how their communication affects others and learn skills to communicate with awareness and respect for emotions through interactive learning with colleagues in the workshops. This strengthens collaboration in the workplace.

The aim is further that the skills are practiced on a "base" of underlying professional clinical care, and an attitude of respect and an intention to care well. Exactly how, and which skills are needed, depends on the context and on the challenges facing the health professional, in each case. As each situation and each patient is unique, there is no simple solution to communicating well: The provider must have her/his basket of skills as an invisible resource she/he carries in her heart, and in her being – knowing that using these, she/he will be providing the best care she/he can. Building the skills and confidence to assess and meet the needs in each situation is a main aim of the training.

The manual does not aim to give a complete overview of the health communication training field but does include many of the main concerns being addressed in the current debates in Europe, the US and Africa which are relevant for managers, decision makers and trainers.

The aims for decision makers and managers are –

- **To provide convincing evidence** of what can be gained by the health sector or institution by investing in a training model and process that benefits patients as well as providers and their supervisors and leaders;
- **To motivate them to invest** in such training.

To review why such training is needed, see chapter 2.
To see what the training is about, read chapters 1 (overview) and 3.
To see how to organize the training and the management requirements, read chapter 6.

The aims for trainers of health providers (nurses, Clinical Officers, physicians, medical officers, counsellors, treatment supporters, other health providers) are –

- **To motivate them to plan and carry out** this process as a CME training, and
- **To provide them with the tools** to do so.

1.5.2 Organizing the training and selecting trainers

Skilled and motivated trainers are essential for implementing a successful course, and selecting the right trainers for the course is crucial. Trainers need basic knowledge, skills and experience in planning and implementing training courses, using participatory and experiential learning methods.

The trainer has a crucial role as a role-model and facilitator of the learning processes – to demonstrate an open, exploring attitude of non-judgment, to stimulate discovery and learning, and to help rekindle the motivation to care. The trainers need to have a willingness to learn, and be emotionally intelligent – with capacity to use this competence with the participants. Furthermore, trainers should have a degree of self-confidence and be able and willing to learn by doing, and focus on participants' learning. They should be people who have the capacity to "facilitate learning", as opposed to "deliver training". See chapters 6 and 7 for background on training methods and on skills needed for trainers.

The training can be organized in several different ways:

- ***A team of trained trainers (e.g from a training institution)*** can be hired to use the manual to train providers in different locations. The team members would need to have skills in experiential learning methods, and to have had the opportunity to try out the modules during a Training of Trainers' course, with feedback from experienced trainer(s) – before implementing it for providers.
- ***Train trainers internally in the institution***, using an experienced trainer to start the process. The institution could be a hospital, or a training institution, or others.
- ***Hire external trainers.*** The same requirements as described for the MOH team will be relevant for these trainers.

The advantages of using a team from an institution are that they become a resource for their area which can be used in many institutions, and strengthen the skills of an already existing team. Disadvantages may include that trainers might be "stuck" in previous approaches to training (which may often be didactic/lecture based), and be less open to the (unfamiliar) approach and the methods used in this training. *Managers may also underestimate the time and effort needed to learn how to conduct this training well – to achieve the results needed.*

The main advantages of training a team internally in an institution is that it creates a resource within the institution which will help build a strong environment for a new way of communicating with patients, to achieve patient-centred care. This team can also be used to support other types of training within the institution and ensure sustainability of the new skills and attitudes. The trainers – who are also providers themselves – know the work and the communication challenges from their own experience, and therefore have a high credibility as trainer, mentor and role models. A main disadvantage is that this approach takes time, and that selecting trainers among the providers is a challenge: Managers will often expect the trainers to continue with their regular work – AND do the training duties on top of these. A conscious process and negotiations are needed to choose the providers most suited for becoming trainers, and to prevent trainer overwork and burnout.

The primary advantage of using external trainers is that they are already professionals, e.g. from an institution, a university or an organization. They can be chosen on the basis of their suitability and capacity to lead such a training programme, and should have demonstrated that they have skills in using experiential learning methods, supportive group processes and critical thinking.
A **disadvantage** is that the trainers may not know the local situation well enough, and thus not be able to connect well with the participants' daily work and challenges. Another disadvantage could be the cost – as this training must be carried out over a long period of time. A final disadvantage is that the external trainers' skills do not stay in the institution, and organizing follow-up courses to maintain and strengthen skills learnt is more difficult.

