be cause health
Belgian Platform for International Health

Be-cause health matters
Newsletter - June 2011

Feedback from the workshop on 'People-centred care: a global concept'

6 April 2011, Centre Polygon, Brussels, 130 participants

Foreword – How about you?

The fewer years ahead of me, the more my mind goes back to the old days.
It occurred recently. I was staring at my screen trying to figure out complicated tables when suddenly a 25 years old image popped up into my mind: an image of myself daydreaming above my anatomy books. I even remembered the daydreams of that time: I saw myself attending future patients, the atmosphere was cosy and pleasant, patients felt comfortable and I felt appreciated. It is still my favorite and 'ideal' vision on medical practice: an enriching human interaction based on mutual respect and warm-heartedness.
The gap between my former student dreams and my current daily struggle with health indicators on my computer seems huge. This gap shouldn't be real as there is evidence that a people-centred approach of care improves health outcomes. Throughout the world, health systems may benefit from a more people centred approach. Bringing a human dimension into care yields.
Working on people centred care gives me the feeling that former dreams and current ambitions coincide.

How about you?

As Be-cause health working group we are very glad with the high interest for the workshop **'People-centred care: a global concept'. The workshop aimed** to share concepts and evidence, to reflect on personal experiences and best practices, to identify further areas for reflection and to enhance action. **The intended objectives were largely met. We hope you enjoy reading the present overview of key note speeches and fascinating discussions.**

Peter Decat chair of the Be-cause Health working group on People-Centred Care (PCC)
International Centre for Reproductive Health (ICRH) - University of Ghent



Images by Patrick Kolsteren, Maxime Madder & Jan Jacobs

Editorial People Centred Care

Health care systems are increasingly under pressure and one could ask where that leaves the patient. Treatment of Non-Communicable Diseases requires more than essential medicines. Access to health information, psycho-social support and participatory decision-making are crucial too. Not surprisingly, WHO identifies People Centred Care (PCC) as one of the major fields of action for improving health in the twenty-first century. To promote the concept and to exchange best practices Be-cause health started a working group around PCC with a kick-off workshop on 6th of April 2011.

What did I think when I first heard about PCC? Another fancy concept, nice for reports, but difficult to put into practice? After the workshop I realized that I was fundamentally wrong about three prejudices:

Firstly it is not at all a new concept. WHO already defined health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' decades ago and the 1978 Alma Ata Declaration confirmed that. Maria Zuñiga, one of the key note speakers explained that already way back in 1975 several networks started to work on the democratization of knowledge and on communities' participation in decision-making.

My second mistake was thinking that it is difficult to put PCC in practice. A new wave of young practitioners already see it as an evident and integrated practice in Europe and North America. For them it is now quite normal to take the social environment and psychological well- being of the patient into consideration. Bart Criel made us reflect by saying that traditional medicine is by nature people centred.

My third mistake was to think that PCC would be less of a priority for developing countries, Africa in particular. Haven't many studies illustrated the problem of the low acceptability of modern health care services in African countries? Isn't this in sharp contrast with the high utilization of traditional medicine?

Gradually I'm starting to realize that it is high time to translate the narrow bio-medical approach into a wider holistic concept, without losing the benefits of the former. Of course one may see many constraints to implement PCC. Not only patient but also health care providers are human beings. Lack of proper working conditions and long waiting queues do not always make it easy.

But that should not be an excuse. It all depends on the right mindset. PCC is about the difference between that comforting 'Please sit down and tell me…' to a young mother who looks very scared with her baby in her arms and the habit of asking 'What's his temperature?' while looking through the medical file. Evidence has shown that it takes about one minute for a patient to tell his/her story. Why then health care providers already tend to interrupt their patients after 18 seconds?

All depends on using the proper communication techniques and developing the right mindset.

So what are we waiting for?

Kathia van Egmond
Medical coordinator for Medics Without Vacation

Key note: Bart Criel - Patient Centred Care

Bart Criel introduced the workshop from a double perspective: on the one hand as a patient, a Belgian citizen who uses the health system and on the other hand as a medical doctor and public health practitioner and scientist in Belgium and in Sub-Saharan countries. Patient-centred care requires a wider bio-psychological focus with the patient as a person, a human being at the centre.
A balanced power and accountability relationship between the patient and the practitioner is important to avoid misunderstandings: PCC aims at a better understanding of the patient (by decoding his expectations and requests) and the nature of the problem (the diagnosis) to come to an acceptable treatment that fits the patient's habitat.

Studies about the acceptability of health care services reveal that a lack of attention for the patient's demands and expectations, a poor continuum of follow-up between the moment of arrival at the hospital and care and an almost dehumanized standardization are at the core of the low use of health care services. A strong patient expression 'they don't even look at you…' says enough.

