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ARI NIEMINEN & ARJA SUIKKALA (EDS.)

TOOLS FOR WELLBEING AND DIGNITY II

Developing multi-professional collaboration competence among the disciplines of nursing, social work and microbiology

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Developing multi-professional collaboration competence among the disciplines of nursing, social work and microbiology

Diaconia University of Applied Sciences
Helsinki 2022

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ABSTRACT

Ari Nieminen & Arja Suikkala (eds.)

TOOLS FOR WELLBEING AND DIGNITY II
Developing multi-professional collaboration competence among the disciplines of microbiology, nursing and social work

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The ability to cooperate with each other is a crucial skill for people and their propensity for thriving, along with their well-being. When it comes to the well-being of others, it necessitates that humans are approached as integrated human beings and not as loose mixtures of bodily, medical, social, and other elements. Enhancing people's well-being requires cooperation and a holistic approach.

This book offers conceptual and practical tools for the holistic enhancement of wellbeing and dignity in higher professional education, learning, and cooperation. Hence, a multi-professional perspective is the central approach in this publication. Originally, this book was written to offer learning material for professional education in Vietnam and Nepal, but it may well offer usable contents for education elsewhere as well.

The book is divided into four parts: Part one concentrates on utilizing multi-professional teamwork and simulations as a method of teaching and learning it. Part two describes the usage of qualitative research methods for health and social professionals. Part three illuminates how communities can be developed with appropriate methods, co-creation, and innovations, in which the active participation of community members is stressed. Lastly, part four offers practical tools for holistic work in distressing situations.

Keywords Higher Education Pedagogy, Multi-profes¬sionalism, Teamwork, Simulations, Co-creation, Co-development, Qualitative Research Methods

CONTENTS

Ari Nieminen

INTRODUCTION: TOOLS FOR WELLBEING AND DIGNITY

In general, it seems that the ability to cooperate with each other is a crucial skill for people and their propensity for thriving, along with their well-being. This idea can be verified by historical observations that even societies with poor natural resources have been able to guarantee decent living conditions to their members, whereas the lack of cooperation and internal or external conflicts have made this unattainable.

Education is one of the means of enhancing cooperation, well-being, and dignity that often result from it. In this book, we offer conceptual and practical tools for enhancing well-being and dignity in higher professional education, learning, and cooperation. An important point of departure in this publication is that because individuals constitute integrated beings rather than loose mixtures of bodily, medical, and social elements, it is reasonable to combine nursing, social work, and microbiology perspectives into a holistic, united framework. Hence, a multiprofessional perspective is the central approach in the following pages. This book was written to offer learning material for professional education in Vietnam and Nepal, but we hope that it will offer usable contents for education elsewhere.

This book is divided into four parts: Part one concentrates on utilizing multiprofessional teamwork and simulations as a method of teaching and learning it. Part two describes usage of qualitative research methods for health and social professionals. Part three illuminates how communities can be developed with appropriate methods, co-creation, and innovations, in which the active participation of community members is stressed. Lastly, part four offers practical tools for holistic work in distressing situations.

There is another publication related to this one: "Tools for Wellbeing and Dignity I. Curriculum for multi-professional cooperation in nursing, social work and microbiology." Tools for Wellbeing and Dignity I describes contents, pedagogical principles, and teaching methods for holistic and multi-professional education. The curriculum includes six study units, and the subjects of these study units con-

stitute bases for the contents of the book at hand. In other words, chapters in this book concretize the curriculum described in Tools for Wellbeing and Dignity I.

The book at hand and the curriculum were created as a cooperative endeavor by the DVINE project team (Holistic tools for competence-based curricula to promote Dignity in Vietnam and Nepal). The DVINE project was financed by the European Union´s Education, Audiovisual and Culture Executive Agency (EACEA).

Partners of the DVINE project consortium were: Diaconia University of Applied Sciences (Diak), Finland; Gazi Üniversitesi (GU), Turkey; Hue University of Medicine and Pharmacy (HUMP); Vietnam; Hue University of Sciences (HUSC), Vietnam; Patan Academy of Health Sciences (PAHS), School of Nursing and Midwifery, Lalitpur Nursing Campus (LNC), Nepal; St. Xavier's College (SXC), affiliated with Tribhuvan University, Nepal; and VID Specialized University (VID), Norway.

We hope that the following chapters provide useful approaches, tools, and contents for higher professional education!

Ari Nieminen & the DVINE project team

I
LEARNING MULTI-PROFESSIONAL TEAMWORK THROUGH SIMULATIONS

Lauri Uljas, Phuong T. A. Huynh, Tiina Ervelius and Arja Suikkala

MULTI-PROFESSIONAL TEAMWORK IN SOCIAL WORK HIGHER EDUCATION – STUDENTS' EXPERIENCES OF MULTI-PROFESSIONAL SIMULATION

Multi-professional teamwork plays an important role in promoting the provision of high-quality health care and social services, particularly while working with people with diverse needs and long-term conditions. While collaborative practice in supporting people with diverse needs plays a vital role in social work, multi-professional teamwork is still not a key concept in social work education in contrast to healthcare education. Therefore, the aim of this chapter is to highlight the importance of multi-professional teamwork in social work practice and education through describing Finnish and Vietnamese social work students' experiences during multi-professional simulations.

Multi-professional teamwork in the field of social work and health care and education

There are multiple definitions of multi-professional teamwork, but fundamentally, multi-professional teamwork refers to bringing together the expertise and skills of different professionals in delivering the services that benefit the service users. In other words, it relates to a group of individuals who belong to separate professional groups or different disciplines with a professional group, working together towards the same aim; to meet the complex needs of service users (Jasemi et al., 2017). The composition of a multi-professional team varies, depending on delivery models and settings. In conventional healthcare settings, multi-professional teamwork takes place mostly with health-related professionals, including, e.g., physicians, nurses and physiotherapists. In fact, the health problems and needs of the healthcare clients are diverse, as there is a wide range of physical, emotional, social, and spiritual dimensions. Therefore, multi-professional teamwork should include the

group of members with diverse expertise, including specialist physicians, nurses, occupational therapists, pharmacists, social workers, and so on (Social Care Institute for Excellence, 2018).

It is increasingly agreed that multi-professional teamwork is an important aspect of social work because a more holistic approach is needed in order to be able to solve problems for clients. People and systems are complicated, so any interventions designed to deal with their problems should be based on a multi-disciplinary and multi-agency perspective. Multi-professional teamwork occurs when a team of specialists from different helping professions join the social worker to provide appropriate services to those clients and patients in need. For instance, a physician provides medical treatment for patients, but patients can have psychosocial struggles related to their family and childcare, or face financial costs related to their treatment, so they may benefit from receiving help by a social worker. In these cases, a social worker can give first-hand psychological aid, advocate for the families, inform them of their options, and connect them with financial assistance.

Creating and offering multi-professional teamwork opportunities in higher education can be good, particularly for social work students (Kobayashi & Fitzgerald, 2017). Firstly, these opportunities provide social work students with the opportunity to learn how to collaborate and navigate complex interactions within the multi-professional team context. Secondly, they help social work students imagine the importance of social workers as essential parts in collaborative care teams, particularly in health care settings (de Saxe Zerden et al., 2018). Social workers can have many specialities, but they need to collaborate with a wide range of professionals while supporting their clients. For instance, a health care social worker needs to work with primary care physicians, physician specialists, nurses, and home caregivers to be able to provide cohesive care services for older people, thus improving their quality of care (Melin Emilsson et al., 2022).

Simulation as a teaching method in social work and healthcare education

Social work education combines the teaching of professional and theoretical knowledge with the development of practical skills and experience (Boisen & Syers, 2004). Despite that, curriculums are often predominantly compartmentalized in such a way that professional and theoretical knowledge is largely taught in the classrooms, while practical skills and experience are mostly developed in workplace settings (Meredith et al., 2021).

Simulation is a teaching method that places students in scenarios where they can put their learnt knowledge into practice to actively solve the problems of real-life situations. In health care, simulation as a teaching and learning method has been a part of curricula for a long time, and it has been continually evolving nowadays (USAHS, 2021). Simulations can be held in different kinds of learning environments, ranging from classrooms to spaces built specifically for simulation practice. They can also involve individuals trained to portray the roles of service users, their family members, or others. Keeney et al. (2019) have highlighted simulation as a creative teaching method in social work education to achieve knowledge and competences. In the context of social work education, there is a rising interest in using simulations as a teaching method, even though there is still very little academic discussion and references about simulations as a teaching method in the field of social work. Through their involvement in simulated scenarios, social work students develop themselves as professionals by gaining critical theoretical knowledge and achieving relevant working skills.

Implementation of multi-professional teamwork simulation

In collaboration with higher education organizations in Nepal, Vietnam, and Finland, we designed and implemented a scenario of multi-professional teamwork in social work and health care using simulation as a key teaching method. During this process, the students in social work, interpreting, and health disciplines from different countries attended theoretical lectures and practical simulations, where the professionals in social and health sectors worked together to deal with the problems of a patient in a hospital setting. The implementation of the simulation session took place in November 2021 through an online platform between Hue University Sciences, Hue University of Medicine and Pharmacy, Kathmandu ST. Xavier's college, Kathmandu Lalitpur Nursing Campus, and Diaconia University of Applied Sciences (Diak).

The online simulation via Zoom was organized by Diak's lecturers in healthcare, social services, and in Finnish Sign Language and AAC interpreting. A total of 31 social work students from Finland and Vietnam participated in the simulation along with nursing students from Finland, Nepal, and Vietnam. The social work students engaged in the simulation in both direct and indirect ways; i.e., one student in Finland directly took up the role of a social worker in the simulated scenario, whereas the rest of social work students played as the observers.

The simulation scenario

The patient is a 41-year-old woman on rehabilitation support, living with her deaf 7-year-old child. The woman has a Bachelor of Social Services degree by profession, not currently at work. The underlying disease is the swelling and tenderness of joints (arthritis), chronic respiratory disease (exertional asthma), and pain and tenderness in the right knee (osteoarthritis). She has had chronic pain all over her body for a long time.

For a few days, the patient has suffered from headaches focusing on the right side. Pain disappeared at times, but returned. Now the patient's VAS scoring varies, with its worst at grade 8–9. The pain can be rated by a visual analogue scale (VAS) by numbers 1–10. Number 0 means no pain at all, and number 10 is the most severe pain. The patient's right side of her face is numb, as well as numbness on the front of both hands and feet. The left hand does not move normally; the extension deficit and restricted movements. As symptoms worsen, the patient has called an ambulance. The patient's headache is getting worse from any movement, sound, and light. Speaking is also difficult and abnormal; whole sentences have been hard to speak. Focusing with eyes is not normal either.

The patient has had addiction problems. In the emergency unit, she was worried about her deaf child, who was coming home at that same time from school. Nurses of the emergency unit contacted a social worker, while the patient contacted a deaf family that was a supporting family for the daughter. The social worker also organized safe travels for the daughter to the supporting family.

The main purpose of the simulation was to improve communication between the patient, nurses, social worker, and interpreter to minimize errors during surgery, prescription, crisis interventions, and general practice. This was a totally new practice in Diak, where nursing, interpreting, and social work students from three campuses took part in a simulation online. At the Oulu campus, there was a patient with a deaf daughter; nursing students in healthcare staff roles took care of the patient in the emergency unit, whereas the social worker student was involved in the simulation at the Helsinki campus, and a deaf support person was available for the daughter at the Turku campus. This online simulation scenario was a very realistic situation in a case where an intoxicated person is being treated in the emergency unit of a hospital.

Social work students' experiences of multi-professional teamwork simulation

In the online simulation, social work students learned new skills. According to our survey, most of the social work students were satisfied with their own role in the online simulation and with their own learning. A few students, however, would have preferred to have more of an active role in the simulation than they actually did. In addition, five social work students were interviewed to explore two key questions: (i) How is multi-professional work important for social workers/social work students? (ii) What are the challenges for social workers/social work students in collaborating with a wide range of professionals? Below are the key responses from the students of social work at Hue University of Sciences (HUSC):

> *I think multi-professional work is very important in supporting disadvantaged individuals and groups for some reasons. For instance, it can help people be more responsible in their work because when we work with other professionals, you cannot stop or delay while the others are working. In addition, it helps to have more relevant solutions for the problems of the clients. It is also a dignity approach. (Student A, Hue University of Sciences).*

> *For me, multi-professional work is very important because we can work and link with others from different disciplines. For instance, the collaboration between a nurse, a social worker, and a psychologist can be more effective to have a treatment plan for a client with both physical and psychosocial problems. (Student B, Hue University of Sciences).*

> *From a social work perspective, I think multi-professional collaboration is really important because it can help us have more appropriate interventions for the clients. More importantly, we can know and connect more resources for supporting clients properly. I can also learn from other professionals for their expertise. (Student C, Hue University of Sciences).*

Despite the recognition of the importance of multi-professional collaboration, the social work students stated some challenges for the effectiveness and sustainability of this approach in practice. The challenges are listed below:

> *Social work students are lacking communication and connection skills in promoting and collaborating with other professionals.*

> *The working environment in Vietnam is not ready for multi-professional work, particularly in health and social care.*

> *The understanding about a multi-professional approach among the stakeholders is limited, leading to their conflicts and lack of collaboration.*

Most of the students recognized the importance of multi-professional teamwork in social work practice and education. However, they also expressed the challenges of applying multi-professional teamwork in practice due to the culture and understanding of stakeholders. In addition, during the engagement in simulation, the social work students in Vietnam faced some challenges, mostly related to their English skills and internet access, which is reflected in the following statements:

> *English skills of social workers/social work students are very limited, which hindered the collaboration with the students and teachers.*

> *The lack of or limited access to equipment and internet connection for learning and practicing multi-professional work, particularly in the COVID-19 pandemic, is a real challenge for us as the students. We could not communicate well with others and fully understand the lectures.*

Stimulating multi-professional collaboration through the use of a simulation

This chapter described and discussed multi-professional teamwork from the perspective of social work with a case of simulation in a hospital setting, highlighting

the importance of seamless multi-professional collaboration in holistically solving the problems of the client. In order to provide better care for people with diverse needs, a wide range of professionals with different expertises should work together, and social work professionals should have a key role as well.

The multi-professional simulation experience gave us a new perspective in understanding a multi-professional approach as one of the key concepts for organizing a larger and deeper cooperation between the disciplines of nursing, microbiology, and social work without forgetting sign language or alternative and augmentative communication (AAC) methods. According to students' feedback, we were able to realize that multi-professional teamwork with simulations motivates social work students, and helps them to learn necessary academic skills and competencies. In their future professional career as social workers, they will most likely benefit from this new and creative experience.

REFERENCES

Boisen, L., & Syers, M. (2004). The integrative case analysis model for linking theory and practice. *Journal of Social Work Education 40*(2), 205–217. https://doi.org/10.1080/10437797.2004.10778490

de Saxe Zerden, L., Lombardi, B. M., Fraser M. W., Jones, A., & Rico, Y. G. (2018). Social Work: Integral to Interprofessional education and integrated practice. *Journal of Interprofessional Education and Practice 10*, 67–75. https://doi.org/10.1016/j.xjep.2017.12.011

Jasemi, M., Valizadeh, L., Zamanzadeh, V., & Keogh, B. (2017). A Concept Analysis of Holistic Care by Hybrid Model. *Indian Journal of Palliative Care*, 23(1), 71–80. https://doi.org/10.4103/0973-1075.197960

Keeney, A., Hohmana, M., & Bergman, E. (2019). Interprofessional Education: A Poverty Simulation with Elementary Teachers and Social Work Students. *Journal of Teaching Social Work 39*(2), 148162. https://doi.org/10.1080/08841233.2019.1586808

Kobayashi, R., & Fitzgerald, C. (2017). Teaching note –Asserting social worker's role in developing an interprofessional education project. *Journal of Social Work Education, 53*(4), 737–743. https://doi.org/10.1080/10437797.2017.1284627

Melin Emilsson, U., Strid, AL., & Söderberg, M. (2022). Lack of Coordination between Health Care and Social Care in Multi-Professional Teamwork – the Obstacle for Coherent Care of Older People Suffering from Multi-Morbidity. *Journal of Population Ageing 15*(2), 319–335. https://doi.org/10.1007/s12062-020-09300-8

Meredith, C., Heslop, P., & Dodds, C. (2021). Simulation: social work education in a third place. *Social Work Education.* https://doi.org/10.1080/02615479.2021.1991908

Social Care Institute for Excellence (2018). *Integrated care research and practice.* Accessed through https://www.scie.org.uk/integrated-care/research-practice on May 07 2022.

USAHS (2021). *How Simulation in Education Benefits Students and Patients.* https://www.usa.edu/blog/simulation-in-education/#:~:text=Educational%20simulation%20is%20a%20teaching,for%20hands%2Don%20learning%20experiences.

Ulla Niittyinperä, Minna Partanen-Rytilahti,
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MULTIDISCIPLINE SIMULATIONS – THE EXPERIENTIAL APPROACH OF TRAINING NURSES AND INTERPRETERS TOGETHER

This article aims to describe the multidisciplinary simulation scenarios, which were implemented in cooperation with nursing and interpreter lecturers, and as a pedagogical approach, it outlined interpreting exercises inside the simulations. Teaching methods exploited the simulation pedagogy and cooperative learning with the goal of teaching new skills and knowledge to nursing and interpreting students. Overall, students viewed the multidisciplinary simulation with real deaf customers as a more authentic and motivating experience than without an experienced person. Moreover, challenges, e.g., how to visualize the guidelines, how to settle in the simulation of care, and to whom the speech should be directed, were met.

Different levels of simulations

The simulations can be divided according to how they correspond to reality, and how well they are faithful to it. Yaeger et al. (2004, p. 328) divides the simulations into low, middle, and high-level simulations according to the level of the reliability. *Low-level simulations are* used when students watch the signed videos and train their individual skills. The *middle-level simulations* are used when organized and acted role plays are included in exercises. Then the situation is more realistic, but does not require the full preoccupation of the student in the situation. Exercises could also be videos. The video could be a 360-degree video, which means that a video is filmed by using multiple camera lenses with overlapping angles simultaneously. The 360-degree video technique has been tested in the interpreter trainings, and these videos develop more realistic situations. (Järvinen & Ekola, 2014.)

In the *high-level simulations*, as multidiscipline simulations, the participants must react in some way to the interpreter's actions. The challenging elements are

added to the high-level simulations. These elements can be technical equipment, the real-life place, an expert participating in that scenario, or a deaf person taking part in the simulation. All these add cognitive challenges for the interpreter because they require the interpreter's attentiveness to be divided into different targets. Additionally, the interpreter has the responsibility to check that everyone understands each other, and the interpreter is taking care of the technical equipment during interpretation. For example, in remote interpreting settings, the headset can be a disturbing or beneficial element for the interpreter. To give an example, interpreters may point towards the headset during interpretation, or they orient towards it in other ways (positioning, gesturing, or using their direction of gaze), or they are holding it.

The different roles in simulations

Role play is a commonly used teaching technique and learning activity from the 1980s, which spontaneously acts out a certain situation. Students assume an active role to practice a variety of skills. Role play can be used as a testing method, an educational method, or a research method (Dahnberg, 2015, pp. 29–31). Role play was a part of this multidisciplinary simulation. Role play can help explore interpreter-related turn-taking and repair mechanisms, and it aims to find out whether these are affected by the presence and absence of a script (Dahnberg, 2015, p. 184). The problem regarding the authenticity of role plays for training purposes is a question about authentic interaction. Exploring role plays is essential for noting the difference between closed (scripted) and open (non-scripted) role plays. Since the role plays in multidiscipline simulations included preparation materials for nursing students about the patient and the scenario, it was not totally an open role play. It had parts of non-scripted and spontaneous talk, along with parts of scripted talk that was integrated in the simulation. Spontaneous oral language is characterized by repairs and restarts, overlapping talk, and elliptic expressions, so it is a very different language mode than written language. The interpreter's coordinating role is reduced by the presence of a script (Dahnberg 2015, pp. 185–189).