The decision about what kind of team to select is of course also dependent on each local situation, and the opportunities available.

1.5.3 The organization of the training resources for the model

The resources are organized in five main parts.

1. **Part A: The manual** (Ch 1-10) describes why and how the iCARE-Haaland model was developed. It contains the background from the literature showing challenges for health providers to communicate and manage emotions in their work and evidence of what works. The model, its special features, the learning methods, the essential role of the trainers, and the planning process are then described.

2. **Part B: Discovery** describes the planning and preparation (phase 1) for the learning process. This part includes all the individual learning tools of Phase 1.
3. **Part C: The Basic Workshop (Phase 2)** introduces the Training of Trainers (TOT) and includes the 12 modules used in this workshop, as well as pptx presentations.
4. **Part D: Skills into Action** includes planning and preparation for **phase 3**, and the individual learning tools for this phase
5. **Part E: The Follow-up Workshop (phase 4)** includes the last 11 modules, and presentations.

1.5.4 Overview of the modules

1.5.4.1 Basic workshop: 12 modules

Module 1: Introduction of workshop programme and participants

a) Introduction to course concepts and contents, and introducing participants

Module 2: Communication and conscious learning

a) How do adults learn? Using learning theory with patients and colleagues
b) Feedback from observing how you communicate (from baselines and observations)
c) Gold standard communication theory, skills and strategies in practice

Module 3: Understanding and managing emotions

a) Feedback from observing how you manage emotions (from baselines and observations)
b) Communicating with awareness and emotional competence: Effects of safety, anger and insecurity on how we communicate
c) What makes people change attitudes and behavior? And why doesn't the patient do what I tell him?
d) Recognizing, managing and preventing stress with communication and emotional competence
e) Managing conflict with awareness and emotional competence to maintain dignity and respect

Module 4: The function of research in clinical care

a) Communicating about research with awareness and emotional competence

Module 5: Building and using communication strategies with emotional competence

a) Using communication skills and emotional competence to educate patients
b) Strategies to communicate with awareness and emotional competence

1.5.4.2 Follow-up workshop: 11 modules

Deepening understanding and sharpening skills

Module 6: Introduction, celebrating growth and facing challenges

a) Introduction and review: Gold Standard communication Strategies with patients and colleagues
b) The Big Changes: Confirmation of growth, and Challenges participants still have

Module 7: Understanding and managing strong emotions consciously:

a) The many phases of anger: Recognize, acknowledge and handle with respect.
b) Managing conflict with emotional competence: From confronting – to stepping back, and dialogue
c) Using power with awareness and emotional competence
d) Recognizing bullies in the medical profession: Using emotional competence to confront and prevent bullying
e) We can't always Cure, but we can always Care: Managing death and dying with emotional competence
f) Professional closeness or professional distance? Conscious use of personal and impersonal language
g) Using emotional competence to recognize, manage and prevent burnout

Module 8: Building and practicing communication strategies with emotional competence

a) Working with emotional competence in a research environment: Understanding and communicating about the difference between research and treatment (*optional*)
b) Strategies for effective information and communication: Communicating with awareness and emotional competence

1.5.5 How to use the manual

The bulk of this manual is the modules (about 400 pages), with a detailed "cook-book" advice on how to teach each of the modules to a group of participants***. See parts C and E of this resource collection.***

The trainers can use the manual in the following way:

- To prepare for the training, by reading the modules.
- Trainers should read chapters 4 and 6, to understand the thinking and theories behind the training, and chapter 7 to review and revise their own training strategies;
- Discuss with managers – help them see the need for the training and get their support.
- Invite participants, select them, call them for meeting (see chapter 8, and part B)
- Organize timing for the training
- Carry out the observation and reflection tasks, in the same time period as participants, see part B. (*NB it is essential that trainers also have had experience doing this, as so much of the training is building on participants' discoveries and learning during this period)*
- Organize a training team (minimum two, preferably four trainers)
- Organize and run a training of trainers' course, to let trainers teach all the modules to a small group of participants, and get familiar with the materials

1.5.6 How the modules are organized

Each module includes a background section for the trainer which reviews relevant knowledge the trainer needs to be able to run the module well. The module furthermore contains an overview of the contents, the slides with commentary, and the exercises, demonstrations and role-plays.

In the part containing the slides there are suggestions for points to be raised by the trainer during the session to each of the slides or set of slides. The trainer must of course use her own background and style to make the points and make the training relevant to her participants.