In 1993 Paul Bossyns did away with the classical excuses of PCC as a utopia in Africa. PCC is a complex concept playing on the individual, organizational and cultural and structural level. But with the right mindset and integration in the medical curriculum it is feasible to apply PCC as well in the North as in the South. PCC is about a synergy, a synthesis, a combination of the community-based approach of the South and the individual patient-centred care approach in the nord. Both can learn and mutually benefit from exchange. Hence PCC has a universal value and is the key for an uptake, utilization and trust in health care services.

Research about PCC has two main challenges: on the level of the offer of care, we need to find out under what conditions (methodology, organization…) PCC is acceptable for all stakeholders (best practices). On the level of the demand for care, we need to further study the impact patient and community empowerment have on the offer of care.

An enlightening talk on the complex matter of PCC with reverberating echoes during all of the workshops.

An Appelmans, Institute of Tropical Medicine Antwerp

Coffee break...

... resuming the discussions

Key note: Maria Zuñiga - Community Empowerment

The regional committee for the promotion of community health (RCPH) is a network of Primary health care programs in Central America. The major objective is the democratization of knowledge and participation in decision-making about health in communities. The activities are basically directed at community-based health workers and includes training, technical assistance and monitoring of local health initiatives by and for communities. By working this way RCPH enables the expansion of health services to marginal populations and the poor in the region. The RCPH emphasizes the need to deepen the relationship between community health and people's right to health and health services. Besides, RCPH stimulates youth from grassroots communities to get actively involved in advisory and decision-making structures at national and regional level.

Peter Decat, International Centre for Reproductive Health – University of Ghent

Fish Bowl 1: Claudia Hanson
People Centred Care and sexual and reproductive health

Claudia Hanson presented EQUIP, Expanded Quality Using Information Power to improve maternal and neonatal health, a FP7 funded intervention and operational research project in Tanzania and Uganda.

Rationale of the EQUIP project: Effective intervention packages are known, but taken up insufficiently by those in need. E.g. Skilled birth attendance. Young pregnant women and their families do not find the accessible and acceptable services.

Services and their uptake can be improved through information. That information can be obtained by doing surveys on services in health facilities and households' expectations. Information dissemination projects show a positive effect on services (e.g. health worker presence) and impact (e.g. under five mortality).

EQUIP plans to reanimate the existing but non-functioning health village committees as a conduit to advise the health facilities with the information received. Participants were invited to give feedback on whether this is the best way.

Elements from the Fish Bowl discussion:

- Should the role of the community be limited to advise / explain their problems (as is mostly the case), or should they co-manage, co-decide on the appropriate solutions?
- Gender issues: clients here are mostly young women. How to make them talk, how to get their input? Input from husbands and mothers-in-law should obviously be obtained , but we should not forget the young women themselves.
- Health committees may not be the best or only tool for community participations. Other experiences/suggestions are community health workers, village assemblies, existing and functioning groups from the community such as farmers groups, cooperatives
- Financial input, for an emergency fund or a support fund for improved services may also improve community implication.
- Training of health workers should be improved (e.g. nursing student learn to nurse, not to prescribe or to negotiate with the community; medical students learn clinical skills, but not communication, management, cultural competence...)

Tine Demeulenaere, Damien Foundation

Fish Bowl 2: Raoul Rottiers & Marleen Goossens People Centred Care and Diabetes

Diabetes takes an increasingly important place in health problems in SSA. The importance of the disease in Africa is significant because of its increased prevalence from 7.3 to 14.1 million cases between 1995 and 2010, a 93% increase. Probably the figures are underestimated because of insufficient information and diagnostic tools. Diabetes has become a public health problem in these countries, recognized by both national authorities and the WHO. Unfortunately, there is a wide gap between the political rhetoric and the implementation of preventive actions and case management of cases.

Medics Without Vacation's project 'Diabetes in Africa' aims at reducing that gap. It operates in the Democratic Republic of Congo and its actions include all aspects of care for diabetic patients: (1) lifestyle (2) food, (3) medication, (4) capacity building. Capacity building is done through training of health personnel, patients and families.

The fish bowl discussion showed the following consensus:

- Strategies for capacity building must go hand in hand with a holistic approach taking into account other health issues. It also calls for a broader debate on the issue of human resources in our countries.
- The fight against diabetes must underwrite an integrative approach as much as possible to limit further fragmentation of health systems.
- The experiences of several countries in Africa show that the stigma surrounding the disease remains strong. Hence the importance of a people-centered approach as it integrates the management of patients with dimensions that go beyond the biomedical.

Isidore Sieleunou, PhD student at the Institute of Tropical Medicine Antwerp (Cameroon)

Fish Bowl 3: Nele Rasschaerts & Eline Scheire Communication in Health

Nele and Eline, two dynamic medical masterstudents from Ghent University shared the findings of their thesis: they closely studied the doctor-patient communication from the patient perspective in a health centre in Nicaragua. Implementation of a new health care model provided them with the opportunity to take a closer look at the impact the model has on the doctor-patient relationship and more particular on the communication. For the patients three aspects turned out to be crucial: first that they were listened to, second that a diagnosis was made and third that they got a clear explanation. The patients felt they were not actively enough involved in the decision-making process on the treatment and lacked information and communication about different treatment options and adverse effects. The fish bowl discussion immediately picked up that continuity of care has a positive effect and claimed that that is not restricted to the patient-doctor relation. PCC ideally reverberates throughout the entire health system, starting from the hospital guard who welcomes the patient at the hospital gate. An average waiting time of 2h36 per patient evoked an interesting discussion: not only the patients feel 'they [doctors] don't even look at us' but the practitioners too feel left out as it is not easy to consult patients in an optimal way when waiting queues stand in front of their door every day.
Communication in health is crucial for the well-being of patient and doctor and preferably in a well-organised health system.