Utilizing experts of experience is beneficial in simulations. When deaf people are taking part in the high-level simulation, it adds social challenges and unpredictability. Going to real-life places increases mental stress. For example, the interpreter needs to find the right entrance to the hospital at the appointed time, and the interpreter should decide where to stay in a public place or during an operation. The most difficult stage of the *higher-level simulations* contains more than

one challenging element: technical equipment, deaf person, place, audience, or evaluation. For example, the final examinations at Diak are extremely heavy-laden for the students. In final examinations, they meet the real customer in an examination situation and there is also a lecturer as an evaluator. Furthermore, the situation is recorded by the lecturer to add validity, and to help the lecturer to carry out the evaluation. The test reliability is controlled by using scripts in tests, and dialogues are the same to all interpreter students.

Pedagogical approach in simulations

In this article, the concept of "multidiscipline" has been chosen to describe a team-based approach in health care simulations. Health systems around the world are struggling with multiple health system challenges. Aging populations and increasing numbers of clients with complex health conditions need team-based treatments. Health care teams are described with the terms "interprofessional," "multi-professional," "interdisciplinary," and "multidiscipline." The term "multidiscipline" is more frequently used than other terminology to describe health care teams (Chamberlain-Salaun et al., 2013).

The multidisciplinary simulations involve the practice of cooperative learning, scripted scenarios, and an interactive learning environment that imitates a real situation. Simulating reality gives a student an opportunity to practice and develop one's own skills in a safe environment. A topic in the simulation training of professionals is the integration of theory and practice, and how to organize motivational learning activities that prepare students for their future practice (Skaaden, 2013, p. 13).

The pedagogical approach is based on constructivism, and influenced by cooperative learning (Johnson & Johnson, 1986, 2009) and simulation pedagogy (Jeffries, 2005). Cooperative learning research about the student's interaction shows that when they work together, it is much more powerful than working alone. Students are motivated to learn and develop more positive attitudes while working together. These findings suggest that lecturers should structure more of their teaching into heterogeneous and cooperative groups. (Johnson & Johnson, 1986.) Cooperative learning has been an instructional practice in educational psychology. Knowing that one student's performance affects the success of the group seems to create responsibility forces that increase the student's efforts (Johnson & Johnson, 2009, pp. 365, 367).

Simulation pedagogy has roots in nursing education, and it emphasizes opportunities for using simulation-based learning (Jeffries, 2005, p. 96). As simulation pedagogy uses active learning strategies and student-centered learning, it has been adopted in medical education as a method to learn skills for life-threatening situations. It was later introduced to the training regarding the entire treatment, and the entire team that was required for providing the treatment. Clinical simulation offers ways to teach students about the real world of nursing in a cost-effective, efficient, and high-quality manner. Multidiscipline simulations are discovered to be well-suited for nursing education, as they prepare nurses for safe and efficient practice in various settings. Health care settings have become more technical, and quick decision-making in treatment situations and multi-professional cooperation are needed (Poikela & Poikela 2012, p. 10).

In simulation, the team can include assisting staff members, nurses, and interpreters. The scope of learning outcomes extends beyond mere acute treatment situations, as it also involves interaction, ethical issues, and patient guidance. To ensure a successful simulation learning experience, the lecturer must provide a supportive climate where students feel valued, respected, and free to learn in a dignified environment and follow the idea of positive pedagogy (Poikela & Poikela, 2012, p. 10). Multidiscipline team-based simulation exercises are being used to promote teamwork and communication among various members of the teams. In a similar way to its usage earlier in the aviation industry, this type of team-based simulation has shown promising results in improving teamwork and safety (Stroud & Jenkins & Bhandary & Papadimos, 2017, p. 104). Multi-professional education in interpreter training can create the conditions for interpreting students to develop a more insightful and reflective approach to their interpreting practice in the future (Krystallidou et al., 2017, p. 126).

Implementation of simulation scenarios

The authors work as lecturers in Diak and have faced a challenge that our students do not meet during their studies; they do not cooperate over the study programs, but after graduation, they need to cooperate in their working lives. That was one of the major reasons to choose a multidisciplinary approach in this experiment.

In Finland, persons with speech disabilities have the same legal right as deaf persons to use sign language interpreters in everyday life situations. Persons with speech disabilities use alternative and augmentative communication (AAC) methods. Finnish Sign Language (FinSL) and Finnish-Swedish Sign Language (Fin-

SSL) are the native languages used by the deaf communities in Finland. Sign language interpreters work in various settings, and many interpreting assessments are connected to health care. Sign language interpreters interpret simultaneously in both directions, speech to sign language and vice versa. For that purpose, Diak has a four-year (240 ECTS) degree program for both sign language (SL) interpreters and AAC interpreters. Moreover, Diak trains nurses in their Bachelor's Degree program in Health Care, Nursing. The successful completion of the program leads to qualification to work as a nurse in primary care, specialized nursing care, and social services in the first and third sectors and various international organizations. The program's extent is 210 credit points (ECTS).

Aims for the multidisciplinary simulations

Lecturers organized simulations for Diak's interpreter and nursing students. The special learning aims of the simulations for nursing students was to use test methods, along with initiating the care of the patient. The first was the ABCDE method, which was used in assessing the patient's clinical status (A/Airway, B/Breathing, C/Circulation, D/Disability, E/Environment, exposure, extra). The second method was the ISBAR (Introduction, Situation, Background, Assessment, Recommendation) reporting tool, which helps convey patient reports to other professionals in a clear, reliable, and safe way (I/Identify, S/Situation, B/Background, A/Assessment, R/Recommendation). The learning aim for the interpreter students was to improve their skills in preparation for interpreting settings in health care, and learn simultaneous interpreting strategies in a challenging situation. The aim was also to practice the interpreter's turn-taking strategies during the intensive dialogues.

In 2019, two senior lecturers of interpreting, two senior lecturers of nursing, 45 nursing students, and 15 interpreter students participated in the multidiscipline simulations in Diak. The group of nursing students studied in the last and 7th term, and the group of sign language interpreter students in their third year and 6th term participated in simulations. In the simulation, there were two interpreter students (IS1 and IS2). The interpreter lecturer (IL1), who is deaf and a native sign language user, played the role of the patient's relative. Two nursing students (NS1 and NS2) were taking care of the patient.

There were three different scenarios in simulations, and each of them lasted 4 hours. The simulation scenarios were 1) the patient had an ectopic pregnancy, 2) the patient had pneumonia and 3) the patient had a cerebral hemorrhage. In

scenarios 1 and 3, the role of the patient was not played by a human; we used a manikin that nursing students could treat safely during the simulation. In the simulation, the students were divided into groups that worked together for one day. When simulation is used as a teaching method, at least two lecturers are needed at the same time because one person is not enough to guide the simulation and make all the observations and notes. The lecturers made the division of the roles, and gave instructions for the simulation at the beginning. The simulation scenario about the patient who had pneumonia is visualized in Figure 1.

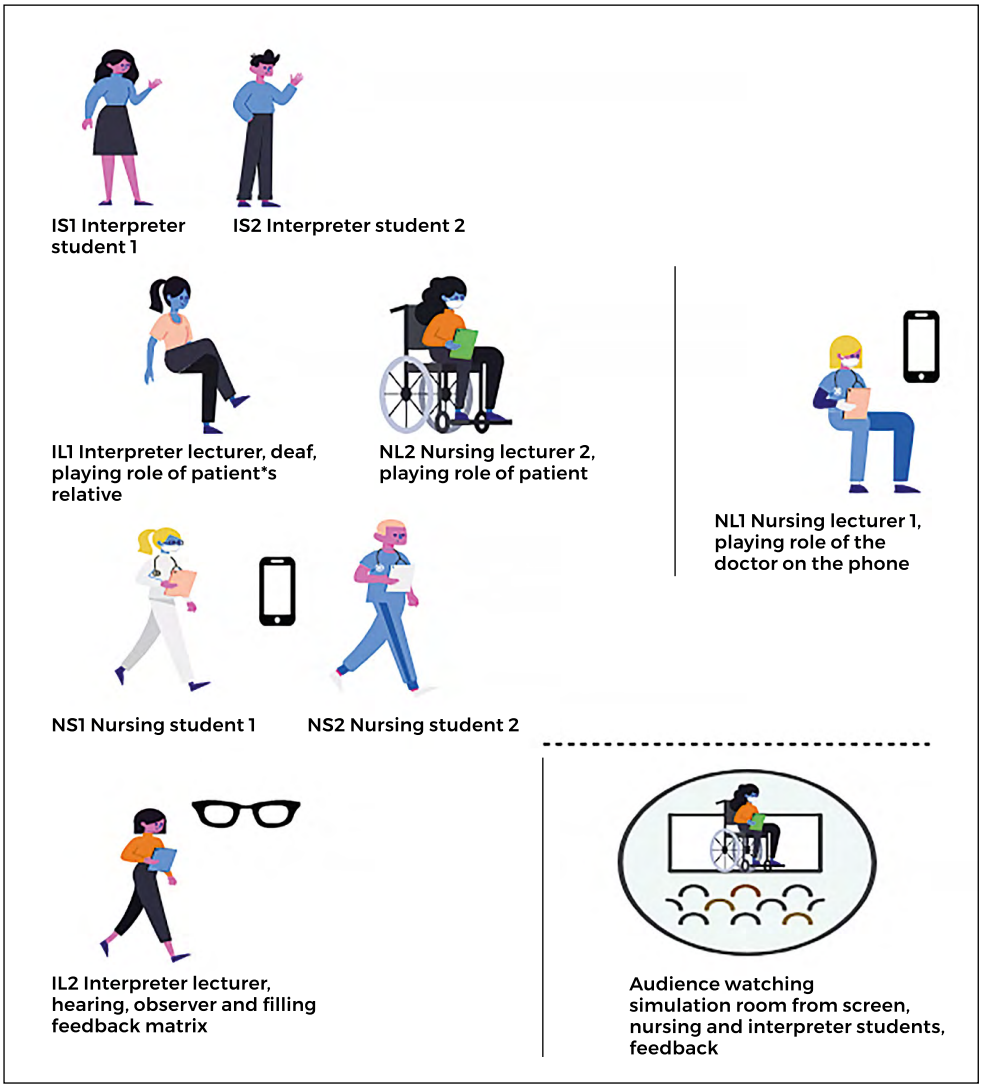

Figure 1. Participants of the simulation scenario where the patient had pneumonia

The nursing lecturer (NL1) was in a different room; she could see and hear through a window and microphones to observe what was happening in the simulation room, and she was playing the role of the doctor on the phone. The role of the patient was played by another nursing lecturer (NL2). The interpreter lecturer (IL2) was a hearing lecturer, and she observed the interpreters' work and filled in the feedback matrix (see Table 1.) regarding the interpreter students. The audience was following the simulation from a screen in a separate classroom. Other students were in the audience, and they had a task to write down feedback for the learning discussion.

Feedback matrix
Name:

Table 1. Feedback matrix for SL interpreter students about the multidiscipline simulations in 2019

Number	Attitude	Output, interpretation	Language skills and fluency
5	Professional behavior Appropriate behavior Brave to talk and meet people Helpful to other colleagues	Comprehensive and strict Equivalency No mistakes	Quick and fluent Smoothly produces signs Vocabulary under control in both languages (Fin, Fin SL) Excellent understanding of the source language
4	Brave Appropriate behavior Persistence	Mostly good equivalency No remarkable mistakes	Fluent Easily produces signs Sufficient vocabulary in both languages or skills to produce meaning in other ways Good understanding of the source language
3	Brave Appropriate behavior Persistence Does not give up in challenging parts	Quite good equivalency Some mistakes	Quite fluent Quite easy production of signs Quite sufficient vocabulary in both languages Quite good understanding of the source language
2	Brave Does not give up in easier parts	Lack of information Quite a lot of mistakes	Slow pace in producing utterances Slow production of signs Vocabulary is quite deficient Understanding of the source language is quite deficient
1	Tries to interpret challenging parts Does not give up Appearance and facial expressions show that the interpreter has problems in interpreting	A lot of information is lacking Many mistakes	Very slow pace in producing utterances Very slow production of signs Vocabulary is deficient Understanding of the source language is deficient
0/abandoned	Quitting the interpreting Does not try to interpret	There is no output	Does not understand the source language There is no interpretation

In the feedback matrix, attention was paid to the points that were related to the interpreter's situation management skills and the smoothness of the communication. During the simulation, the feedback matrix was filled for each of the interpreter students by the interpreting lecturer. The students did not get graded from that simulation, but they asked to get a numeral evaluation (1–5) as feedback to themselves about their interpreting skills and level.

Multidiscipline simulations as a teaching method

The multidiscipline simulations can be a teaching method that gives a student an opportunity to practice and develop skills in a safe environment. Multidiscipline simulations in health care settings are directed, interactive, and authentic learning situations. In multidiscipline simulations, it means that professionals from different training programs work together. The simulations can be organized, e.g., with nurses and doctors, or nurses with hospital priests and social workers. Multidiscipline simulations may be an excellent tool for contributing to better working conditions for interpreters, and better treatment and care for their customers. The multidiscipline simulations between the professionals are important places for discussion – and in them, inner values and attitudes arise.

Multidiscipline simulations can be used in the projects as an activity and learning experience. Multidiscipline simulations have been used in the Diak projects. The DVINE project promotes a multidisciplinary approach to developing curricula and the use of simulation pedagogy in health care education (Dvine-project, 2020).

Multidiscipline simulations can be researched with several methods. The research data about multidiscipline simulations in this article was collected from discussions and observing the simulations, interviewing participants, and sending questionnaires. Planning the multidiscipline simulation, along with its progress, was a process itself. The nursing students made introductions about the symptoms and illnesses beforehand, and the interpreter students listened to the introductions through the remote connection.

In our simulation, the interpreter students were able to prepare and find out the relevant lexicon and signs when performing a certain scenario. Multidiscipline simulations had three phases for the interpreter students: firstly, listening to introductions and preparing to interpret the scenarios; secondly, taking part in the simulation, including a learning discussion for one day; and thirdly, answering a feedback questionnaire.

The nursing students had a bigger role: they planned and presented introductions, and they had peer evaluation roles in the learning discussion. The nursing students who did not partake in the simulation were observers, and they wrote peer feedback to the participants about three different themes: a) systematic inspection by using the ABCDE -method b) consulting the doctor via the ISBAR-method c) communication with the patient and relatives. In regards to the following observations about communication, some examples are: how the nurses did their own introduction, how they showed empathy and noticed safety in the situation, and how they managed to tell the patient's situation to his relatives clearly.

Learning discussion in simulations

Learning discussion outcomes from both groups were written down in notes by all four lecturers and a feedback matrix by the interpreting lecturers. The feedback questionnaire was sent in an email to the interpreter students (15), and answers were classified in a qualitative way. In the learning discussion, the students described their experiences and evaluated their own roles, decisions, group work, and communication after the simulation. The learning discussion, which is kept after every simulation, is important and is identified as a critical element of the simulated clinical experiences. The learning discussion is a student-centered group discussion with active participation from each member. The primary goals of the learning discussion are: identifying strengths and areas for improvement using positive thinking, and utilizing a 3-step learning discussion to achieve a more holistic nursing experience. The 3-step learning discussion includes 3 phrases: description, analysis, and implementation. Firstly, the description phase collects what happened and a description of what students did in their own words. Secondly, the analysis phase identifies which emotions were involved, either individually or as a group, and which aims of the simulation were achieved and how they were achieved. Thirdly, the implementation phase identifies the different views formed by each student, and what students want to take with them for real life.

During the learning discussion, working methods can be repaired; for instance, theoretical knowledge can be increased, other matters can be checked, experiences can be shared, and feelings can be taken into discussion. This is similar to a learning model proposed by Kolb (1984) and others, which is introduced in Skaaden (2013, 2017) about facilitating interpreter students' roleplay and group reflection in an experiential-dialogic approach to learning skills. In the experiential learning model, the student's involvement is seen as a main thing in learn-

ing, and the idea is that students should make their own discoveries first, rather than hearing or reading about the others' experiences. These experiences must be observed, and reflection and dialogue are organized after the learning experience (Skaaden, 2013, p. 13).

Planning the multidiscipline simulations included scheduling the situations and planning the patient scenarios. The lecturers created different scenarios for every simulation. These involved cases of an ectopic pregnancy, pneumonia, and a cerebral hemorrhage. The important factors in scenario planning are: naming the patient, describing the patient's illnesses, and the planning of changes and symptoms, which will take place during the simulation. The changes can be controlled by the lecturers, e.g., the body temperature or effects of the treatment. In simulation, the patient can be played either by a person or a manikin. Simulation manikins have different capacities, and students can practice specific tasks or procedures. Manikins help students to learn the assessment of a patient by providing cues about vital signs, such as the pulse rate, the breath rate, or circulation. (Charnetski, 2019.) In the multidiscipline simulation of an ectopic pregnancy scenario, we had a deaf person playing the role of a patient, and in the cerebral hemorrhage scenario, the patient was a manikin, and the manikin's spouse was a deaf person.

The evaluation of the simulation was distributed to the students before the simulation. The evaluation and feedback for the interpreters were given by the deaf sign language lecturer and the interpreting lecturer in written form after the simulation. For the feedback, a matrix was drawn up (see Table 1).

In order to answer the following questions: 1) what knowledge and skills do students learn from multidiscipline simulations for their future working life, and 2) how can students develop their interaction skills in multidiscipline simulations, the data were collected in three ways. Firstly, the data collection included the learning discussions directed by questions from students and writing notes about these discussions; secondly, the feedback matrices written by the interpreter lecturers; and thirdly, it was conducted via a feedback questionnaire that was sent in an email to the interpreter students (15). The questionnaire data was classified in themes. All the data was examined by using a thematic analysis (Tuomi & Sarajärvi, 2018).

Student perceptions of multidiscipline simulations

The data showed specific points for interpreter students and for nursing students. Themes that came up repeatedly were: in both groups, students' experience in the multidiscipline simulation with a *real deaf customer was more authentic* and motivating, and the *appreciation of one's own profession* was raised up in the multidiscipline simulation. The respect and feedback of other students towards their profession was motivating and rewarding.

> *One feels more real when there is the deaf person, and she uses sign language. (Nursing student)*
> *This is so real. It is great to follow your professional treatment of the patients. (Interpreter student)*

The students in both groups learned to pay attention to the interaction. Students noticed the common habit that people are talking over each other, and how they need to remember the importance of listening skills. The nursing students recognized that they should avoid talking at the same time when another nurse is talking. The interpreter students learned that they need to control turn-taking, and divide the speakers that they are going to interpret, or use interpreting strategies by asking again what was said or asking nurses to speak one at a time. One theme in the discussions was that the interpreter student needs to separate the speakers more carefully, so customers know who is talking during the simulation. Having a certain kind of courage to communicate, along with empathy, turned out to be advantageous for the nursing students during the simulations. The nursing students described that the thoughts regarding visuality opened up in a new way. Also, questions about using a visual language and hands arose. For example, when a nurse is thinking about which hand the cannula is to be placed on, it would be excellent to ask the deaf patient which hand he/she prefers to use for signing. The last multidiscipline simulation had an inspiring effect on the nursing students, as ten nursing students wanted to participate in SL courses afterwards.

The interpreter students pointed out themes in the feedback questionnaire about the journey; they traveled from Turku to Helsinki, and back to Turku (360 km) during the simulation day. Nursing students did not travel. The interpreter students felt that the experience was worth the traveling. The interpreter students' opinion about the simulations were that the simulations were inspiring, and they

liked the simulations as a study method. The interpreter students described that it was interesting to take part in many patient case scenarios and to cooperate with the nurses.