The exercises, demonstrations and role-plays are explained in detail after the slides, providing purpose, procedure and main points to be brought out in discussion from each activity. These can be used as is, and can also be used as "recipes" to develop your own materials.
You find all the modules in parts C and E of this resource collection.

1.5.7 Adapting the contents of the modules: Keep the relevance

Participants will feel the module is relevant to their needs when they recognize the situations, examples and quotes from the modules. It is therefore important that you spend time putting in your own examples, from the baselines and observations carried out by your participants before the workshop***. If you drop this part, chances are very high that the participants will not feel that the training is relevant to their own situation (the examples and situations in the modules will be from somewhere else), and thus they will be much less motivated to learn.***

You are of course encouraged to also adapt the modules in other ways to fit your situation.

Before you do – consider that these modules are built and revised, based on feedback from more than 20 training courses in nine countries, and that they follow a logical way of guiding the

participants to learn the theory and the skills, piece by piece, each building on previous learning. ***The sequence of the topics is important – to build competence and confidence: Participants will feel they master the topics, because they have the foundation knowledge needed to understand the next point***. When you adapt – please keep this in mind.

If you make big changes – we strongly recommend that you try out the revised module with a small group to test the logic and the flow of the learning – before you use it on a bigger group. Also, read chapter 6.1 to understand how the original learning elements build on each other, to be able to plan well how to adjust the learning contents, but as much as possible follow the logical learning sequence.

1.6 Prologue, history and professional commitment

The reflective learning methods at the core of the iCARE-Haaland model have been developed in collaboration with professional colleagues over several decades, using an action research approach. It started at a rooftop in Mombasa in 1993 where Ane Haaland, then working with Tropical Disease Research (TDR) at WHO, Geneva, and Sassy Molyneux, then a PhD student doing research in Kilifi, planned how to train field workers to communicate better with research respondents[3].
The manual has been written over a period of the last five years, based on work with the training model in six countries in Eastern Europe and Africa 2006-9, then in Kilifi, Kenya 2009-present, in the Gambia 2014-2017 and in Cardiff, Wales (UK) 2016-2017.

The consistent work with and support from the Kilifi team of trainers, researchers, managers and staff over a decade has been crucial to the continuous development and implementation of the model. The work with the team in Cardiff, Wales showed that the methods are equally useful to doctors in training in the UK as they are to nurses and doctors of all ages in African and Eastern European countries. ***When medical professionals strengthen their self-awareness when they communicate, they can learn to recognize and manage emotions. With these skills, they can improve the way they treat patients, relate to colleagues, and take care of themselves.***

The development of this training model has been an exciting journey of discovery in collaboration with good colleagues, fuelled by curiosity and by the determination to get to the core of the problems and then deal with them, in collaboration with those who experience these challenges. The model is a product of 45 years' professional work in 30 countries and is the most important work I have engaged in during my long career. ***I have, from the very early days of developing this model, insisted that real learning and change of behaviour takes time and requires reflective practice with supportive feedback.*** We have all agreed about the structure and contents of the learning process as it has emerged and has been refined over the years, using an action research approach. It has been a more challenging process to get agreement that the training needs to be conducted over a period of 6-9 months, with complex themes included, for the training to really make a difference. When given such time and complexity, the training can make a real difference to participants' understanding and practice of communication skills and emotional competence. However, most managers and institutions want a "quick fix". I am happy to see that our findings re complexity and length of the training (*i.e. the training needing to be conducted over several months, and include a broad and relatively complex mix of knowledge, skills and attitudinal challenges*) are now being supported by more and more research findings and by managers in this field – who have seen the results.

My respect for health providers has increased steadily throughout the years of working with the model, as I have experienced providers struggling with making sense of death, cruelty, difficult working conditions, unrealistic or unkind managers, babies who die and patients who have lost hope.

[3] Communication skills for field workers (…): Ane Haaland and Sassy Molyneux

The respect was further tested as I accompanied my husband through treatment of his aggressive brain cancer from 2012 until he died in 2016, and experienced what made a difference to him and us in vulnerable situations. Many of the doctors and nurses we encountered did not know how to meet his vulnerability and emotional needs, or our needs as a couple, and made the trauma worse. Others made a huge positive difference and made it a bit easier to live with the death sentence hanging over him. Thus, this manual is primarily dedicated to all the health providers, with the hope that the methods we have described will be made available to many and help make their lives a bit easier.