An Appelmans, Institute of Tropical Medicine Antwerp

Fish Bowl 4: Fanny Polet – Community Empowerment

Gabriela is a platform in the Philippines that brings together various women's organizations. Its objective is to organize communities so as to encourage them to take destiny in their own hands. To get in touch with the people, Gabriela's organizations provide training in primary health care and courses regarding social determinants of health.

The workshop was attended by several witnesses on the issue of women empowerment, especially in Africa. During the lively discussion they agreed on the fact that education and training of women about rights is important, although for some the effect is limited if the underlying causes are not addressed, such as economic empowerment of women.

Some believe that the presence of women organizations does not necessarily improve access to health services and their quality. African women often organize themselves to improve their individual situations or to find answers to their specific needs, without questioning and defending their rights and common interests.

True empowerment comes from the base and local leadership is essential. Empowerment cannot be 'imposed' by an external actor, it is about creating the right environment through which people feel secure enough to defend their rights. Health is a multi-sectoral and multidimensional field and joint action on the determinants of health (agriculture, work, housing, education, etc.) to improve the health of communities is crucial.

Anuschka Mahieu
Intal, Partners & Policy

Key note: Myriam Deveugele – Promoting communication in health: local approaches for global principles.

1. The science of communication, its importance and consequences. The communication patient-practitioner has always been important. Effective communication is a central clinical function that a doctor cannot delegate. **Communication is related to satisfaction**. Research shows that most doctors interrupt the patient to direct him/her towards the medical aspect, cutting his telling the story. **Communication is related to compliance.** The doctor must ask his opinion on the treatment and let him decide. Language must be clear and understandable. The patient has to be explained aboutgth, diagnosis, about what he can do, and about side effects of the treatment. **Communication is related to the outcome**: Good communication in health practice results in a better health outcome. There is a proven need to listen to the fears, stress and to read carefully the complaints. Empathy is not enough. Communication must be patient/people centred ("What would you like?"), integrated and contextualized..Talking is not communicating. Skills need to be learned and practiced and should be integrated in the curriculum of nurses and practitioners.

2. Communication between a health provider and a patient from a different culturt. D study on migrant patients in Belgium found out that language is more important than culture. It suggests that if both patient and doctor have a good knowledge of a common language the medical outcome will be better. But if the knowledge of a common language was poor, the result was disastrous. It is important to learn the communication behaviour of the local people.

3. Nicaragua as an example. The University of Ghent carried out a communication training for health providers of public health centres. Videos taken in consultations wer, reviewed with the practitioners. Feedawas given and role play practiced. Communication skills wers kills taugh: to ask open questions and to explore the needs of the patient.

Also in Nicaragua patients prefer a patient centred approach with shared decision making. They want to have a voice in the conversation and to tell their whole story. Patient and doctors' frameworks of communication are parallel. While the patient wants to tell his unique experience of the illness, his feelings and expectations, the doctor agenda is centred on the disease, medical history, physical examination and laboratory investigation to find out the diagnosis and to propose a treatment. Both agendas have to be integrated, with the doctor taking time to listen to the patient agenda.

4. Conclusion. The Nicaragua experience arose interest in communication in health practice among health providers, university teachers and health authorities . We learned that Communication skills as taught at European universities can be useful for other countries and cultures as long as the different contexts are taken into account. It is possible and meaningful to train doctors in other countries on patient centred communication and shared decision. Skills need to be rehearsed. One day, communication mighy be introduced as a discipline in the medical curriculum all over the world.

Begona Inarra
Africa Europe Faith and Justice Network

Food for thought

The single biggest problem in communication is the illusion that it has taken place
(G.B. Shaw)

The way we communicate with others and with ourselves ultimately determines the quality of our lives
(A. Robbins)

Save the date

Regional seminar on health systems strengthening,
12 – 15 September, Gisenyi, Rwanda, a collaboration with the Belgian Technical Cooperation

Seventh annual seminar on Social Determinants of Health: 15-16/12/2011

Half of the participants were master students from the South. On the photo: the Masters of Disease Control students of ITM.

Be-cause health is a pluralistic network of both individual and institutional members such as NGOs, academia and public services, who consider health and health care as fundamental human rights. Current themes and working groups: human resources for health, access to quality medicines, sexual and reproductive health, people-centered care, social protection and universal coverage, HIV/AIDS, social determinants of health and cooperation in RD Congo.
www.be-causehealth.be