The interpreter students described that it was extremely interesting to learn the nursing students' treatment and reporting methods. The students answered that it is important for the interpreter to know the ABCDE method, and how it is used in assessing the patient's clinical status. Also, the students described that knowing the meaning of the ISBAR reporting tool helped them to interpret in the simulation because it had the strict structure of the dialogue used in reporting. The learning discussion after each simulation scenario was described as rewarding by the interpreter students, but they hoped for more exact and more personal feedback on their own interpretation. The interpreter students also hoped that they would get more peer feedback from the nurse's point of view.

In the questionnaire, we asked the interpreter students about hopes for the simulations in the future. The interpreter students described that a part of the simulation can possibly be organized by a remote interpreting solution. According to their opinion, it is too valuable to be changed to a totally remote simulation.

The interpreting students advised nursing students in the learning discussion that during a conversation with the deaf patient, it would be good to have visual materials. For example, for estimating the pain, it would be helpful to have a visual scale from 1 to 10. It can be used with deaf patients, people with speech disabilities, and immigrants. Instead of talking about the pain, it may be easier to present the pain as a picture or a visual scale.

In the simulation, there was a deaf patient who used sign language as a native language. The usage of sign language raised many new themes to the nursing students' consciousness. During the learning discussion, the nursing students described that they got new information about deaf culture and visuality. Meeting the deaf customer helped the nursing students to imagine how to visualize their demonstrations of treatments. Nursing students found out in the learning discussion, that if the nurse shows a visual demonstration by her/himself on how to take, e.g., medicine at home as an injection on your own stomach, it is more visual for the deaf patient. When sign language interpretation is added to the demonstration, it is clearer after the visual demonstration for all participants how a special injection should be taken. It is also clearer for hearing patients if you get information in many ways – if you hear and see how you should give an injection to yourself, it may be easier to do so.

Furthermore, lecturers had discussions with the nursing student group about how shouting does not help when talking to deaf people. Rather, clear speech, mouthing, writing, or drawing may be a solution towards better communication. The nursing students' observations about the interpretations were interesting. They described that the interpreters were a small bonus, and it was nice to know more about interpreting, sign language, and the work of the interpreters. One of the students described that the interpreter is like a narrator of the message between the nurses and the customers. Furthermore, the students stated that it is nice to meet other students at Diak, and step outside their own bubble and comfort zone.

The nursing students discussed deaf people and persons with speech disabilities from a linguistic point of view during the learning discussion, and the patient's rights in Finnish health care. They learnt how to organize an interpreting service for the deaf, and for persons who use AAC-methods in communication in Finland. The nursing students discussed as to whom they are expected to talk, and the interpreter students informed that the customer is always answering the questions. The interpreter's role is not an assistant, and interpreters do not function as representatives of the persons they interpret for. The interpreter's role is defined by the code of ethics (WASLI, 2020). Furthermore, knowing the interpreter's working methods and role is an advantage for the nursing students. For example, it should be noted that the interpreter always interprets in the form of "I" or "me" when a deaf person signs "I" or "me," and the messages should be addressed directly to a deaf patient.

The nursing students' observations were discussed in the learning discussion about the specific themes: *inspection by using the ABCDE -method, consulting the doctor via the ISBAR-method, and communication with the patient and relatives*. The interpreter students took part in the learning discussion, and had an opportunity to partake in the discussion and comment on different phases from the interpreters' viewpoint. In the learning discussion, it is essential that the lecturers and peer students give constructive feedback to the students. It can be challenging and demands a confidential learning atmosphere.

We got feedback from both groups of students that we succeeded in creating an atmosphere of real situations and real dialogue. That can be explained by the circumstances that we were in, and by the students' competence. The simulation was organized in a highly technological simulation class at Arcada UAS in Helsinki. The classroom was like hospital patient rooms, and the manikins looked like living persons with clothes. The students who were not involved in the roles of the simulation followed the simulation through a video, which was streamed by two

cameras from the patient's room to another classroom. The nursing students used nurses' uniforms, and the interpreter students were wearing nameplates and black clothes as SL interpreters often do in Finland. All the students could speak Finnish, so it was the native language for the dialogue. The students were also competent and had working life experience from practical placement periods, so they did work like professional nurses and interpreters. During the simulation, the dialogues were rich in nuances of communication. The student groups did not know each other beforehand. The participation required lots of social skills from the students, and being skilled in meeting new people. The students also needed to work under pressure, knowing that others were watching the simulation.

Practical implications and developmental needs

As a result, we found out that students learned many skills from multidiscipline simulations for the working life. They were well-motivated to meet and interact with the real customer, they developed appreciation for their profession, and they learned to pay attention to the themes of interaction. They also gained knowledge about nursing, interpreting, communication, and cooperation. As lecturers, we were happy that students described that it was nice to meet other students outside of their study unit.

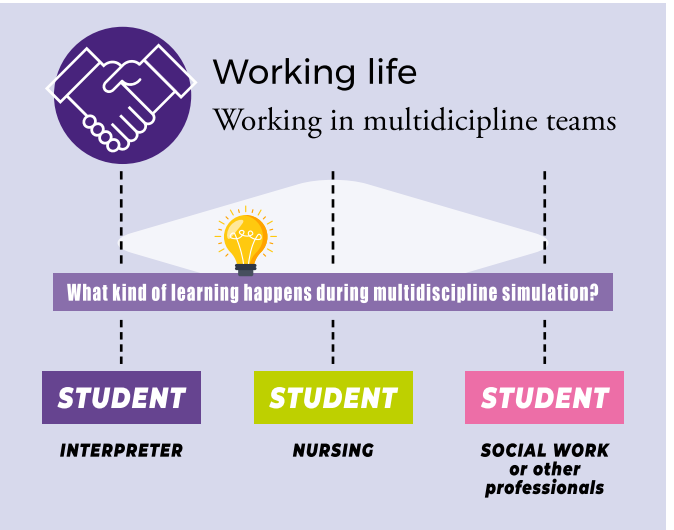

Figure 2. Learning in multidiscipline teams

Many questions are still open and need more research. As Figure 2. points out, the students have different backgrounds, and the learning process needs more research and evaluation with a more structured data collection. Simulation pedagogy is becoming more common in training for workers in social services and health care (Keskimäki et al., 2017, p. 6). Simulation pedagogy develops students' skills in reflection, teamwork, decision-making, and communication. Logie et al. (2013) observed that most of the studies reported in the years between 1997 and 2011 in social work settings did not report what challenges the standardized client simulations faced in practice. According to Logie et al. (2013), simulations are well accepted by students, but there is a need for replication with standardized, reliable, and valid tools for trainers. Reporting students' satisfaction about the realistic atmosphere and the benefit of developing professional skills in simulations is valuable, but lecturers cannot assess the effectiveness of simulations in evaluating students' competency without reported and comparable performance measures. Well-described protocols for using multidiscipline simulations, and for studying educational outcomes, are needed to develop additional research in simulation pedagogy.

Interpreting is a new field in Finland in multidiscipline simulations, and it is a complex mental process for interpreters. Interpreter students need to practice how to use situation consciousness how to be situated in the best possible place, and how to master their social skills, cognitive processes, and cultural skills during the simulations. In the multidiscipline simulation, the interpreter students can practice the methods of meeting customers, situation control skills, and interaction with multidiscipline teams. Multidiscipline simulations are very challenging for interpreter students, and students need to have prerequisite skills prior to the simulation. In the simulation, interpreter students learn more about using situation consciousness and how to place themselves in the room in the best possible way. Furthermore, the students strengthen their cognitive interpretation processes and understanding of cultural differences, which affect interpreting. During the learning discussions after the simulation, students and lecturers reflect on the situation and results in a positive way.

The lecturers who organized the simulations noticed the importance of the typical planning time. During the multidiscipline simulations, improvisation skills often replace the exact plans, so it would be wise to have enough planning time to write simulation scenarios and role play cards beforehand. The interpreter students and the deaf lecturer proposed that it would be informative to have informa-

tion lectures with the nursing students about interpreting and interpreters' work prior to the simulations. Then it would be possible to better inform the nurses the interpreter's work, sign language, and the deaf community beforehand. From the lecturers, the simulations require creativity and strong know-how of their own profession. The lecturers also played some roles in the simulation, so they also needed some acting skills. It also requires the ability to tolerate pressure. Organizing skills must be effective, and timetables must be clear for all the participants.

Interpreters generally benefit a lot from receiving contextual information, and it is relevant when the health care treatment and consultation involve special test methods. Planning the multidiscipline simulation included the planning of the patient scenarios. The dialogue was not scripted, but basic information was provided to the participants who played roles in the simulation. Dahnberg (2015, p. 181) discussed the differences between role plays based on scripts and role plays that are more open, e.g., based on role cards. He found out that turn-taking is more complex in open role plays, and that was the same finding in our experience with the multidiscipline simulation. According to Dahnberg (2015, pp. 185, 190), participants in role plays focus on different matters in the simulation compared with a real one. He distinguishes that turn-taking in the scripted role plays follow written lines prepared ahead of time, while the non-scripted role plays prompt more spontaneous talk.

Furthermore, it would be useful to share information about different customers' communication needs. Some customers who use interpreters may need more time to process the information; stressful environments increase the need for extra time, especially in hospitals. There is a lot of individual variation in communication needs. Also, clarifications must be done when there is an interpreter present. It is important to meet the patient who uses an interpreter without hurry. This information is important for the nursing students to know because there is not an interpreter available in the hospital all the time.

This article has identified simulation pedagogy in implementing multidiscipline simulations during the training of nurses and SL interpreters. Multidiscipline simulations have focused on educational purposes rather than evaluative purposes. The aim is to achieve skills that students need later when working in multidiscipline teams. Further discussion is needed about the process of learning. Organizing multidiscipline simulations demands cooperation in planning, evaluation of the roles, and preparing materials. As Johnson & Johnson (2009, 365) described, we need time to create a common understanding and that is the way to achieve better results when organizing simulations.

Future directions

The article has explored experiences with multidiscipline simulations. The method of collecting data from learning discussions and feedback questionnaires was efficient in evaluating the students' satisfaction and working in multidiscipline groups. But there is a need to improve the understanding of the different roles in multidiscipline simulations. The collected data do not answer the role questions, or make comparisons about learning in different roles. Further research is needed about the validity of the interpreter's output in both working languages like spoken Finnish and Finnish Sign Language. It would be useful in the future to analyze the interpreter students' transcripts in a more detailed way. The use of nearly authentic samples of dialogue produced during the simulation, which was inauthentic activity, could be an efficient way to teach dialogue interpreting. As Gavioli (2018) noticed, activities that train the students to switch languages appropriately are in real need for teaching interpreting. Also, students need to realize that word-for-word translation is a weak solution, and it may result in poor understanding. In teaching, more processed teaching materials are needed, and the nearly authentic data produced during the multidiscipline simulations could be a resource for designing dialogue-interpreting teaching materials for future use.

Afterwards, lecturers who participated in the multidiscipline simulations were able to share their know-how to colleagues in Diak's in-house training, and international interest also became evident. The multidiscipline simulations were observed by colleagues from Finland, Nepal, Turkey, Norway, and Vietnam. The international guests brought more challenges because the simulation scenarios were in English. The international guests described that the simulations were inspiring for them and educational, because the use of sign language in higher education is not available in Vietnam and Nepal. The Finnish nursing students noticed cultural differences about the patient's autonomy. In the Nordic countries, the patient is always carefully informed about the situation and what medicine is given. This method is not common all over the world. In Vietnam, the patient is not always told that she might have cancer; it is only told to the family members. As we work more and more in a global world, these cultural themes must be understood when planning scenarios for multidiscipline simulations. Moreover, international interest is clear, and communication, cultural competency, and diversity fit well in the simulation pedagogy. Issues of diversity – ethnicity, culture, disability, and language barriers – could be integrated well in multidisciplinary simulation scenarios.

REFERENCES

Chamberlain-Salaun, J., Mills, J., & Usher, K. (2013). Terminology used to describe health care teams: an integrative review of the literature. *Journal of multidisciplinary healthcare 2013*(6), 65–74. https://doi.org/10.2147/JMDH.S40676

Charnetski, M. (2019). Medical Simulation Methodologies: A Closer Look. *HealthySimulation.com.* https://www.healthysimulation.com/20371/medical-simulation-methodologies/

Dahnberg, M. (2015). *Interpreter-Mediated Conversations as Role Play.* Doctoral dissertation. Acta Universitatis Upsaliensis.

Dvine-project. (2020). *Holistic tools for competence-based curricula to promote Dignity in Vietnam and Nepal.* https://dvine.diak.fi/project-info/

Gavioli, L. (2018). Do authentic data mean authentic learning? On the use of authentic samples and (in)authentic activities in teaching and learning dialogue interpreting. *inTRAlinea Special Issue: Translation and Interpreting for Language Learners (TAIL).* https://www.intralinea.org/specials/article/2292

Jeffries, P.R. (2005). A Framework for Designing, Implementing, and Evaluating Simulations Used as Teaching Strategies in Nursing. *Nursing Education Perspectives 26*(2), 96–103.

Johnson, D.W., & Johnson, R.T. (1986). *Encouraging Student/Student Interaction. Research. Matters... To the Science Teacher.* National Association for Research in Science Teaching. https://eric.ed.gov/?q=Learning+Together+and+Alone.+Cooperative%2c+Competitive%2c+and+Individualistic+Learning.+Fourth+Edition.&id=ED266960

Johnson, D. W., & Johnson, R. T. (2009). An Educational Psychology Success Story: Social Interdependence Theory and Cooperative Learning. *Educational researcher, 38*(5), 365–379. https://doi.org/10.3102/0013189X09339057

Järvinen, A.M. & Ekola, L. (2014). *Turning point – A practical assessment of using 360 video in sign language interpreting studies* [Bachelor's thesis, Diak]. http://urn.fi/URN:NBN:fi:amk-201404295266

Keskimäki, I., Sinervo, T., Kujala, S., Heponiemi, T., Juujärvi, S., Silvennoinen, P., & Niiranen, V. (2017). *Competent workforce for the future – COPE. Report 2016.* Finnish Academy. https://www.researchgate.net/publication/321314544_Osaavan_tyovoiman_varmistaminen_sosiaali-ja_terveydenhuollon_murroksessa_COPE-konsortio_Tilannekuvaraportti

Krystallidou, D., Van De Walle, C., Deveugele, M., Dougali, E., Mertens, F., Truwant, A. Van Praet, E., & Pype P. (2018). Training doctor-minded interpreters and interpreter-minded doctors. First insights into the benefits of collaborative practice in interpreter training. *Interpreting 20*(1), 126-144. https://doi.org/10.1075/intp.00005.kry

Logie, C., Bogo, M., Regehr, C., & Regehr, G. (2013). A critical appraisal of the use of standardized client simulations in social work education. *Journal of Social Work Education 49*(1), 66–80. https://doi.org/10.1080/10437797.2013.755377

Poikela, E., & Poikela, P. (2012). Developing Simulation-Based Education. In E. Poikela & P. Poikela (eds.), *Towards simulation pedagogy: Developing nursing simulation in a European network* (pp. 10–14). Rovaniemi University of Applied Sciences. http://www.ramk.fi/fi/Palvelut-tyoelamalle/Julkaisutoiminta/Sosiaali-,-terveys--ja-liikunta-ala/Towards-Simulation-Pedagogy

Skaaden, H. (2013). No Set Answers? Facilitating Interpreter Students' Learning in an Experiential Approach. In C. Wadensjö (ed.), *Training the Trainers: Nordic Seminar on Interpreter Education* (pp. 12–26). Tolk- och översättarinstitutet Stockholm University.

Skaaden, H. (2017). That we all behave like professionals – An experiential-dialogic approach to interpreter education and online learning. In L. Cirillo and N. Niemants (eds.), *Teaching Dialogue Interpreting* (pp. 323–340). John Benjamins.

Stroud J.M., & Jenkins, K.D. & Bhandary S.P. & Papadimos, T.J. (2017). Putting the pieces together: The role of multidisciplinary simulation in medical education. *International Journal Academic Medicine 3*(1), 104–109. http://www.ijam-web.org/article.asp?issn=2455-5568;year=2017;volume=3;issue=1;spage=104;epage=109;aulast=Stroud

Tuomi J., & Sarajärvi A. (2018). *Laadullinen tutkimus ja sisällönanalyysi* (uud.laitos). Tammi.

Yaeger, K.A., Halamek, L.P., Coyle, M., Murphy, A., Anderson, J., Boyle, K., Braccia, K, McAuley, J., De Sandre, G., & Smith, B. (2004). High-fidelity simulation-based training in neonatal nursing. *Advances in Neonatal Care 4*(6), 326–331. DOI: 10.1016/j.adnc.2004.09.009

WASLI. (2020). *Code of Ethics.* https://wasli.org/your-wasli/code-of-ethics

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MULTI-PROFESSIONALISM FROM THE PERSPECTIVE OF HEALTH AND MICROBIOLOGY

Every student must study different subjects until they master one particular field. Different teachers from various fields, majoring in a particular subject, come together to provide the student with a good education. To make this possible, collaboration plays an important role. Likewise, for the betterment of people's health, only one profession cannot give quality service to the patient. This chapter aims to give insight on multi-professionalism from the perspective of health and microbiology.

The significance of microbiologists in healthcare

Microbiology in healthcare has contributed tremendously. Microbiology research encompasses the aspects of micro-organisms, such as their behavior, ecology, evolution, physiology, and biochemistry, along with the pathology of diseases that they cause (Pelczar, 1999). Many important discoveries have underpinned the world's health perspective, such as Alexander Fleming's discovery of penicillin, the vaccine against smallpox created by Edward Jenner, the diphtheria antitoxin by Emil Adolf von Behring, the vaccine against yellow fever by Max Theiler (Pommerville, 2014), and the vaccine against rabies developed by Louis Pasteur and Emile Roux in 1885 (Tarantola, 2017). Moreover, Antonie Philips van Leeuwenhoek discovered a single-lens microscope (Lane, 2015). Charles Lavaran discovered the causative agents of malaria and trypanosomiasis. Joseph Lister introduced sterilization techniques to the field of surgery. Walter Gilbert and Frederick Sanger were the first to develop the method of DNA sequencing in 1977. In the 1980s, Kary B. Mullis discovered polymerase chain reaction (PCR). Hans Christian Gram developed a 'Gram stain'. Additionally, Barry Marshall discovered the bacterium Helicobacter pylori, and deciphered its role in gastritis and peptic ulcer disease. Zur Hausen identified the link between papillomavirus and cervical cancer in 1983. Along with the above-mentioned examples, several researches have contributed to prospering the health of people (Aryal, 2022; Pommerville, 2014).

Joining hands with other professions, along with microbiologists, will certainly promote health care for people. Henceforth, multi-professionalism should be put into practice.

Multi-professionalism

Involving different professions can offer exceptional and extraordinary views, and other ideas on the given matter, which ensures better health care outcomes (Mahajan et al., 2018). If people from different professional backgrounds collaborate, it can be termed as multi-professional work or multi-professionalism. The collaboration of multiple professionals includes various dimensions, such as occasional recurring contacts, regular collaboration, and appropriate integration, in order to close the partnership depending on its feasibility or the need to produce the best benefit for the target recipients (Melin Emilsson et al., 2022; Collaborations in Social Work – How to Effectively Serve Clients through Teamwork, n.d.). The multi-professionalism approach is not only about the institution or any discipline, but it focuses on all of us as human beings. The multi-professional team coordinates their services, and gets the team working together towards a specific set of goals (Sørensen et al., 2018).