It has been a privilege to carry out this work, and I want to thank everybody who has been involved and made the work possible. *See also the full story of how the iCARE-Haaland model was developed, and what triggered the focus on emotions, in the last chapter.*

1.6.1 Dedication to providers, and leaders: Sincere professional pride

This manual is dedicated to health providers who care, to their trainers and role-models who help them discover how to show it, and to the progressive leaders who saw the potential in this training model and invested in it.

During my years of working to develop this training model I have collaborated closely with medical doctors and nurses in many countries, and with their leaders, and my respect for them and for the incredible job they are doing, has kept increasing. The providers have voiced their strongly felt needs for learning to communicate better, and many have also discovered needs they were not aware of - *like learning to recognize and manage emotions, with awareness*. Working closely with them and facilitating their hard work to become better communicators, despite large challenges within the health system, has left me inspired, hopeful and humbled:

- **Inspired** – as I have seen their motivation to learn, evolving – once the learning and the methods felt relevant and respectful to them;
- **Hopeful**, as I have experienced their engagement in and contributions to building a training model that meets their needs to care well for patients with their clinical skills and their hearts, and to communicate better with colleagues, and wanting colleagues in other places to also get these skills, and
- **Humbled,** by their sincerity and pure joy when they recount stories of how they have used their new skills to relate better to patients and colleagues, solve problems, and enjoy their work – with professional pride.

Five trainers have important influence on and contributions to the work

Mwanamvua Boga and Ane Haaland, in Kilifi

From 2008: Mwanamvua Boga, a nurse manager who participated as a trainee in Zambia, helped take the training to Kenya and has been the main trainer in Kilifi since 2011. She has been a main collaborator in the development of the final version of the 23 training modules, and has contributed important thinking to the course process and to the development of this manual – supported by an experienced research team. Mwana has led the team of 10 trainers in Kilifi, and independently conducted many training courses for providers in Kilifi and in other hospitals and institutions in Kenya.

In March-April 2015, Mwana conducted her first international training course in the Gambia, together with Hiza Dayo, another of the experienced trainers in Kilifi. In 2017, she received the "Heroines of Health" award from the UN as one of 13 emerging women leaders.
Mwana has burnt endless litres of "midnight oil" to dive deeper, question herself and others – including me – with respect, and having joy in working with these skills and see the fruits of the work with participants: She has seen many nurses and doctors emerge to communicate with awareness and to enjoy their work more – and become better colleagues.
Mwana has presented the work in several national and international conferences and workshops. Since 2017 she has also trained researchers and health managers in communication and management of emotions. In 2019, she has also trained leaders and teachers on emotional intelligence.

In 2017, **Dr Thomas Kitchen and Dr Isra Hassan** took the initiative to start a second course for trainee doctors in Cardiff, Wales. They felt the training they participated in during the pilot course in 2016 met an important learning need for doctors. All places on the course were filled in two days, indicating a recognition of need for these skills. Thomas and Isra have presented the work nationally and internationally and continue to work to create awareness about the need for doctors to learn to recognise and manage emotions, and for the need for changes in the health system.

In the early years of working with the model, two trainers were particularly influential.
Dr Rita Sopiene at the TB Hospital in Siauliai, Lithuania, was part of the first course in 2006. She is a paediatrician with a vision who initially saw the potential in the model and contributed important questions and professional inputs to the development of the courses. Rita led the training team of five doctors and nurses in her hospital. The team conducted several independent training courses in Lithuania and Estonia.

2007: Esther Kamenye in Namibia, a nurse manager who saw that this training transformed the way providers treated TB patients and went on to do her PhD on developing guidelines for training of TB nurses in communication skills in her country. She received her PhD in May 2014, and is currently a lecturer at the University of Namibia, teaching community health nursing science.
In the picture, Esther is participating in a role play during the first course in Namibia.

Manuals evolve through cooperation, and several leaders have influenced the early work

This manual is also dedicated to the progressive leaders and researchers who believed in the communication training model and supported me and my colleagues to develop it further. They have understood that quality work takes time – and that the close involvement of and cooperation with the users is the key element. These leaders are:

- **Mette Klouman**, the leader of the international section in the Norwegian NGO (LHL), who in 2006 asked me to work with them on patient empowerment (which we soon turned into health provider communication training) and
- **Dr Vita Globyte**, the director of the TB hospital in Siauliai, Lithuania, who wanted all her staff to learn better communication skills, and used her management skills to ensure that her hospital became the first institution to run this training.