Regardless of the distribution of responsibilities between various authorities, there might be some difficulties in working within a multi-professional team, e.g., disagreement, territoriality, distraction, and breaking from the status quo (Collaborations in Social Work – How to Effectively Serve Clients through Teamwork, n.d.). By creating a guideline for working together, it clarifies the roles of everyone, establishes how to deal with disagreements, clarifies who will take credit for what, and explores a variety of collaborative approaches that have worked. Therefore, we can experience numerous advantages and benefits from working collaboratively in a multi-professional team. Moreover, multi-professional teams are often seen as the obvious solution to the lack of collaboration (Melin Emilsson et al, 2022; Collaborations in Social Work – How to Effectively Serve Clients through Teamwork, n.d.).

For any coordination and forming multi-professional teams, dignity is very important. Dignity is the core value, which strengthens self-worth and autonomy, as well as making others understand about the importance and value of other professions. While dignity plays its part, empathy also has a great role in connecting with individuals, especially patients. It is perceived from the heart, understood by the senses, and experiences and responds to another person's emotional state of

ideas. Though dignity and empathy both play an important role, there are several other factors that need to be highlighted, such as conviviality, cooperation, communication, comfort interaction, trust, and a spark of hope (Sabatino et al., 2016). To promote dignity-based practices, the improvement of inter (within) and intra (between) professional interaction is important (Bruno et al., 2018).

If we work in a multi-professional team, team members from different backgrounds can bring their individual expertise to the group, ensuring that any problems are addressed from different angles. Multi-professional teams can easily share responsibilities on the basis of their expertise, have fewer professional barriers, and partners may have access to different tools. By allowing various professionals to contribute ideas, it increases knowledge and creates opportunities for innovation (Melin Emilsson et al., 2022; Collaborations in Social Work – How to Effectively Serve Clients through Teamwork, n.d.). Pooling resources can reduce costs for individuals and ensure that teams can work efficiently. To excel in collaboration, one must be able to comprehend deliberate practice, as it is one of the methods of improving your performance in a specific area through continuous and focused efforts. There are nine elements of deliberate practice, which includes a high level of motivation and concentration, an appropriate level of difficulty, well-defined learning objects, focused and repetitive practice, feedback, rigorous and reliable measurements, evaluation and performance, monitoring and error correction, and advancement to the next task (Banga, 2014).

Bottlenecks in collaboration

Collaboration is widely regarded as being useful and desirable, even though it can be quite difficult to achieve. The team members often see themselves more as representatives of their own discipline than members of a collaborative team, which can be one of the prominent reasons. Another reason can be rivalry between different professional groups, such as different medical specialties, and this can become even more of an issue when resources are limited. Traditions, roles, and gender stereotypes are additional obstacles in collaboration (Roodbol, 2010). Multi-professional collaboration has so much to give, and is essential for the delivery of effective and comprehensive care services, but there are many challenges hindering the flexibility of this approach. One of the main challenges is the lack of collaborative procedures across institutions, and the delayed implementation and adoption of technology. Other challenges include the level of power over the service user by different professionals, power of knowledge, unclear professional roles

in the team, organizational or departmental hierarchy, professional stereotypes, language barrier, lack of implementation regarding multi-professional teamwork and education, communication gap, lack of system and policy-level support for integrating the projects, and inadequate leadership (Levesque et al., 2018; Sørensen et al., 2018).

When there is insufficient coordination among the professionals working toward a common goal, it leads to a domino effect of other problems, such as the lack of responsiveness and efficiency in health systems (Jacobsen et al., 2019). If professionals work together in the beginning, it would be difficult to get a good overview of the work by different groups of healthcare professionals. In addition, collaborating and working in a team is complicated. Healthcare workers typically belong to different professional groups that have their own cultures, standards, and values (Humphris, 2007). There can be many barriers, during which the work is done by professionals with different backgrounds. Professionals that are given roles can be absent by not having a sense of responsibility and depending on others. There can be miscommunication, and tasks may be conflicted. The lack of knowledge about other professions and negative attitudes can be the individual-level barrier that one can encounter (Fruhen et al., 2020).

Multi-professionalism, healthcare and microbiology

Multi-professional collaboration and teamwork have been presented as a positive and superior practice in healthcare and community development programs. In the DVINE project, people from the backgrounds of nursing, social work, and microbiology worked together, thus experiencing the benefits of working in a multi-professional team. Of these multi-professional teams, a microbiologist, nurses, and a social worker are very essential because all three professionals are working for the welfare of the society, and their common goal is to help people in our society by their problems. As healthcare is too broad for any one profession to understand completely, specialization is necessary in the fields of medicine, microbiology, nursing, therapy, and technician work. Moreover, collaboration is needed between different professions to make sure everyone understands their role (Roodbol, 2010).

While microbiology knowledge is important in order to get a job at the university labs, research institutes, and industrial companies, and to investigate microbes in the fieldwork, it is also very essential in a wide variety of our daily activities and for people in a wide range of careers and professions. All around the world, there

are microbiologists making a difference in our lives; ensuring whether the food is safe to eat or not by testing the microbiological quality; preventing and treating various types of diseases by recognizing the causative agent and producing various types of preventative vaccines and antibiotics to treat the diseases by performing antimicrobial susceptibility tests; developing green technologies or tracking the role of microbes in climate change; identifying and using various types of organisms that can be used to reduce the pollutants from industrial waste; developing various types of eco-friendly products like biofertilizer, biopesticides, biogas, etc., which has a great impact on our health directly and indirectly. Microbiologists are able to answer many important global questions by recognizing and understanding the nature and abilities of microbes (Nai et al., 2016).

Healthcare workers are more crucial in supporting the physical needs of patients and treating the disease that the patient has. Social workers, for their part, assist the patients and families by addressing and helping their emotional and psychosocial needs through counseling, providing referrals for support groups, contacting family members, different organizations, and other services that support patients throughout their recovery. If microbiologists are also involved with these two professions, they will try to find out what has caused the disease, along with treatment options to help the patient heal as quickly as possible. Similarly, they will also try to search for preventive measures in order to protect others from similar problems (Melin Emilsson et al., 2020; Social Workers in Healthcare: How They Make a Difference, 2021). If microbiologists identify the causative agent of the disease and find the treatment option for the disease, it will be easier for the health professional to go for the best treatment option in time. In this way, if microbiologists, health care workers, and social workers work together, it will be much easier to help the patient in all aspects; it may reduce financial costs or other burdens, as well as ensuring that the work will be smoother and faster.

Multi-professionalism in education system

Multi-professional education (MPE) or multi-disciplinary training (MDT) is an educational approach that involves students from different disciplines working together. This type of training can help to stimulate creativity and collaboration among students, situational awareness, decision making, and problem solving, which may lead to more successful careers in the future. Not only will it encourage team spirit and communication, but it also fosters mutual understanding and respect (Roodbol, 2010).

According to the World Health Organization (WHO), multi-professional education is a group of students involved in health-related fields with diverse educational backgrounds, who are learning and working together during certain periods of their knowledge-gaining experience. This process allows for different perspectives and knowledge to be shared amongst the group, which can lead to a better-rounded education (WHO, 1988).

Multi-professional education strives to create interactive and integrated learning experiences between at least two different health professions. The goal is to increase the development of collaborative skills for teamwork, and enhance the understanding of the specific roles of each professional. The collaborative multi-professional practice comprises a dynamic process, where professionals with different educational backgrounds work in an interdependent and integrated manner; exchanging their skills and knowledge, and being empathetic towards each other by expressing a positive attitude in order to share responsibilities for the improvement of the patient care. Dignity-based multi-professionalism should be promoted through interprofessional education (Araújo et al., 2021).

Multi-professional collaboration between health professionals and social workers is important to address different types of problems related to health and socio-economic factors in our society. For example: various types of acute and chronic diseases can be diagnosed, treated, managed, and prevented by the collaborative efforts of persons from diverse sectors, such as health professionals specialized in numerous fields, microbiologists, and even people from social work backgrounds. To make people from multiple sectors work together, interprofessional or multi-professional education is required at the higher secondary and undergraduate levels. But in most parts of the world, academic activities in many professions are performed independently and separately. Therefore, at the school and college levels, students have very limited knowledge about the other professions. They have very limited communication, coordination, collaboration, and teamwork skills until they enter the 'real work' environment. To overcome this type of challenge, the multi-professional education system and collaboration should be incorporated into the curriculum globally. It helps to learn about the knowledge, skills, and expertise of each person in a team in order to make a team more competent, and to function well in a collaborative manner (Aldriwesh et al., 2022).

Flourishing and giving quality to one's life can be achieved by multi-professional approaches. It can be very beneficial by maintaining community-focused support, specific to the needs and requirements of the social context, and should be practiced and implemented worldwide (Böhm et al., 2016). Therefore, the

knowledge of multi-professionalism, its importance, and the necessity of multi-professional work for the development of the society and the whole country is very essential. In order to implement multi-professional education and collaborative practices, the transformations in the education system or policies and the curriculum, along with changes in the health system and reinforcing the sharing of responsibilities between professionals and users, are required in an interdependent and articulated manner (Araújo et al., 2021). It is also important to give this knowledge to high school students and college students by incorporating these topics into their curriculum.

REFERENCES

Aldriwesh, M.G., Alyousif, S.M., & Alharbi, N.S. (2022). Undergraduate-level teaching and learning approaches for interprofessional education in the health professions: a systematic review. *BMC Medical Education 22*(1), 13. https://doi.org/10.1186/s12909-021-03073-0

Araújo, HPA, Dos Santos, L.C., Da Silva Domingos, T., & Alencar, R.A. (2021). Multiprofessional family health residency as a setting for education and interprofessional practices. *Revista Latino-Americana de Enfermagem 29.* e3450. https://doi.org/10.1590/1518-8345.4484.3450

Aryal, S. (2022). 'History of Microbiology and Contributors in microbiology'. *Microbes Note.* https://microbenotes.com/history-of-microbiology/

Banga, F.R., Truijens, S.E.M., Fransen, A.F., Dieleman, J.P., Van Runnard Heimel, P.J., & Oei, G.S. (2014). The impact of transmural multiprofessional simulation-based obstetric team training on perinatal outcome and quality of care in the Netherlands. *BMC Medical Education 14*(1), 1–9. doi:10.1186/1472-6920-14-175

Böhm, C., Lilja-Viherlampi, L., Linnossuo, O., Mclaughlin, H., Gómez, E., Mercado, E., Martínez, Ó., Kivelä, S., Männamaa, I., & Gibson, J. (2016). Contexts and approaches to multi-professional working in arts and social care. *UAS Journal – Journal of Finnish Universities of Applied Sciences.* https://uasjournal.fi/in-english/contexts-and-approaches-to-multiprofessional-working-in-arts-and-social-care

Bruno, A., & Dell'Aversana, G. (2018). 'What shall I pack in my suitcase?': the role of work-integrated learning in sustaining social work students' professional identity. *Social Work Education* 37(1), 34–48. https://doi.org/10.1080/02615479.2017.1363883

Collaborations in Social Work – How to Effectively Serve Clients Through Teamwork. (n.d.). Social Work License Map. https://socialworklicensemap.com/social-work-careers/collaborations/

Fruhen, L., Carpini, J.A., Parker, S.K., Leung, Y., & Flemming, A.F.S. (2020). Perceived barriers to multiprofessional team briefings in operating theatres: A qualitative study. *BMJ Open.* 10(2), 1–7. doi:10.1136/bmjopen-2019-032351

Humphris, D. (2007). Multiprofessional working, interprofessional learning and primary care: A way forward? *Contemporary Nurse.* 26(1), 48–55. https://doi.org/10.5172/conu.2007.26.1.48

Jacobsen, F.F., Akman, M., & Aarendonk, D. (2019). The establishment and functioning of the PRIMORE (European Primary care Multiprofessional Researcher network) project. *Primary Health Care Research & Development 20,* e114. https://doi.org/10.1017/S1463423619000276

Lane, N. (2015). The unseen world: reflections on Leeuwenhoek (1677) 'Concerning little animals'. *Philosophical transactions of the Royal Society of London. Series B, Biological sciences, 370*(1666), 20140344. https://doi.org/10.1098/rstb.2014.0344

Levesque, JF., Harris, M.F., Scott, C., Crabtree, B., Miller, W., Halma, L.M., Hogg, W.E., Weenink, JW., Advocat, J.R., Gunn, J., & Russell, G. (2018). Dimensions and intensity of inter-professional teamwork in primary care: evidence from five international jurisdictions. *Family Practice,* 35(3), 285–294. https://doi.org/10.1093/fampra/cmx103

Mahajan, R., Mohammed, C.A., Sharma, M., Gupta, P., & Singh. T. (2018). Interprofessional Education: An Approach to Improve Healthcare Outcomes. *Indian Pediatr,* 55(3), 241–249.

Melin Emilsson, U., Strid, A.L., & Söderberg, M. (2022). Lack of Coordination between Health Care and Social Care in Multi-Professional Teamwork – the Obstacle for Coherent Care of Older People Suffering from Multi-Morbidity. *Journal of Population Ageing 15,* 319–335. https://doi.org/10.1007/s12062-020-09300-8

Nai, C., Magrini, B., & Offe, J. (2016). Let microorganisms do the talking, let us talk more about microorganisms. *Fungal biology and biotechnology 3,* 5. https://doi.org/10.1186/s40694-016-0023-9

Pelczar, R.M. (1999). 'Microbiology'. *Encyclopedia Britannica.* https://www.britannica.com/science/microbiology

Pommerville, J.C. (2014). 'Fundamentals of Microbiology'. 10th edition. Jones and Bartlett Learning. ISBN 9781449688615.

Roodbol, P. (2010). Multiprofessional education to stimulate collaboration : a circular argument and its consequences. *GMS Zeitschrift für Medizinische Ausbildung,* 27(2), 7–10.

Sabatino, L., Kangasniemi, M., Rocco, G., Alvaro, R., & Stievano, A. (2016). Nurse's perceptions of professional dignity in hospital settings. *Nursing Ethics* 23(3), 277–93. https://doi.org/10.1177/0969733014564103

Social Workers in Healthcare: How They Make a Difference. (2020). Adelphi University Online. https://online.adelphi.edu/articles/social-workers-in-healthcare-how-they-make-a-difference/

Sørensen, M., Stenberg, U., & Garnweidner-Holme, L. (2018). A scoping review of facilitators of multi-professional collaboration in primary care. *International Journal of Integrated Care, 18*(3), 13. https://doi.org/10.5334/ijic.3959

Tarantola, A. (2017). 'Four Thousand Years of Concepts Relating to Rabies in Animals and Humans, Its Prevention and Its Cure'. *Tropical Medicine and Infectious Disease, 2*(2), 5. https://doi.org/10.3390/tropicalmed2020005

WHO. (1988) Learning together to work together for health. World Health Organization.

II
QUALITATIVE RESEARCH METHODS

Erik Skjeggestad

QUALITATIVE RESEARCH FOR DEVELOPING HEALTH AND SOCIAL SERVICES

Students in Nepal and Vietnam have solid methodological competence in quantitative methods, but little knowledge about qualitative methods. Therefore, this chapter aims to give students that are unfamiliar with the qualitative method some insight into the qualitative method, and some arguments why the qualitative method is relevant in health and social services. A brief overview of how to conduct a small interview study and a thematic analysis, as well as some examples from the Erasmus+ project, could help students to have an overview before reading more advanced literature about the qualitative method.

Why introduce qualitative methods for students in healthcare and social services

Introducing students in health and social education training to insights in qualitative research could be relevant for several reasons. The most important is probably the ability to teach skills in critical thinking. Qualitative studies often give students insight into others' perspectives that promote the student's reflection and often their self-understanding as well. Training in the exploration of users' experience and perspectives could be relevant for students in nursing and social work. Such knowledge is crucial for health and social workers' practice, and it could be helpful in reflecting one's own practice and the service user's/patient's situation. Furthermore, the qualitative method could be a way for students to increase their competence in the fields of practice in which they are interested, e.g., in student projects or in their bachelor's or master's theses. The last argument I want to promote is that learning the qualitative method is also about learning knowledge and academic skills that could be relevant for students later in their studies or their work.

Qualitative research for developing health and social services

In general, quantitative research focuses on answering questions, such as "What?", "How much?", and "Why?", whereas qualitative research focuses on answering the questions "Why?" and "How?" (Kuper et al., 2008). This differentiation states that qualitative methods give a different sort of knowledge than quantitative approaches.

Qualitative research has had a significant role in forming the modern professions of health and welfare services in the USA and Europe (Collin, 2010). For instance, important thoughts have been contributed by sociologists Talcott Parsons (Parsons, 1991) and Eliot Freidson (Freidson, 1970), among others, who describe and problematize phenomena related to the profession regarding knowledge, morality, and power. Such research has given knowledge to understand different aspects of professions, like the mandate of the professions and the identity of professionals. For instance, their research is still often referred to when talking about professional ethics, or the power that the professionals hold with their knowledge and position that have an impact on patients' and service users' lives.

Today, qualitative research gives fundamental knowledge to support the construction and development of health and social services. Qualitative methods have a special ability to give knowledge about complex situations, and underdeveloped and less practiced fields where there is little knowledge. In general, qualitative studies include explorative and critical perspectives. Such studies can be just as relevant as applied research in understanding relevant topics in health and welfare services, and these studies can be helpful for understanding the practice, services, and development. Qualitative research can be especially important for acquiring knowledge about minorities, and people who lack the autonomy to raise their own voice about health and social services. Moreover, most of the qualitative research in health and social services is directly applicable, but qualitative methods also support basic research to develop new knowledge or theories that do not have an aim to be directly applicable to the field of practice.

Qualitative method – a panorama of different methods

A common misunderstanding is that the qualitative method is just one method. The reality is that the qualitative method is an umbrella term, including a

panorama of different qualitative approaches. Some have fundamental differences between each other. For instance, there is disparity between the research design where the researcher does observations (e.g., a conversation analysis of videorecording of real-life situations), and the research design where the researcher could do interventions in organizations they are a part of and describe the process and eventual changes (Action-research). Another example of a totally different design is historical research (studying historical materials, often in text) versus conducting interviews with individuals or groups for exploring phenomena in everyday life. Doing qualitative research is therefore much about making informed choices, including choosing an appropriate qualitative research design to explore the research topic. Some methodological books give an overview of many approaches in qualitative methods (Denzin & Lincoln, 2018; Flick, 2022; Kvale, 1996). Some often-applied methods in student work and health and social work are phenomenology (background from European philosophy), discourse analysis (background from linguistics/semiotic), or grounded theory (background from sociology) (Starks & Brown Trinidad, 2007). As you can see, they have quite different backgrounds. I will shortly give an initial presentation of those three different qualitative traditions.

Phenomenology in research focuses on lived experience. This is often about capturing the essence of the experience of being in a situation, like being a patient in intensive care or being a child who has lost its parents. Discourse analyses involve the analysis of words and language, which is something written or said. The analysis focuses on "how people use language to create and enact identities and activities," (Starks & Brown Trinidad, 2007, p. 1373). As for the grounded theory, the aim is to make a theoretical description of social processes that are often studied by observation. These three (shortly presented) methods are all broad categories of qualitative methods, and they all consist of several different methods.

How to start a qualitative study – a brief introduction

A qualitative researcher's first choice is to choose and define what to study. In some qualitative traditions, making one or more research questions is a part of this work. In other traditions, describing a precise theme to explore is feasible. Most qualitative researchers acknowledge that this task is an important first part of making a qualitative study. A research question should be so precise that it is

possible to answer while having the aim of providing fresh knowledge that is not already known. A functioning qualitative research question is normally open-ended. My experience is that most students struggle when asked to make good research questions, so supervision by their teachers or mentors is often necessary prior to the data collection.

This early definition of the research aim is normally not understood as a process that is finished early in the research process since the justification of pre-understanding and hypothesis is a part of the research process. Good qualitative research is typically exploratory by nature, and researchers therefore have to make changes in the research process as they go along.

In most studies, the next thing to do after defining the research question is to establish a solid knowledge of what is already known about the topic that will be studied. Qualitative researchers normally do a literature review of previous research papers, and, if suitable, gray papers and other literature that can enlighten the research topic. Relevant theoretical input in the topic is also consulted early in the research process to improve the choices that the researcher can make later in the research process.

The next important choice is to choose a relevant methodology and design for the study. For students, finding a methodology often is about what kind of data you want to collect. Data could be interviews (by single persons or groups), observations, all kinds of texts, pictures, or videos. This design process includes choices about size and argumentation concerning how this sample could be the best for exploring the aim of the study. For instance, the researcher who has chosen to conduct interviews has to take into concern how to recruit people for the interviews, and how the interviewees are positioned to enlighten the research topic. Often, larger qualitative research projects have a design that includes more than one kind of data.

The next stage of the research is to go actively into analysis. The analysis has been an ongoing process from the beginning of the project, and the researcher should be aware of how he or she has been informed earlier. For instance, the research method book suggests that one should take personal notes in the research process to gain awareness of their own research process. Qualitative method literature presents a wide range of how to conduct the analysis. This short chapter will present only a brief overview of strategies for the analysis. Two common strategies are thematic analysis and content analysis (Vaismoradi et al., 2013). Thematic analysis can be defined as an analysis method for identifying patterns within the data (Braun & Clarke, 2006). Content analysis is a wider term of analysis that is

also open for counting elements in a text, and doing another analysis rather than searching for patterns in the material. Another major difference in the analysis is the choice of either an inductive or a deductive approach (Azungah, 2018). A deductive approach follows a hypothesis or starts a list of themes, and sorts the collected data thereafter. An inductive approach starts with less of a defined focus and aims to grasp new insights through data, and by coding the data without starting with predefined codes. As a consequence of the choice of design, the phases in the analysis process will be somewhat different.

In the course of the qualitative method in the DVINE project, we limited the scope to a thematic analysis of transcriptions from the interviews. This was related to a phenomenological tradition. First, the students interviewed each other and wrote transcriptions of the questions and answers. They shared the transcriptions, so they all had at least five different transcriptions of interviews with different persons about the same topic. Prior to starting the interview process, they put together a semi-structured interview guide. They have trained with a teacher to make open-ended questions related to their research questions. Such an interview guide consists of relevant questions the interviewer can ask in the interview, but the interview should also be open to the participant's voice and the order of the questions can be changed. Often in interviews, the participants thematize the question before it is asked, thus allowing that question to be left out altogether.

An important resource in this course has been the article by Braun and Clark (2016), who present six phases in a thematic analysis. In the course, the teachers have supported the students to do their analysis or their transcriptions systematically through these six phases.

Phase 1: familiarizing yourself with your data. This work is about reading the material several times with the aim of becoming familiar with all parts of the data. The researcher normally takes notes in this process to be aware of good choices for questions and alert the team to questions that are especially interesting.

Phase 2: generating initial codes. A code is understood as a crystallization of what sentences or longer passages in the text in the transcriptions are about. A code is normally a short sentence that can be applied several times in the material to summarize parts of the transcription. A good code is a nuanced description of what the text is about, not a subjective interpretation by the researcher. It is normal to redo the coding process several times to get more succinct codes. Conducting a dialog with your co-researchers, your supervisor, or your colleagues can often improve the quality of coding.

Phase 3: searching for themes. Themes can be understood as patterns in the material. A theme often consists of a combination of two or more of the codes found in the last phase that make sense together as a phenomenon. In most qualitative research, some codes are not included in a theme and will not be a part of the rest of the study.

Phase 4: reviewing themes. The main intention of this phase is to do a quality control check of the themes made in the previous phase by going back to the transcriptions, and checking how the themes are supported. There are different ways to perform the control check. For beginners, it could be relevant to code the entire data with the themes. Normally, the themes that we adjusted through this phase and control for relevance in the transcriptions will be redone.

Phase 5: defining and naming the themes of the study. The aim of this phase is to write out the themes that have been uncovered in the text. An important part of this work is to develop definitions and limitations of the themes to make a clear distinction with other themes. If it becomes too complicated to make good distinctions, it could be relevant to go back to phase 3.

Phase 6: producing the report. The objective of the last phase is to produce a final text that presents all the themes in a well-written way. This phase is not about making substantial changes, but instead, it is about clarification of the text and possibly limiting the text to the essential ideas.

Notice that in the description of the phases, theory is not mentioned. The application of theory is for ensuring new knowledge and contextualizing the findings for others. Searching for relevant research and theory is always a resource for the research project, and a means of increasing the relevance and quality of the analysis. Supervision and cooperation with other students or researchers will often increase quality by including different views and understandings.

How to ensure quality in qualitative research

Student work seldom has the aim of producing publishable research. The objective is mostly a learning process for future research after one has become skilled in the methodologies. Making good qualitative research is time-consuming, and in the healthcare and social professions, researchers may require years of experience gaining in-depth knowledge of the field and practice before publishing their research results.

Important quality criteria for all research, including qualitative research, means being reflective on how the study is done, and being aware of both its weakness-

es and strengths and the choices of importance the researchers have done in the study. Such clarity improves the reliability of the study. Also, qualitative student projects should illuminate these issues.

For an experienced investigator, the validity of a project could otherwise be improved by answering important questions related to the study. For a beginner, it could be hard to see what questions are relevant; consulting one of the acknowledged checklists for qualitative research, such as the one by Malterud (2001), could be helpful.

REFERENCES

Azungah, T. (2018). Qualitative research: deductive and inductive approaches to data analysis. *Qualitative Research Journal,* 18(4), 383–400. https://doi.org/10.1108/Qrj-D-18-00035

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Collin, J. (2010). Qualitative contributions to the study of health professions and their work. In I. Bourgeault, R. Dingwall, & R. De Vries (Eds.), *The SAGE Handbook of Qualitative Methods in Health Research* (pp. 53–70). SAGE Publications Ltd. https://dx.doi.org/10.4135/9781446268247.n4

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2018). *The SAGE handbook of qualitative research* (5th ed.). Sage.

Flick, U. (Ed.). (2022). *The SAGE Handbook of Qualitative Research Design* (Vol. 2). London: SAGE Publications Ltd. https://doi.org/10.4135/9781529770278

Freidson, E. (1970). Profession of medicine: a study of the sociology of applied knowledge. Harper & Row.

Kuper, A., Reeves, S., & Levinson, W. (2008). Qualitative Research: An Introduction to Reading and Appraising Qualitative Research. BMJ: *British Medical Journal, 337*(7666), 404–407. https://doi.org/10.1136/bmj.a288

Kvale, S. (1996). *Interviews: an introduction to qualitative research interviewing.* Sage.

Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *The Lancet, 358*(9280), 483–488. https://doi.org/10.1016/s0140-6736(01)05627-6 (NOT IN FILE)

Parsons, T. (1991). *The social system.* Routledge.

Starks, H., & Brown Trinidad, S. (2007). Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory. *Qualitative Health Research, 17*(10), 1372–1380. https://doi.org/10.1177/1049732307307031

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences, 15*(3), 398–405. https://doi.org/10.1111/nhs.12048

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WHEN TO USE QUALITATIVE RESEARCH

The researcher's interest decides the nature of the research problem, and this indicates the appropriate type of research to follow. Once the objectives of a research project have been established, the issue of how these objectives can be met leads to the consideration of which research design should be chosen. The research design provides a framework for the collection and analysis of data, and subsequently indicates which research methods are appropriate. Thus, the appropriately chosen types of research are crucial. Below is the discussion about the reason for using qualitative research.

Qualitative research focus on words rather than numbers

The main reason for selecting qualitative research is to understand the human experiences by adopting a variety of methods and intervening the underlying contributing factors. Qualitative research is best suited for addressing a research problem in which you do not know the variables and need to explore. In addition, qualitative research can be used to explore a wide array of dimensions of the social world, including the texture and weave of everyday life, and the understandings, experiences, and imaginings of participants. The literature might yield little information about the phenomenon of study, and you need to learn more from participants through exploration. For example, the literature may not adequately address the use of sign language in distance education courses. A qualitative research study is needed to explore this phenomenon from the perspective of distance education students. Unquestionably, using sign language in such courses is complex and may not have been previously examined in literature. A central phenomenon is the key concept, idea, or process studied in qualitative research. Thus, the research problem regarding the difficulty in teaching deaf children requires both an exploration (because we need to better know how to teach these children) and an understanding (because of its complexity) of the process of teaching and learning.

Qualitative research is used to inquire about the developmental and historical processes within institutions, communities, and markets. One of the great advantages of qualitative methods is that they enhance the capacity not only to describe events, but to understand how and why the "same" events are often interpreted in a different, sometimes even conflicting manner, by different stakeholders. In the context of policy research in particular, qualitative methods have been used to document the perspectives and interactions among multiple stakeholders (Sofaer, 1999).

Qualitative research has the potential to contribute significantly to the development of meaningful quantities; however, they have inherent as well as instrumental value. Qualitative research helps to provide rich descriptions of phenomena. It enhances our understanding of the context of events, as well as the events themselves. The use of qualitative methods tends to enhance one's peripheral vision, which is especially important at the early stages of inquiry. In addition, qualitative methods can help to identify patterns and configurations among variables, and to make distinctions. Not only does qualitative research serve the desire to describe, but it also helps move inquiries toward more meaningful explanations (Mason, 2002). For the following reasons, qualitative research can be used (Joshi, 2009):

Clarifying the concepts: qualitative research is useful for the health professionals as it provides detailed information related to the unclear phenomena, and it is often conducted by biomedical personnel in explaining the attitudes and behaviors of different groups, particularly among drug abusers, patients living with AIDS, family planning defaulters, non-compliance with TB treatments, etc.

Emic perspectives: the qualitative research provides emic perspectives of those subjects who have undergone the complex feelings and experiences they live with; where they explore the local perceptions of health and diseases, and investigate relevant intervention strategies based on the identified issue. It also provides accurate information about a phenomenon by identifying relevant questions and their appropriate wordings.

Experiences of reality: Qualitative research findings enable others to make sense out of reality, as the researcher starts with a topic or a setting by asking themselves, "what is going on here?" and systematically explains the topic by holding the assumption, and the known information is kept aside until they are conformed.

Life experiences: Qualitative research is also used to answer the questions pertinent to what the experience is likely to be, such as sickness and illness-related behaviors in particular: does this chronic sickness cause any change in their behavior, and how do they cope with their lifestyles?

Refining the theory: The qualitative research approach uses the inductive process in developing or refining the theory for providing a rich description that enables an understanding of reality based on the obtained information, which can be used in clinical setting, as well as in developing a conceptual framework, testing instruments, or triangulating the qualitative findings.

Generating the theory: Qualitative research is also used to construct a valid theory that guides the development of knowledge within a discipline, as the qualitative researcher uses a rigorous time-consuming, intellectual endeavor.

Characteristics of qualitative research

Qualitative research relies on a research strategy, which is flexible and iterative in nature. This approach allows for the discovery of an unexpected important topic, which may not have been visible. It has an elastic emergent study design, which is capable of being modified in the due course of data collection.

In the qualitative approach, the researchers need to act as an instrument in order to get in-depth information about the study phenomenon. It adopts a holistic approach while assessing and understanding the health of human beings. It seeks to describe and analyze the culture and behavior of humans and their groups from the viewpoint of those being studied through "emic perspectives." It places an emphasis on providing a comprehensive understanding of the social settings in which the researcher is conducting a study, where social life is viewed as an evolving and interlocking series of events needed to be fully displayed to reflect the realities of everyday life. As data collection and data analysis occur simultaneously to reveal the concepts, it requires an ongoing analysis and interpretation of data based on evolving issues (Joshi, 2009).

When to select a qualitative research design

The choice of selecting a qualitative research design depends on several factors, such as the nature of the phenomena to be studied, maturity of the concepts, constraints of the setting, phenomena to be explored, and the ability of the researcher regarding the methodological issue, as well as threats of validity. Moreover, while selecting the types of qualitative research, one should be clear about the context and the purpose

of the study, and should follow the governing rules of the concerned method. The researchers need to be very clear about the underlying principle and methodology of the approach before choosing appropriate methods (Joshi, 2009).

In most of the settings, the qualitative research questions are posed in exploratory style, so it needs to describe the situation in detail regarding the occurrence: what is happening? How does it happen? And what else needs to be done? In most cases, according to Joshi (2009), the research needs to select the best approach based on the nature of the problem and the type of information that needs to be obtained regarding the study phenomena, and the researchers need to consider the following three points:

(a) Nature of the phenomena: While considering the nature of the phenomena, the researchers need to consider the nature of the question, types of probable variables, and the purpose of the proposed study, along with the methods of the data collection (interviewing, observing, and asking to describe their perceived feeling regarding a particular issue). In addition, the necessary external resources consider the expertise of the researcher, budget, time, and constraint.

(b) The maturity of the concept: Before conducting the study, the researchers need to explore the present status of the proposed phenomena: how much has already been investigated? What additional information needs to be explored? Is there any need for verification in the present findings? Is there any need for further exploration related to the study phenomena?

(c) Constraints from the participants/settings: Before starting the study, the researchers need to learn more about the characteristics of the participants, as well as the setting of the study. The researchers must know the language, and need to be familiarized with the culture/subculture of the participants. The researchers also need to specify the data collection procedures based on the nature of the respondents: in cases of infants, elderly, and disoriented respondents, observational techniques could be much more appropriate than the interview or other methods.

This article focused on reasons for using qualitative research. Qualitative research is useful when measures don't uncover the things to be investigated. When the research topic is not well defined or there is little or no previous research, qualitative research is helpful. Moreover, when the researcher is interested in understanding the context and hearing authentic ideas, opinions and feedback from service users, rich data can be reached by collecting qualitative data from the participants in person.

REFERENCES

Joshi, S. (2009). *Qualitative research for health personnel.* Makalu Press. Pp. 1–114.

Mason, J. (2002). *Qualitative Researching.* (Second edition). SAGE Publications.

Sofaer, S. (1999). Qualitative methods: What are they and why use them? *Health Services Research, 34*(5).

Truong Thi Xuan Nhi and Nguyen Quoc Phuong

HOW TO MAKE EFFECTIVE NOTES DURING DATA COLLECTION: A QUALITATIVE APPROACH IN SOCIAL WORK RESEARCH

We can all remember what happened a week ago, which is quite possible. However, clearly remembering every exact detail is almost impossible. This is where taking notes can help you capture the exact details of data collection. Moreover, taking notes is an important task that qualitative researchers cannot ignore. The method of creating effective notes during data collection is something that every individual must have through practice. Below is the discussion about the basics of making effective notes.

Why should you take notes

Field notes are always widely encouraged during qualitative research (Dube, 2022), especially during data collection – this is seen as a means to record necessary information about the context, the informant, and whatever arises. Although data collection in qualitative research is now greatly supported by technological devices, such as camcorders, cameras, and audio recorders, these devices can hardly replace the flexibility and the speed of paper notes (Mulhall, 2003; Phillippi & Lauderdale, 2018).

We all understand that taking notes in qualitative research is a strict requirement when doing research. This is the process that helps to augment the data, creating rich context for the analysis. Even making notes during data collection is considered necessary, as it becomes a criterion when reviewing qualitative research reports by researchers (Phillippi & Lauderdale, 2018).

Make a note during data collection

Taking effective notes is no easy feat. There are many forms of notes used depending on the different purposes of the researcher. German sociologist Niklas Luhmann divides notes into three categories: fleeting notes, literature notes, and permanent notes (Mon, 2022). However, most of the time, in the process of collecting qualitative data, we often use fleeting notes – this is a quick way to record your thoughts and findings. These notes don't need to be too long, sometimes just encapsulated in one or two words, and we don't need to be too concerned about the arrangement (Mon, 2022). And one thing to keep in mind to be effective is that we also need to understand the function of notes in the process of collecting qualitative research data. These functions are shown in Box 1 below:

Box 1. Functions of field notes in qualitative research within the original study

- Prompt researcher(s) to closely observe the environment and interactions
- Supplement language-focused data
- Document sights, smells, sounds of the physical environment, and researcher impressions shortly after they occur
  Encourage researcher's reflection and identification of bias
- Facilitate preliminary coding and iterative study design
- Increase rigor and trustworthiness
  Provide essential context to inform data analysis

(Phillippi & Lauderdale, 2018)

In order to take effective notes when collecting qualitative data, we must carefully consider and examine the following:

1. Preparation is extremely important before conducting qualitative data collection. Investigators need to thoroughly understand the contents of the information collection tools (Condens, 2022). There should be discussions and exchanges about the information to be collected, and the appropriate communication methods; prepare necessary items, such as sticky notes, pens, crayons, and supporting devices, such as camcorders, cameras, and audio recorders.
2. Sort and classify objects that provide information to optimize the data collection process. On the other hand, when there is an arrangement and classification of objects that provide information, we can think about ways to take good notes (Condens, 2022). For instance, we can take notes with a piece of paper and pen, but we can also make notes by marking data through video tapes, images, etc.

3. If it is a group with many members collecting information together, it is necessary to assign tasks to each member. Each person will take on a different job, and from different perspectives, we will get different notes about the context, people, interactions, and information. Sometimes within each data collection group, there will be a member who specializes in notes – this is entirely up to the qualitative research design team.

We do not have a common framework for notes during qualitative data collection. There is always a debate between using handwritten notes and typing notes on a computer, or using supporting tools, such as camcorders and audio recorders, of which there is no need to add notes (Jenkins, 2021). However, according to Ayat Shukairy, *"don't underestimate the use of pen and paper to capture information during usability testing or customer interviews. The way our brains work, putting pen to paper is very different from trying to type it out,"* (Dube, 2022). Below, we will take a look at each different method of qualitative data collection, and what should be noted to be able to create effective notes that serve the research process.

Observation

Observation is a method of data collection that takes on a variety of forms and requires quite careful note-taking. To observe in order to better understand the research context and actual behaviors, observers can be participants or non-participants in the field. If it is a participatory observation, the observer becomes part of the research context (Busetto et al., 2020). For example, observers are involved in the care of children with disabilities. For non-participating observation, the observer is not involved in the events, i.e., being present but not becoming a part of the situation, trying not to influence what is happening (Busetto et al., 2020). Therefore, it is very important to take notes during the observation; usually, the observer will have pre-prepared checklists when designing the study. Observers are responsible for filling in all the information they see in the requested content. However, if it is a free observation, the notation is also a free note. Observers need to take note of everything that happens around them (Busetto et al., 2020). This notation can be done during or after the observation depending on the field feasibility. While it may be the same context, we will get different notes from different observers.

To take effective notes, the observer must first adhere closely to what is outlined in the study design; the need to take full notes, and try not to omit any de-

tail; if there are special developments, observers should take notes immediately so as not to miss or forget them for a long time; observers must take objective and honest notes, and avoid putting their subjective opinions in the notes. In case there are many observers, it is advisable to limit the exchange and discussion during the note-taking process – this will cause misinformation in reality (Mulhall, 2003).

Observers should not limit the number of notes in each observation session. More notes will lead to higher efficiency, and provide a more detailed description of the observational context. One thing the observer should do when taking notes is to try to highlight or create links between notes, which will make it easy to code and handle the notes.

Semi-structured interviews

A semi-structured interview is a qualitative information collection method commonly used to identify an issue related to a person's subjective experiences, opinions, or motivations (Busetto et al., 2020). The interviewer will not have to completely passively rely on the questionnaire, but rather try to create a conversation based on open-ended questions.

With this method, the interviewer can ask for permission to video-record or audio-record to get the interview data file. The role of taking notes is no longer the same as making observations. The interviewer is now tasked with noting new findings from the respondents, sometimes important findings for the research content. This is done based on the interview experience and logical thinking; the notes will show connections in the interview content, valuable content regarding the research topic, or sometimes new ideas.