Several other leaders welcomed the training of their staff and contributed to the early development of the model: **Dr Vaira Leimane** in Riga, Latvia, **Dr Nina Nizovskaya** in Arkhangelsk, Russia, **Dr Neema Kapalata** in Temeke, Dar-es-Salaam, Tanzania, **Sister Nelumbo,** the regional TB coordinator in Windhoek, Namibia, and **Alick Nyirenda** of CHEP, Ndola, Zambia. These training courses were all supported by LHL.

The inclusion of research in the programme

In 2009, **Dr Vicki Marsh** in KEMRI-Wellcome Trust Research Programme in Kilifi, Kenya, applied for and received a grant from the Wellcome Trust to implement the training in Kilifi District Hospital, with her as the PI, and in close collaboration with **Dr Sassy Molyneux**. Vicki and Sassy are both social scientists, and Vicki is originally a medical doctor. They saw the potential of the training to contribute to also strengthening health providers' skills on and collaboration with the many medical research projects in Kilifi. Thus, the programme was strengthened by inclusion of research modules, and by the previous focus on TB and HIV being broadened to include other diseases and medical concerns. In the last few years, training researchers directly on communication and management of their emotions has added an exciting new dimension to the work.

Professor Debbie Cohen invited the author in 2015 to come to Cardiff, Wales to implement the model with trainee doctors, based on a presentation of the work in Kenya at a medical conference in Greece. Action research was an important aspect of this work as well – to assess how the model could be adapted to be used with a group of young doctors, with shorter workshops and a different schedule – but using the same principles as for the original training.

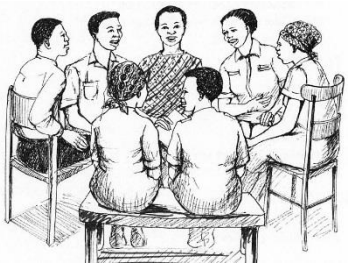
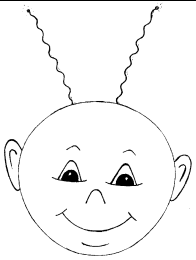
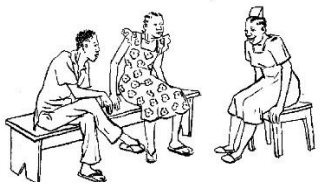
Susan Schwartz Senstad, a psychologist and writer, has been an important contributor to developing the model. Susan has reviewed and sharpened the contents on emotional management and educated me in the process. She has also read and commented on manual and modules, especially on the contents related to emotions.

Financing the work: The original work was financed by the Norwegian Heart and Lung Patient Association (LHL) and their partners in Lithuania, Latvia, Russia, Namibia, Zambia and Tanzania. In Kenya the work has been conducted under a grant from the Wellcome Trust. KEMRI-Wellcome Trust has also hosted and funded numerous courses over the last ten years, thus supporting with Mwana's time and involvement, administrative requirements and with links to and relationships with other institutions. In Wales, the work was financed by the Wales Deanery.

A more thorough list of dedications and of people influencing the work of this manual, as well as trainers and participants contributing to build the modules, can be found in chapter 10, together with the full history of how the model was developed.

1.7 Drawings and illustrations

The drawings in the manual are largely the same as those used in the modules. The main drawings are made by June Mehra, Italy and Bosco Kahindi, Kilifi, Kenya. Other drawings are made by Rasma Janeliuniene, Siauliai, Lithuania and Narendra Basnet, Nepal. Drawings on Tuberculosis counselling, and more, are drawn by Mosses Luhanga, Tanzania.
Drawings have also been borrowed from "Helping health workers learn" by David Wener and Bill Bower, and from the Uganda Health Manual.
The photos from training sessions are mainly taken by Ane Haaland and Mwanamvua Boga.

		
The drawings showing relationships between HP and patients, and more, are made by June Mehra		
		
The famous awareness guy, the faces showing emotions and the questioning man – and many more - are drawn by Bosco Kahindi from Kilifi, Kenya		
		
The persuasion trap, and many more, by Narendra Basnet, Nepal	*Relationship between doctor and patient, and many more, by Rasma Janeliuniene, Lithuania*	*Drawings from TB councelling, and more, by Mosses Luhanga, Tanzania.*

Thank you very much to the artists for allowing us to use their drawings in the modules and manual.