To make effective notes on this method, we must have a good understanding of the research content, and be adept at guiding questions so that the respondents reveal key issues. One note when taking notes is that the interviewer must have harmony between the questions and answers and taking notes; try to keep it short, and the interviewer can use specific characters to speed up note-taking.

In-depth interviews

In-depth interviews – this is the key data collection method in qualitative research. Most qualitative studies use this method to collect research data. By designing a guide on what to collect, the in-depth interview method gives the interviewer complete freedom in creating an informal conversation (Busetto et al., 2020).

However, the freedom in the interview inadvertently causes many difficulties for the interviewer to both lead the story with physical interaction with the respondent and take notes at the same time. Of course, for in-depth interviews, a video or audio recording is almost mandatory, but noting the findings from the interview process is still indispensable (Eisenhauer, 2022).

Still, there are ways to help interviewers create effective note-taking if the following tips are applied: try to pacify the interview so that there's a balance between the physical interactions and create time to take notes about important information; try to arrange topic groups when interviewing, so you will be able to create notes by topic; use important keywords to take notes to save valuable information, and you can add or remove notes right after completing the interview; ideally, we can have more colleagues to take notes, then the interviews and notes are always conducted simultaneously and fully.

Focus group discussion

The focus group discussion method is a method that requires the participation of many members, from the information group to the research team members. The goal of focus group discussion is to discover how and why the majority hold certain views or behaviors. The organization of the discussion will be based on a discussion guide that includes pre-designed topics. The process will have one member directly moderating the discussion (questioning and leading the discussion) and one or two people responsible for taking notes. The ideal organizing team should have three people, a moderator, a secretary, and a person who specializes in taking valuable notes from the discussion.

Because of the specialization in the work, the notes of this method are often quite effective in terms of (complete) volume. Notes in discussions can be repeated many times (Phillippi & Lauderdale, 2018) when the moderator wants to focus on a deep understanding of a certain issue/information.

Some notes for effective note-taking with this method are: try to have multiple notes, and each sheet will be a certain topic; note-takers should maintain eye contact or action with the moderator, so that important issues can be identified; Note-takers also need to have gestures to communicate with members providing information to improve the confidence of respondents during the process of information extraction.

Field diary

The field diary has never been classified as a formal method of information collection, or more precisely, it is often seen as a summary record of data collection. However, a field diary is a document that provides diverse data in spatial and temporal sequences, showing the meticulousness and thoroughness of the information collector. The field diary also does not have a fixed framework; depending on the research design, there are different field diary templates. However, to have a good field diary, it is necessary to adhere to the following (Jenkins, 2021):

We always check an individual's information collection schedule over space and time. Attached to the schedule are corresponding products, such as video files, audio files, and quick notes.

Always try to document key timelines – times and places where something interesting happened during data collection.

Fully record every event that occurs during data collection, even if these events seem inconsequential.

Mark items that are missing or incomplete, and should specify a time and place for this. Even better, make short notes about why we are missing information or not completing tasks.

Finally, make a general summary of our data collection session, which may be accompanied by a description of feelings or personal thoughts about the work.

Coding, processing, and data discussion

All the notes we get from the field are mostly fragmentary and very messy. Therefore, coding these notes helps us to organize the notes in an orderly manner. There are many ways to encrypt notes, which can be manual coding, such as numbering the notes according to the method of information collection: by time, by location, or by research topic. However, this encoding is only suitable for simple notes and a small number of notes. For complex and large numbers of notes, we should use specialized software that processes qualitative data to encode and provide relationships between notes. The outstanding software that can be mentioned are Nvivo and maxQDA. With the use of software, we will easily mark notes according to each attribute, the content, or by the relationship.

Coding the notes is the step to processing these notes. It should be noted that the data processing from the notes must be tied to the research content outlined in the design. Based on the study design, we put the notes in the correct place according to each data item. In addition, there should be comparisons between different notes at the same time, omitted data, problems with data collection, and new ideas. For the processing of notes, we should also use the above-mentioned processing software for synchronization and convenience.

The last and most important step in this process is to discuss the data obtained from the notes. Sufficient notes, properly handled, will provide effective information for the research process. This discussion process will transform valuable data from the notes into important content for research results.

Taking notes improve the quality of the data

Noting in qualitative data collection is an issue that has been raised by ethnologists, which is an important methodological issue (Smalley, 1960). Although today's science and technology have maximum support with modern tools for researchers, taking notes is an indispensable thing in each data collection. Effective notes improve the quality of information regarding the research content. Getting effective notes is not simple, as it requires the researcher to have experience and think logically, along with the careful preparation of the design of the works and data collection tool. Within the scope of this article, it is not possible to cover all the important aspects of taking notes during qualitative data collection. The content shared above will hopefully bring certain benefits to students or those starting qualitative research.

REFERENCES

Busetto, L., Wick, W., & Gumbinger, C. (2020). How to use and assess qualitative research methods. *Neurological research and practice 2,* 14. https://doi.org/10.1186/s42466-020-00059-z

Condens. (2022). *User Research Note Taking – How To Get It Right From The Start.* Retrieved from https://condens.io/user-research-note-taking/#tools

Dube, S. (2022). *Writing effective qualitative research notes.* Invesp. Retrieved from https://www.invesp-cro.com/blog/writing-effective-qualitative-research-notes/

Eisenhauer, K. D. (2022). *Try These Approaches to Interview Note-Taking.* Dscout. Retrieved from https://dscout.com/people-nerds/note-taking

Jenkins, J. (2021). *9 Tips To Improve Your Note-Taking Skills.* Optimal Workshop. Retrieved from https://blog.optimalworkshop.com/9-tips-to-improve-your-note-taking-skills/

Mon, T. (2022). *Notes With The "Wooden Box" Method Zettelkasten.* Vietcetera. Retrieved from https://vietcetera.com/vn/ghi-chu-voi-phuong-phap-hop-go-zettelkasten

Mulhall, A. (2003). In the field: notes on observation in qualitative research. *Journal of Advanced Nursing, 41*(3), 306–313. https://doi.org/10.1046/j.1365–2648.2003.02514.x

Phillippi, J., & Lauderdale, J. (2018). A Guide to Field Notes for Qualitative Research: Context and Conversation. *Qualitative health research, 28*(3), 381–388. https://doi.org/10.1177/1049732317697102

Smalley, W. S. (1960). Making And Keeping Anthropological Field Notes. *Practical Anthropology* (4), 145–152.

Priscilla Samson

RIGOR IN QUALITATIVE RESEARCH

The qualitative research method has been critiqued for lacking rigor compared to quantitative research. Based on this critique, research experts have introduced strategies for enhancing rigor in qualitative research. Therefore, this chapter focuses on the concept of rigor, the importance of rigor, and strategies to enhance rigor in qualitative research.

Rigor

Qualitative studies allow the researcher to investigate the humanistic side, empathy, feelings, and people's life experiences. Nursing and social sciences are the human-centric disciplines based on facts and figures as in quantitative research, but have a "caring" component that can be explored through qualitative research. As qualitative research depends mostly on the researcher's perspectives that may be influenced by his or her cultural background, upbringing, life experiences, values, and prior knowledge, these personal attributes can influence the data analysis and theory construction, causing a threat to the rigor (Shufutinsky, 2020). Therefore, specific criteria need to be strictly followed to make the qualitative research findings more acceptable and evidence-based.

Qualitative rigor is challenging for both novice and experienced qualitative researchers (Thomas & Magilvy, 2011). In simple terms, rigor is a way to establish confidence in qualitative research findings. Allen (2017) defined rigor *"as the degree to which research methods are scrupulously and meticulously carried out to recognize important influences occurring in conducting the research."* It is a set of standards investigators use to evaluate research quality, trustworthiness, and value. Qualitative research is reflexive, and requires awareness and openness to research and produce results. The qualitative investigators need a self-basic disposition and receptive thinking that their previously established inclinations might influence the study findings. Table 1 depicts Glassick's criteria used by Johnson et al. (2020) for quality indicators for rigor in qualitative research.

Table 1. Criteria for assessing the quality indicators of a qualitative research (Glassick, 2000).

Criteria	Question to be asked
1. Clear purpose	Is the goal or research question stated with a supportive rationale?
2. Adequate preparation	Is a thorough, integrated review of relevant literature done?
3. Appropriate Method	Are the research approach and methods aligned to answer the research question?
4. Significant results	Do the results advance knowledge and practice in the targeted field?
5. Effective Presentation	Is the presentation done so that other researchers can emulate the same findings?
6. Reflective Critique	Is there a regular and systematic approach to a question during the research process?

Rigor in qualitative research is defined as how the researcher establishes the trustworthiness of the findings (Morse, 2015). Lincoln and Guba (1985) published "the Four-Dimensions Criteria" (FDC) to promote rigor or trustworthiness in qualitative research, including truth-value (credibility), applicability (transferability), consistency (dependability), and neutrality (confirmability).

Credibility

Credibility allows others to recognize the experiences contained within the study by interpreting participants' experiences. It establishes confidence from the participants' perspective to immediately recognize that this was the experience that they shared with the researcher. Credibility equates to internal validity in quantitative studies.

Examples of strategies used to establish credibility include:

– *Reflexivity* is a crucial strategy in strengthening the rigor of qualitative research. It refers to researchers' awareness of their influence on their study, and how the research process is affecting them (Probst & Berenson, 2014). Reflexivity can reduce the bias in interpreting qualitative findings.
– *Member checking* (a.k.a. the informant/participant's feedback) is another common standard of rigor that increases credibility and confirmability. In this strategy, the research participant is asked to verify the completeness and accuracy of an interview transcript.

- *Peer debriefing or reviewing* is a third-party review, in which the researcher provides an audit trail (step by step procedure) before publishing the findings. The peers who are experts in qualitative methodology will review research site documents, journals written by the researchers, observational notes, and interview recordings to make sure if any key point has been missed out, misinterpreted, or overemphasized (Janesick, 2015).
- *Persistent observation* enhances credibility by focusing on the aspects that are more relevant to the research problem being identified (Lincoln & Guba, 1985).
- *Prolonged time spent with participants/study site* in the natural setting to grasp the "complete picture," including verbal and nonverbal expressions, language, dress, age, gender, culture, etc., can strengthen the findings of the qualitative research, thus increasing the rigor in qualitative research.
- *Using the participants' words in the final report* gives more meaning to the research findings as it provides accuracy and validity to the study findings. Using participants verbatim without disclosing the names of the participants increases rigor in qualitative research.

Transferability

Transferability is how the results can be generalized or transferred to other contexts or settings. The qualitative researcher must keep in mind that the research report is written, so that a similar study can be replicated by any researcher in the future using a similar approach. In quantitative research, transferability refers to generalizability that strengthens the study's external validity.

Strategies for transferability include the following:

- *Powerful sample* to form a nominated sample that can provide a rich and detailed meaning to the phenomenon under study (Forero et al., 2018). In qualitative research, unlike quantitative research, purposive sampling is used to get information from the participants who can give detailed information on the phenomenon being studied. The researcher identifies the people who will provide the rich data.

- *Data saturation* refers to the collection of data until no new information is obtained from the participants. Poorly planned qualitative studies or under-reporting the data saturation may reduce the rigor (Squires & Dorsen, 2018). Most qualitative researchers agree that a minimum sample size of 16 is needed for rigorous qualitative findings (Squires & Dorsen, 2018).
- *Thick description* of the population and the phenomenon refers to a technique by which a qualitative researcher provides a detailed explanation of their experiences during data collection. These experiences may include cultural and social contexts during data collection. Thick descriptions work as a guide for other researchers to replicate the study using a similar approach.
- Using the same data collection methods with different demographic groups or geographical locations also confirms the trustworthiness of qualitative research findings.

Dependability

Dependability can be ensured when the qualitative research findings are repeatable if other researchers do the same research within the same participants and context. It is related to reliability in quantitative research.

Strategies used to establish dependability include:

- *Rich and detailed description of the study methods* that address the following questions:
  What was the purpose of the study?
  How and what was the criterion for the selection of participants?
  How were the data collected, and for how long?
  What techniques were used to determine the credibility of the data? (Refer to the above mentioned strategies for credibility)
- *Having peers participate in the analysis process* can be done through peer-reviewing or debriefing.
- *Attempting multiple ways to ensure that the findings* are presented objectively, and that the researcher took actions during the research process to minimize bias.
- Conducting a step-by-step replication of the study to enhance findings can strengthen the reliability of the qualitative studies.

Confirmability

Confirmability is the last step in qualitative rigor. It occurs once credibility, transferability, and dependability have been established. In quantitative research, confirmability refers to objectivity. The purpose of confirmability is to extend the confidence that other researchers would confirm the research results.

Strategies researchers use to achieve confirmability include:

- *Taking notes* regarding personal feelings, biases, and insights immediately after an interview is vital in reducing bias.
- *Following, rather than leading,* which is the direction of interviews by asking for clarification when needed. Listening is an essential virtue of a qualitative researcher rather than leading the interviews.
- *Reflexivity* (Refer to the above section on credibility)
- *Triangulation* is a research strategy to confirm the findings, and provide a more accurate description in qualitative research. Qualitative researchers may use four different triangulations: methodological triangulation, data triangulation, researcher triangulation, and theory triangulation (Denzin, 1978; Santos et al., 2020). *Methodological triangulation uses* multiple methods, e.g., using quantitative and qualitative approaches in the same study. Data triangulation uses a variety of data sources in a study, e.g., direct observation and interviews. *Researcher or investigator triangulation* is when several researchers collect similar data, and *theory triangulation* uses multiple theories to interpret a single set of data.
- Ensuring the presence of an *audit trail* of study implementation. Audit trails are the records kept by the (Williams, 2018) qualitative researcher on how the study is being conducted. They include field notes, preferably in chronological order, and audio/video recordings. The researcher records each day, what was done, what the participants shared, and how the researcher drew the conclusions. The peer reviewer can also use the audit trails to check the validity of the research findings.

Practical suggestions for ensuring rigor in qualitative research

Qualitative research takes careful planning and implementation to prove its trustworthiness. Based on the above discussion, qualitative researchers must keep specific practical tips to assure that the findings of their study are authentic:

- Evaluate the bias, beliefs, and preconceptions based on past experiences (reflexivity). Avoid conducting research in areas where personal feelings and beliefs can influence the interpretation of the findings.
- Develop the research problem/question by using criteria based on the acronym FINER, where F= feasible, I=interesting, N=novel, E=ethical, R= researchable/relevant. By using the FINER criteria, it helps the researcher select a good research problem that will add onto the body of knowledge (Hulley et al., 2007).
- Although developing a conceptual framework prior to the qualitative study is not mandatory, it is suggested that the novice qualitative researcher should develop a conceptual framework in the beginning stages of the research process.
- Although qualitative research gives flexibility in selecting research methods, include the best methods to ensure rigor and trustworthiness.
- Select study participants intentionally by choosing a purposive sampling technique (Forero et al., 2018). In qualitative research, obtaining rich and insightful data can ensure rigor.
- Use data saturation for determining the sample size for the reasons mentioned earlier in this chapter.
- Qualitative researchers often collect enormous amounts of data; therefore, verifying the completeness and accuracy of interview transcripts from the study participants (member checking) is crucial for ensuring credibility.
- Prolonged time spent with the study participants in the natural setting to grasp the "whole picture," including verbal and nonverbal expressions, language, culture, etc.
- Use multiple data sources and methods. For example, observation field notes and interview transcripts (data triangulation) to obtain data accuracy.
- Use data analysis software for qualitative research, such as NVIVO.
- Get a peer review by providing an audit trail to a third party prior to publication.
- Draw valid conclusions and interpretations of data.

– Practice reflexivity in every step of the qualitative research process. Avoid taking research problems that can influence decisions and actions throughout the research process.

Attempting rigor in qualitative research

Rigor or trustworthiness is the desired goal in conducting qualitative and quantitative research. However, qualitative researchers find it challenging to deal with subjective data, including participants' feelings, views, and their own experiences and feelings. This chapter highlights four essential criteria and strategies that ensure rigor in qualitative research – credibility, transferability, dependability, and confirmability. These criteria, if met, can make the qualitative studies more authentic, valid, and reliable. Strategies for ensuring rigor must be used, from selecting the research problem to communicating the research findings.

REFERENCES

Allen, M. (Ed.). (2017). *The SAGE encyclopedia of communication research methods* (Vols. 1–4). SAGE Publications, Inc. doi: 10.4135/9781483381411

Denzin, N. K. (1978). *Sociological Methods: A Sourcebook.* McGraw Hill.

Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., McCarthy, S., & Aboagye-Sarfo, P. (2018). Application of four-dimension criteria to assess the rigour of qualitative research in emergency medicine. *BMC Health Services Research, 18*(1), 120. https://doi.org/10.1186/s12913-018-2915-2

Glassick, C. E. (2000). Boyer's expanded definitions of scholarship, the standards for assessing scholarship, and the elusiveness of the scholarship of teaching. *Academic Medicine, 75*(9), 877–80. https://doi.org/10.1097/00001888-200009000-00007

Hulley, S. B., Cummings, S. R., Browner, W. S., Grady, D. G., & Newman, T. B. (2007). *Designing Clinical Research.* 3rd ed. Lippincott Williams and Wilkins.

Janesick, V. J. (2015). *The Blackwell Encyclopedia of Sociology.* Peer debriefing. John Wiley and Sons. https://doi.org/10.1002/9781405165518.wbeosp014.pub2

Johnson, J. L., Adkins, D., & Chauvin, S. (2020). A review of the quality indicators of rigor in qualitative research. *American Journal of Pharmaceutical Education, 84*(1), 138–46. https://doi.org/10.5688%2Fajpe7120

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry,* 1st ed. Sage Publications Inc.

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research, 25*(9), 1212–1222. https://doi.org/10.1177/1049732315588501

Probst, B., & Berenson, L. (2014). The double arrow: How qualitative social work researchers use reflexivity. *Qualitative social work, 13*(6), 813–827. https://doi.org/10.1177%2F1473325013506248

Santos, K. S., Ribeiro, M. C., de Queiroga, D. E. U., da Silva, I. A. P., & Ferreira, S. M. S. (2020). The use of multiple triangulations as a validation strategy in a qualitative study. *Ciencia & Saude Coletiva, 25*(2), 655–663. Doi: 10.1590/1413-81232020252.12302018

Shufutinsky, A. (2020). Employing use of self for transparency, rigor, trustworthiness, and credibility in qualitative organizational research method. *Organization Development Review, 52*(1), 50–58.

Squires, A., & Dorsen, C. (2018). Qualitative research in nursing and health professions regulation. *Journal of Nursing Regulation, 9*(3), 15–26. https://doi.org/10.1016/S2155-8256(18)30150-9

Thomas, E., & Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for Specialists in Pediatric Nursing, 16*(2), 151– 155. http://onlinelibrary.wiley.com/doi/10.1111/j.1744-6155.2011.00283.x

Williams, D. D. (2018). *Qualitative Inquiry in Daily Life (1st ed.).* EdTech Books. https://edtechbooks.org/qualitativeinquiry

III
COMMUNITY DEVELOPMENT THROUGH INNOVATION AND CO-CREATION

Đoàn Lê Minh Châu

CO-CREATION METHOD IN SOCIAL SERVICES INNOVATION

There is an evident need for changing methods in creating innovative social services to adapt to the world's situation. This need for co-creating social services is to better embrace the service users, with the ability to empower them with the core values of treasuring people's dignity. The chapter is divided into three main sections: (1) why we need to innovate social services; (2) the need for co-creating social services; (3) the co-creating method and how we can adapt it in different settings.

Towards better life for everyone

Humans' visions of a better world include a better life for each individual. Nevertheless, that imagination is still far for us to achieve, especially when the definition of "being better" does not feel the same for everyone. A social service is held within its goal of delivering the assistance that people need to better their lives. We need to address the unbalanced power in the current social services system related to design acts and running the services. The unbalanced powers do not stem from hatred or the will to degrade the minority groups or vulnerable people in society. It stems from the government's goodwill toward the experts, the caregivers, and the social workers. However, social services starting with goodwill can encounter unexpected consequences. The answer to that dilemma is that the unbalancing powers result in misinformation, unstable solutions, and the failure to empower people in need of services. Furthermore, in the era of VUCA (Volatility, Uncertainty, Complexity, and Ambiguity), suitable social services cannot be made without the innovative methods considering every changing factor because the complex and diverse reasons lead to the problems that social services ought to solve.

What are social services, and why do they need to be innovated

Social services are the acts of provided services intended to "aid disadvantaged, distressed, or vulnerable persons or groups." This concept represents the intervention of professionals who serve professionally in existing social problems, such as hunger, poverty, education, health care, elderly care, child protection, and so on. These problems in modern society are seen as societal responsibilities. Therefore, the society will take measures to intervene, help, protect, and support individuals and share the burden on individuals. Especially in modern society, there are several components: the specialized form of dividing labor and the rational organization of modern society; the dependence of people on each other has become tighter; the sharing of individual responsibilities with community service as a form of emancipation and promotion of individuals to work and create value for socio-economic development.

The development history of the social services system often emerges from the viewpoint of "helping" and giving solutions rather than coordinating people to solve their problems. For example, the historical systems of care, hospice, charity, and distribution of the first orphanage system were built in the Roman era around 400 AD to take care of the children of those killed in military service. Religious systems have pointed out the necessary needs of society, and built a system of care and support for those who have difficulty surviving, developing, and accessing opportunities in the social system ("Christianity | Definition, Origin, History, Beliefs, Symbols, Types, & Facts," 2020). Moreover, they provide services to help solve social problems, especially in times of religious secularization. These charity and philanthropy sentiments have cast a veil of grace on modern-day social services, from the capable and resourceful to the less fortunate in society. This mentality has deprived people of "dignity," and the ability to "empower" vulnerable groups to grow and solve their issues with the proper facilitation and coordination. Social work has been linked closely with the promotion of human rights (Schmidt et al., 2020).

Targeted social service users are often described as: "poor, hungry", "uneducated", "low income", "limited information", "poor", and "need for help." These descriptions in the institutionalized social services system have created a mentality that treats the subjects of social services as the receiving end without consulting their voices. Therefore, the mechanism of operation and design of social services also exists as a closed system. Notably, in the modern state context, de-

spaired attempts to decentralize the state body and organization work, the power, and political idea hierarchies cannot be dismissed; "different political-economic and ideological contexts, this depoliticization of social work has significant consequences for service users and practitioners alike because 'no professional practice can be apolitical'" (Lewis, 2003). Existing hierarchies may interfere with the fact that social services have not seen service users as the sole – equal actor in the social services process; thus, they hardly can contribute to the services.

The operating mechanism of social services is currently maintained in the form of top-down users on the receiving end. The current (traditional) ways of analyzing problems and developing social services can be understood as presented in Figure 1.

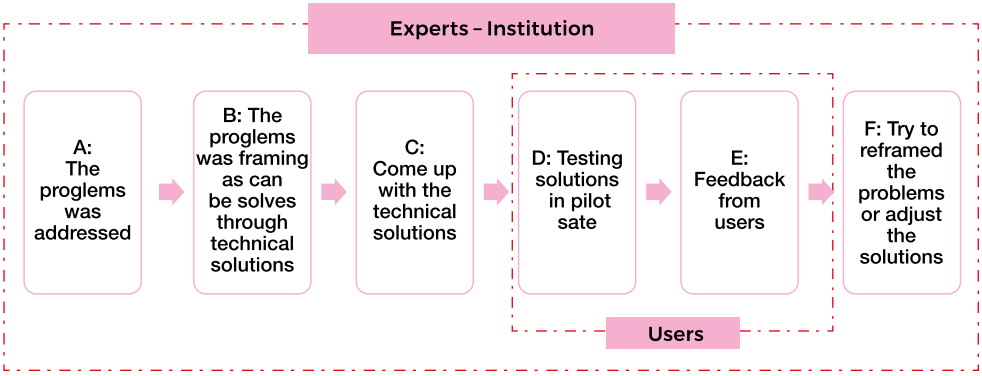

Figure 1. The traditional process of developing and implementing social services

There is almost no space for the user's participation from A to F, leading to disadvantages in the current operating model:

- The user is absent and is seen as unknowledgeable, only receiving the services.
- The process of providing a model, product, or service solution is often lengthy and time-consuming. It requires lots of labor and costs, but the final results are not always suitable for users.
- The problems change in society and become faster, and solutions from the old model are often challenging to keep up with the ever-changing world.
- Under-resourced public sectors, while the problem is often prone to change, leaving services users, especially vulnerable people, without proper care.

- The closed management mechanism of the social services process makes it difficult for users to adapt to the new changes due to the lack of information or guidance.
- Users are disconnected/ excluded from the services, making them more likely to criticize the services.
- Experts create services that often belong to the majority. Thus, they are considered a socially privileged group with little understanding of the struggles that the minorities and marginalized citizens face, along with particular needs or specific real-life experience groups (disability, elders, illiteracy, ethnic minorities, LGBTIQ+, etc.).

With the existing disadvantages in the current social services development models, users are typically excluded from the process, resulting in unsuitable services. Excluding vulnerable people from the service building process also makes it possible for the user's problems to be overlooked since the creators are not the ones experiencing the problem. Moreover, offering a solution that the users themselves do not understand makes them bound to use the service, and feel that the service is not for them, and their voices are not heard. Thus, they are powerless and incompetent. Over time, this causes them to distance themselves from problem-solving responsibilities, see themselves as useless, and find it difficult to make social changes from grassroots levels.

Social work is value-driven, and must align with the human rights credo as a welfare profession. Innovations in social work can arise if social values , such as social justice, social inclusion, participation, etc., are not fully met. The goal of social services is not simply to solve an existing problem on the surface, but to provide the platforms that promote the bridging of social gaps, attack the core problems of society, and empower the vulnerable. Problems cannot just be solved; they also must be treated and prevented. Above all, it needs to be built on the core of ethics, spiritual values, and community to integrate people and transform them into a factor attached to society. Therefore, it is necessary to have a different perspective in order to change the approach when generating ideas, operating, and delivering services to a customer/user-oriented trend to create a shared value.

What is co-creation, and why should we use it to innovate social services

The concept of participation and co-creation is still often used as two similar concepts, especially in implementing social projects in countries that do not have as much research on the development theory. However, there are still weaknesses in participation notions, even though this concept has been dominant in the development field. The concept can cause a power imbalance among stakeholders. The participation framework leaves little space for service users as active agents; the solution ideas and framing problems are still influenced by the organization's creative services, and the background knowledge still belongs to the experts. Local and community knowledge is considered a source of consultation rather than critical knowledge. Unlike the participation method, co-creation changes the approach perspective instead of "creating a participation space" for the "companion" of creation. The following concept explains the general understanding of the co-creation concepts:

> *The co-creation of services denotes collaborative activities in the customer-provider interface associated with the service; it necessitates the involvement, engagement, and participation of at least one customer and one service provider and may lead to beneficial and counterproductive outcomes resource integration. In producing services, co-creation manifests itself in different forms depending on the phases of the service process (co-ideation, co-valuation, co-design, co-test, co-launch, co-production, and co-consumption) and is influenced by a contextual, multi-actor network.* (Oertzen,et al., 2018.)

Co-creation means that from the beginning, every cycle has users as co-constructors, including "knowledge as a common public good." All stakeholders can co-create the value of products and services. Users have many roles and go through the process of creating services.

The co-creation process also needs to consider maintaining the existence of three "three-dimensional taxonomy" dimensions, which are (i) service innovations mainly oriented to non-profit social ends; even though the social services co-creation can consider a business goal (social enterprise), it has needed to keep the social goals as the core; (ii) the co-creation processes must be based on user-oriented (provider in charge, but takes the needs of users into account), users-driven (users participate via formal engagement, active participants), and user-led innovation (the users thoroughly joined, active in the whole innovation process); (iii) co-creation can happen everywhere in every sector. Whether it's provided by the public or private markets of the community, social services can all apply co-creation and provide room for the users, beneficiaries, and multi–actors involved (Gallouj, et al., 2018).

Methods for co-creation processes

A method combines tools, toolkits, techniques, or games strategically put together to address defined goals. The field of design mainly uses co-creation as a method. Besides, various fields use co-creation as an approach. An approach describes the overall mindset needed to conduct the process. Social services co-creation can be considered as the ability to discuss, exchange, cooperate, coordinate, and collaborate between the providers and other stakeholders (De Koning, Crul, & Wever, 2016). Figure 2, which is altered from (Oertzen et al., 2018), summarizes a general understanding of co-creation regarding the services process.

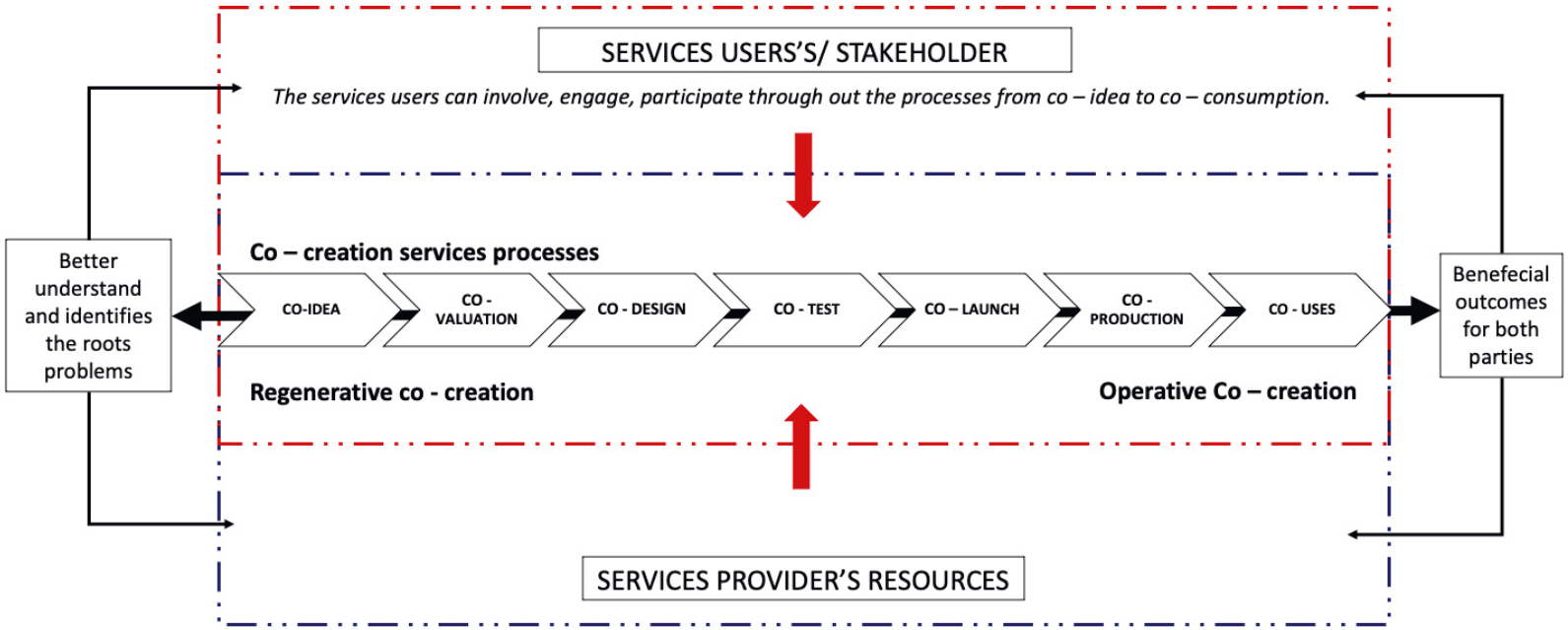

Figure 2. Integrative framework for co-creating service (Oertzen et al., 2018).

This service co-creation can manifest in specific forms, depending on the stages of the service process, such as ideation, co-pricing, co-design, co-testing, co-launch, co-production, and co-consumption. The co-creation of services has beneficial and counterproductive outcomes for customers and suppliers. In addition, the co-creation emphasizes the influence of multi-agent networks in all activities as a part of its process.

Regenerative co-creation: refers to forms of co-creation in the earlier stages of the service process toward service innovation – co-creation, co-pricing, co-design, co-testing, and co-launch

Operative co-creation: is a co-production and co-consumption activity, and describes a typical customer service situation. These real-life experiences contribute new insights for customer service in the subsequent phases of innovation.

With this cycle, there are many ways to realize co-creation, and there is a combination of many tool kits that will be applied. The toolkits in use today are often applied from the perspective of an innovation method, with the implementation steps iterable at each regenerative or operative stage. Depending on the level of complexity, services can directly participate, engage, or participate. The co-creation processes only can complete when the service users/ clients/ stakeholders can involve/engage/participate in every stage. Therefore, even though the methods for co-creation processes mainly appear in the form of guidance for organizations and services providers, it is also helpful for stakeholders to ask for their attributes and space in the co-creation processes.

The process of co-creation and embarking on renewal services will use the process outlined above. The co-creation process will have the following stages: co-ideation, co-valuation, co-design, co-test, co-launch, co-production, and co-uses:

– Co-idea: The process by which an organization and its stakeholders jointly define and generate ideas. This idea formation is applicable. In this step, the output goal is to find the problem to be solved. Besides, it is necessary to identify the potential customers for this problem. The clearer the analysis results are at this step, the less dangerous the product development direction will be. In this step, the activity logistics will go from defining the problem to discovering the issues and challenges involved.
– Co-evaluation: the service provider and the customer create value together. Co-creation is a new approach to value, which means the 'companion and customer create value,' and both the customer and supplier create value (co-creation). Suppliers apply their knowledge and skills in the production and branding of products, and customers apply their knowledge and competence in everyday

use. Thus, the product or service combines value through its actual use (use-value) and not through its selling price (exchange value), and that value is therefore ultimately determined only by the recipient (Lusch & Vargo, 2006).

- Co-design: The service provider, customer, and stakeholders jointly design a solution. This solution is built to solve the problem given in the co – ideation part. Features, shapes, cycles, ways of working, etc., will be factors that need to be co-designed. The result of this cycle is a prototype/sample kit ready to be tested.
- Co-test: This process will take measurements in testing, first-time user experiences, service usage flow, and obstacles that may appear unexpected by design. During this testing phase, ideas and designs are tested for practicality and feasibility, along with suggested improvements prior to its market launch on a large scale.
- Co-launch: Similar to the co-test, but at a larger scale. Co-testing usually occurs in the early stages of a prototype design and is geared towards the co-creation team. Co-launch only occurs when the team has a finished product that can be released to users outside the design team. These co-launch sessions are a way to spread the news about the services, and acquire more diverse feedback from the user's group and other stakeholders.
- Co-production: More than a concept, design, and consultation; co-production shifts the role of beneficiaries, target audiences, and stakeholders from users to service producers or providers. This process is only available when the user is empowered, and explores their ability and willingness to learn, train, and see themselves more than a receiving person. This creates a more comprehensive social network than the scope that services can reach. Each user can also become a giver at some point.
- Co-uses: Providers can also enjoy and benefit from the co-creation services. By creating a product where the user is both the subject of enjoyment and creation, it also helps the service provider to be given more rights than the user.

Stages of co-creation

This section aims to unpack the lengthy, complex process of doing co-creation, which also requires patience. This section is compiled from toolkit documents, tutorials, and co-creation manuals. The integrative framework of doing the co-creation can be divided (or rotated alternatively) into the following stages: Plan, Do Check, and Act-create. The following steps are the overall guidance for performing the co-creation method, not the exact formula to apply it mechanically.

This method should be used from the beginning of the *"research and development of services"* team formation. The formation of the primary team had to respect the criteria of co-creation, and consider the stakeholders' participation as crucial players of the team. Therefore, the service users have to exist in the core team, and have all the rights to be involved in the co – creation processes.

Once the core team has been formed, tools and methods of design thinking can be used in the steps to conduct problem research, build prototypes, develop the service, test the service, and launch the service. It should be noted that co-creation should be viewed as more of an approach than an exact cycle alone.

Plan co-creation

Innovating a product or service, or solving a social problem, can only arise from the right ideas, information, proper motivation, and resources. Therefore, strategies for implementing co-creation are necessary before deciding to put this method into practice.

- Determine the ability of the organizational group: Organizations that decide to do co-creation need to have faith in this method. The implementation of co-creation requires the team to be capable in terms of listening and communicating, accepting differences, and changing prejudices.
- Identify the problem to be solved: In this step, the implementation team needs to have a rough idea based on the initial research on the service, market research, understanding of customers, and the context of service implementation. These ideas are not meant to decide what service to do or how to change it, but to evaluate what other service solutions exist in the market that your team is looking to address. You do not want to waste resources redoing something you already have.
- Determining the resources of the group: The resources here can refer to the organization's available resources, the resources of the cooperation partner, and the additional resources from other partners. Make a list of actors who will contribute to your ideas. In addition to the users, these actors may include stakeholders (cooperation partners from the industry, public authorities, and researchers), as they can bring different perspectives that will help the co-creation process achieve its goals. Identify ways to collaborate and categorize critical stakeholders, and identify strengths and weaknesses when working with different actors/partners.

- Project planning: co-creation is a process that requires the cooperation of many parties. However, it is not a never-ending process. Planning this process should be seen as a manageable project. The organizational team needs to define goals, design a project management framework, and acquire measurement tools for monitoring and evaluating.
- Facilitator is needed: Co-creation is based on respect for dignity and diversity. Therefore, the organizational team needs people who can adequately facilitate the implementation stages, connect the stakeholders, manage, promote, and empower the parties appropriately to ensure all voices are heard.
- **Tools that can be used in this phase may include** Literature research, market research, a SWOT analysis, a Venn Diagram, and a Gantt chart, etc.
- **Expected results of this stage:** A co – creation core team has been roughly established, in which the service users are included as active actors.

Do co-creation

Doing co-creation means you are not just working with one organization. Different organizations and stakeholders will have different working methods, cultures, openness, communication methods, and cooperation criteria. These things can hardly be determined in the preparation step, but they need to be tried, checked, adjusted, and changed if necessary during the implementation process. Therefore, during the implementation of co-creation, it is necessary to have standard working rules, establish trust between the parties, use a suitable exchange platform, and build a common goal among the stakeholders.

- **Activities that can be done in this phase include** Initiation meetings, Brainstorming ideas, and training on tools used in the co-creation process.
- **Expected results:** The service users can involve, engage or participate in developing the team rules and plan, the median, and communication channel, as well as discussing the overall service ideas to adjust for the team member.

Check co-creation

Even if you have done the above steps, there is no guarantee that the co-creation process will be perfect. Therefore, co-creation needs to be done on a small scale (with sufficient control), and its results carefully monitored. During implementation, it is necessary to check that you and your project partners are pursuing a common goal; whether your idea can be further developed into a possible solu-

tion with the help of project partners; whether the project partners can and want to contribute to the necessary resources; whether the cooperation is practical or there are barriers to cooperation, and whether any adjustments need to be made.

- **Tools used in this phase include** World-Cafe and Open Space discussion, questionnaires, Surveys, and Feedback forms.
- **Expected results:** The service users and stakeholders can give open feedback on how the team has performed, what changes should be made, and so on. Through the activities, service users should feel that they have the authority and position to make changes, and their voices have been embraced.

Act and co-create

The co-creation team was officially established and put into operation during this period. The process of actually exchanging and implementing innovation will be done. It should be noted that even though all parties have agreed upon this process, it is still necessary to check, evaluate, and adjust the cooperation process continuously. There are numerous ways to check, evaluate, and adjust the core team. However, the decisions of adjusting should consider the cost and effects on the team performance, since the team has set and built bases on mutual trust between services providers and services users/stakeholders; it should not be totally dismissed or endure major changes. All changes must come with team decisions. Tools used to check, evaluate, and adjust teams include Developmental Evaluation tools (Patton, 2010), Decisions Matrix, and Risk Management.

- **Expected results:** With the co-creation team actively participating in the service, users and other stakeholders will all create new services from developing ideas, creating prototypes, testing the prototypes, feedback, altering the services, and launching. Moreover, using the services creates news values that the service providers can also benefit from.
- **Design thinking in co-creation:** Design Thinking is a methodology that refers to understanding users, identifying problems, and coming up with creative solutions to solve them. Design thinking is a loop process that can be used iteratively with the goal of continuous innovation and improvement. This approach aims to open up a space for experience, bringing people with different backgrounds, opinions, and perspectives to analyze, solve, and create an innovative solution that focuses on users. This method is user-centered with the goal of problem-solving.

After the co-creation group is formed, the latter part of the co-creation practice will be maintained in developing social services with the same method and principles. The developing service can use the steps of design thinking, along with the co-creation process. This method is organized in a vortex structure, unlike the conventional translational structure, maximizing the stakeholder's involvement, especially at an early stage. The three most essential elements of design thinking are: idea, prototype, and test (IDEO, 2020).

Step 1: Develop an idea: The co-creation team needs to focus on the existing problem in this step. What's most important is the detection of root problems. The cause of the existing problem must come from the insights of those directly or indirectly affected by the problem. The prominently affected groups are people in their established co-creators and community networks. Together, analyze and seek insight, based on the knowledge and experience of people who are not experts, but are interested and directly influenced by the existing problem. The idea's output is an analysis of the root problem and possible solutions.

Step 2: Prototype: The first version of the solution is a method to describe the solution, how the solution solves the problem, and describes how to use the solution. This first version need not be a complete solution, but it can be only in the form of digital illustrations, temporary products, and cheap materials. The purpose of prototyping is to convince the solution is feasible before actually investing in bringing the product to life. For example, a prototype of a card solution that aids communication between medical service users and doctors in another language can be in the form of a PowerPoint or hardcover paper instead of a complete print. Ideally, the prototype includes the core functionality of the innovative solution.

Step 3 Testing: The prototype is tested in a workshop or similar facility to undertake improvements or identify further weaknesses. This solution-testing process is similar to the co-testing and co-launching steps. Allowing solution users to test the solution on a small scale, or to evaluate the solution after hearing the prototype idea, helps them understand how the solution can be used and how it works. These testing-step results are the actual feedback coming from the user group outside the co-creation team. These responses can be obtained from quick post-use surveys, solution conferences, or product demonstration sessions.

After the prototypes are tested, the co-creation team needs to check the prototypes and modify the solution according to reality. The prototype can then be developed into a version 2 prototype to be tested again on a larger scale, or it can then be officially released. Depending on the outcome, the project moves back to steps 1 and 2, or the process is completed.

Better society through co-creation

In the global context, co-creation in social services has been adopted, especially in young countries like Estonia, with hackathons to find ideas for co-creation to change public services (Toros et al., 2020). As I am writing this chapter, the social services literature available in Vietnam have not yet adapted co-creation concepts widely. From 2018 to now, Vietnam's political ideology has expanded to discuss the possibility of socializing social services and public-private cooperation in social services to better solve the social problems of the new era. However, in that cycle of change, the ideas have not yet touched the change in the perspective of service providers with the principle of being user-centered; the user is the driving force and agent of change. Co-creation should not be limited to providing service solutions. It should become a core value for governments, policymakers, social workers, and social welfare to really open a dialogue with people and minorities in society. Only then can we create a better society for everyone with their dignity.

REFERENCES

De Koning, J. I., Crul, M. R., & Wever, R. (2016). *Models of co-creation.* Paper presented at the Service Design Geographies. Proceedings of the ServDes. 2016 Conference.

Gallouj, F., Rubalcaba, L., Toivonen, M., & Windrum, P. (2018). Understanding social innovation in services industries. *Industry and Innovation, 25*(6), 551–569.

IDEO. (2020). Design Kit. Designkit.org. https://www.designkit.org/methods

Lewis, H. (2003). 'Morality and the politics of practice', in M. Reisch (ed.), *For the Common Good: Essays of Harold Lewis.* Brunner-Routledge, pp. 130–148.

Lusch, R. F., & Vargo, S. L. (2006). Service-dominant logic: reactions, reflections and refinements. *Marketing Theory, 6*(3), 281–288.

Oertzen, A.-S., Odekerken-Schröder, G., Brax, S. A., & Mager, B. (2018). Co-creating services – conceptual clarification, forms and outcomes. *Journal of Service Management, 29*(4), 641–679. doi:10.1108/JOSM-03-2017-0067

Patton, M. Q. (2010). Developmental Evaluation. *Applying Complexity Concepts to Enhance Innovation and Use.* Guilford Press.

Schmidt, J., Niemeijer, A., Leget, C., Trappenburg, M. & Tonkens, E. (2020) The dignity circle: how to promote dignity in social work practice and policy?, *European Journal of Social Work, 23*(6), 945–957, DOI: 10.1080/13691457.2020.1804332

Toros, K., Kangro, K., Lepik, K.-L., Bugarszki, Z., Sindi, I., Saia, K., & Medar, M. (2022). Co-creation of social services on the example of social hackathon: The case of Estonia. *International Social Work, 65*(4), 593–606. https://doi.org/10.1177/0020872820904130

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COMMUNICATION WITHIN HEALTH CARE SETTINGS

Communication is the art of developing and attaining understanding, as well as promoting dignity between service providers and service users. Patients, service users, and relatives need to feel safe enough to communicate honestly and openly with their care providers to receive effective treatments. Health care service providers need to convey treatment plans and health education clearly, accessibly, and empathetically so that patients/service users can receive optimal care. This article focuses on communication knowledge and skills required in various health care settings. Healthcare providers understand that effective communication in healthcare organizations starts with recognizing the importance of listening to one another.

Key concepts of communication

In communication, individuals use verbal and non-verbal communication to share meaning with one another (Vestal, 1995). Communication is the process of transmitting and sharing ideas, opinions, facts, and information in a manner that is understood by both receivers. In other words, it is the art of developing and attaining understanding between people promoting dignity.

Four main types of communication

Verbal Communication: Information is sent or shared directly, either face-to-face or through a telephone. This form is used generally in meetings, lectures, conferences, etc.

Non-Verbal Communication: Non-verbal communication is the transmission of messages without words, neither verbally or in writing. Most of non-verbal communication is expressed through body language, body positions, and movement.

Written Communication: Written communication is always put in black and white. It can take the form of a statement, letter, memorandum, handbook, or manual reports, etc.

Visual Communication: Visual communication is the practice of graphically representing information to efficiently, effectively create meaning. There are many types of visual communication, e.g., infographics, interactive content, iconography, illustration, supporting text, graphs, data visualization, and animation.

The basic communication skills are speaking, writing, listening and reading (The 4 Basic Communication Skills | Communication Skills Activities, n.d.). The way of communicating with others and presenting the ideas makes a lasting impression on people.

Ways of encouraging effective communication

While communicating to someone, use 'what, who, why, when, where, how' (5 WH + H) questions:

What – Clarify ideas before communication
Who – Identify the need & interest of receiver
Why – Clarify the purpose of communication
When – confirm the date and time of communication
Where – workplace, meeting room, home/field, institute/school, regular classroom, online, etc.
How – Be a good listener, speaking through eyes, maintain the voice level, and maintain facial expressions and postures; ensure proper feedback, and maintain consistency in messages; consult others before communication, and be aware of the language, tone & content of the message.

Communication with patients and service users

Communication errors are the major issues in the context of health care services. At the transitions of care, there is an increased risk of communication errors occurring. This can lead to poor health outcomes, distress, or inappropriate patient care. Effective nurse-patient communication is a core clinical skill. How individuals communicate with a patient can profoundly impact their care experience, and how they manage their health when they leave your care.

Nurses are the key communicators between the physician and patients and service users. When nurses explain information clearly, and with care and compassion, service users develop more confidence and trust, take advice, and follow instructions. Patients and service users ask nurses to be clear when we give them information about their health. They also want us to show care and compassion when we talk and write to them. They are happy to ask questions about advice so that they can take better care of their health.

In order to improve communication, health care providers should be attentive towards service users' response and their situation. Open questions should be asked with summarization throughout the conversation. Health care providers should be bias-free and curious to explore the feelings of service users and relatives. Different means of communication can be used, and there should be shared decision making.

Essential elements for effective nurse-patient communication are:

Fostering relationships
Two-way exchange of information
Conveying empathy
Engaging patient in decision making and care planning
Managing uncertainty and complexity

Communication with angry or anxious patients: Health care providers should remain calm, demonstrate respect towards service users and identify the cause of anger, focusing on their physical and medical needs. Do not take anger personally, and maintain adequate personal space. Break the conversation if a physical threat is perceived.

Communication with patients with visual impairment: Communication with visually-impaired patients can be improved by using large-print material, adequate lighting in all areas, a normal speaking voice, and talking directly and honestly. The patient's dignity should be maintained throughout the conversation.

Communication with patients with a hearing impairment: Communication with hearing-impaired patients can be improved by using written material, maintaining a quiet area, minimizing background noises, facing the patient directly, and speaking slowly. Verify their understanding after communication.

Communication with the patient's and service user's relatives: The family member is the direct family person, or a significant person who is identified as a "close relative." They are essential to the patient because of the role that they play as decision-makers, and their responsibility in fulfilling their wishes. They are the primary communicators with healthcare regarding the care and health decisions surrounding the end-of-life journey of their dying loved ones. Tips for communicating with the patient's/service user's relatives include:

Listen
Summarize and Ask
Look or Pay attention to nonverbal communication
Ensure Patient Privacy/confidentiality
Be Tactful and Honest
Sharing of information

Communication with colleagues

The relationship between colleagues has a significant impact on the ability to provide effective care and support to patients and their families. Communication is necessary to negotiate, to liaise, and to understand a colleague's needs. Communication with colleagues:

Enhance a positive work relationship
Enhance a positive outcome with the patient
Enhance a patient's satisfaction
Increase interaction
Prevent errors

Tips for effective communication with colleagues are:

Use good etiquette
Build a positive relationship
Learn to read body language
Use a compliment sandwich when correcting nurses
Frame criticism as a question
Clearly communicate your needs
Make sure you give and receive a good report

Group discussion skills

Group discussion is a purposeful verbal interaction among group members, in which the knowledge and experiences shared among them is systematically analyzed and organized for the purpose of coming to a certain conclusive decision. The group discussion is a formal round moderated by panelists.

In the process of a group discussion, the maximum number of candidates for a group discussion is 6–12 participants. The group will be judged by a moderator/panelist. Group members will be given a topic by the panelist. A time slot (5 to 10 minutes) will be given to think and frame the points. A time slot (15 to 30 minutes) will be given to discuss the topic with the group. To stop participants from speaking beyond his/her individual time limit, a group discussion panelist might intervene. The panelist might signal the group (by ringing a bell) to end the group discussion round.

The following key skills are important to keep in mind while participating in the group discussion:

- Pay attention to your body language
- Don't be afraid to start
- Be courteous with fellow speakers
- Be confident and keep adding 'good' points
- Ensure that your words make sense
- Write down just 4–5 words because you don't want to risk blank thoughts at your turn.
- Once you are done with your point, listen passionately to what others are speaking.
- Use supportive statistics and examples
- Brush up your general knowledge
- Bring out different views and extracts from the speeches/articles for a topic of current affairs.
- Stay updated at all times

Assessing patients' medical history and service users' background by interviewing

Interview is a purposeful face-to-face interaction between the interviewer & interviewee for getting knowledge, attitude & practices in particular issues. It is a conversation between the interviewer & informant for the purpose of obtaining needed information. The interview and health history is the subjective assessment of patient and service users, in which the patient/ service user tells about him/herself during history-taking.

The purpose of the interview concerning health history is:

To record a complete health history.
To identify the patient/service user's strengths and problems.
To bridge the next step in data collection and the physical examination.

The interview procedure includes:

1. Introducing the interview
Introduce yourself: greet, give your own name and the role. Give the reason for a complete history. Establish a good interpersonal relationship by maintaining privacy. Keep the patient /service user in a comfortable position.
2. The working phase
Encourage the patient/ service user to respond to the questions. Listen carefully, and ask open-ended questions and closed-ended or direct questions (specific information).
3. Closing the interview
At the end, give the patient a final opportunity for self-expression and summarize.

Communication in comprehensive situations

1. Mistakes and apologies
Nursing professionals need to have both confidence and competence in their clinical performance. If the same confidence is inflated, egocentricity can be a significant source of error, poor communication, and relationship conflict. By being overconfident about their knowledge and skills, nurses develop rigid mental tem-

plates, on which they superimpose each patient's information. In analyzing the patient's information, these nurses oversimplify the process in order to accommodate their pre-existing quick judgements. Excessive self-confidence is a major source of mistakes within healthcare. When a nurse/ health care worker makes a mistake, some patients and families may be understandably distressed and show anger and frustration, but some patients and families will bring formal legal action.

With mindfulness, much of this can be avoided with the regular practice of looking inward, which is to ensure that patients receive the safest, high-quality care. Mindfulness allows for self-correction and refocuses on the patient's treatment. Just as we do after taking a wrong turn on a road trip, we stop, examine the situation, adjust our thinking, and redirect our efforts back to advancing toward our desired destination, the same can be said for quality patient care. Mindful practice can help decrease the potential for mistakes, and effectively address them when they happen. Being attentive, listening, doing one thing at a time, focusing, and tuning out distractions are some skills that prevent nurses from making mistakes. But when mistakes do happen, apologies are necessary.

Apologies are best when they are sincere, and delivered with humbleness and understanding. There is a lot of good data showing that when people apologize for mistakes, patients and their families are more forgiving than they would be if they were to find out later that something happened, no one said anything to them and they received no acknowledgement or apology.

We have to keep the patient and/or family in a private area, where there is no one listening in and then an apology should be given. We have to be ready to listen to the responses of the patient/ families. It is not just saying, "I'm sorry," and leaving. It is saying, "I am sorry," and waiting for a response.

Whether you should apologize or not is a personal decision. If you feel it can be helpful in easing your distress, and it helps the patient or family, then you can apologize. But many lawyers argue that apologizing may put the nurse at risk for lawsuits.

2. Hope

Hope is a kind of optimistic longing for something that represents an improvement in their current circumstances. When hope for a cure is realistic, then we need to encourage such a hope. Communicating hope relies on choosing words that are encouraging.

3. Breaking bad news

Breaking bad news is one the fundamental elements of communication with patients and families and health professionals, which may be doctors/ nurses or any health- professional. It should be delivered sensitively, and in a manner at a time that fits with the patients and their parties.

It should be based on their needs and circumstances. It should be done if patients and their families want it only. Provide a "warning shot." This could be a statement, such as, "I'm afraid I have some difficult news," which helps prepare the patient for what's to come.

The SPIKES model for breaking bad news was invented in 1950–1970. During the treatment of cancer, most physicians considered it inhumane and damaging to the patient to disclose the bad news about the diagnosis. The SPIKES model helps to identify a solution to the problem, and it enables doctors, nurses, and other health professionals to enhance their communication skills for breaking bad news.

The steps of breaking bad news with the SPIKES six-step model (Bayle et al., 2000) include:

S – Setting up an interview: all available information regarding the patient should be made ready, and manage time constraints and interruptions.
P – Assessing the patient's perception regarding the patient's disease/ condition
I – Obtaining the patient's invitation
K – Giving knowledge and information to the patient.
E – Addressing the patient's emotions and response with empathetic responses
S – Strategy and summary

4. Grief

Grief is the internal part of the loss; it is the emotional feelings related to loss. There are many theoretical models of the grieving process. Among them, the most common model is of Kubler-Ross, in which she identifies five stages: denial, anger, bargaining, depression, and acceptance.

There is no "closure" and "resolution of grief." Therefore, it is important for health professionals to give the grieving person the opportunity to talk about their loved one, and describe the meaning and impact that the deceased had in

their lives. Empathy and facilitative listening are the key principles. Health-care providers need to allow the expression of tears to relieve tension, and then listen to the patients' feelings and concerns. Nurses may experience this personally, or they may be the support system for patients and their families going through grief and loss.

5. Expressing condolence

Condolence is expressing sympathy to another person. Sometimes when our patients die, we, as health care providers, struggle with when to, how to, and to whom we should express our sympathies. In many cases, we express those condolences verbally at the bedside at the time of death. For some patients with whom we have worked closely or been significantly involved, we might choose to send their family members a formal condolence note.

For the patient's loved ones, it is comforting to receive notes of sympathy from closely involved clinicians. Condolence should be expressed to those who are intimately connected to the deceased, rather than in some way trying to discharge our own pain or suffering.

Basic components of condolence include expressions of sorrow, such as: *"I am so sorry for your loss. I am saddened by the death of your mother."* It also can be a description, a memory of the deceased, in a warm and gentle manner. Or it is a wish for comfort, such as: *"My heartfelt condolences to you and your loved ones during this difficult time."*

6. Disgust

In the course of our work, we are exposed to patients' most basic human products: urine, feces, pus, blood, and vomit, to name a few. We see gaping wounds, disfiguring traumas, and exposed bones. We encounter smells, see anatomical parts, hear bodily sounds, and touch things that people outside of health care can only imagine. Some of these things are very difficult to experience; yet, doing so is not only a part of the job, but doing it graciously with acceptance and sensitivity.

Communication across cultures

Cross-cultural communication is the process of recognizing both differences and similarities among cultural groups in order to effectively engage within a given context. In other words, communication between people who have differences in any one of the following: styles of working, age, nationality, ethnicity, race, gen-

der, sexual orientation, etc. Each individual can practice culture at various levels, where they grow up. Cross-cultural communication creates a feeling of trust and enables cooperation.

In today's rapidly changing professional world, it's critical to gain an understanding of how cultural elements influence communication between Professionals and patients/clients in a clinical setting. Developing strong cross-cultural communication skills is the first step in creating a successful work environment, and it's also essential in preventing and resolving conflicts and building supportive relationships.

Strategies for effective communicating across cultures

When two people of different cultures encounter each other, not only do they have different cultural backgrounds, but their systems of turn-talking are also different. Cross-cultural communication will be more effective if both consider some strategies like: know yourself, learn about different cultures and values, use a shared language, consider physical and human settings, improve communication skills, encourage feedback, allow for corrections and message adjustments, develop empathy, speak slowly, practice active listening, write things down, avoid closed questions, be careful with humor, and be supportive.

Cultural models in cross-cultural communication

L.E.A.R.N. Model of Cross–Cultural Communication include:

L – Listen with sympathy and understanding to the patient's perception of the problem
E – Explain your perceptions of the problem
A – Acknowledge and discuss the differences and similarities
R – Recommend treatment
N – Negotiate agreement (The LEARN and RESPECT Models of Cross-Cultural Communication | Center for International Rehabilitation Research Information and Exchange, n.d.)

The R.E.S.P.E.C.T Model of Cross – Cultural Communication include:

Rapport: Connect on a social level, seek the patient's point of view, consciously attempt to suspend judgment, recognize and avoid making assumptions
Empathy: Remember that the patient has come to you for help, seek out and understand the patient's rationale for his or her behaviors or illness, verbally acknowledge and legitimize the patient's feelings
Support: Ask about and try to understand the barriers to care and compliance, help the patient overcome barriers, involve family members if appropriate, and reassure the patient you are and will be available to help
Partnership: Be flexible with regard to issues of control, negotiate roles, when necessary, stress that you will be working together to address medical problems
Explanations: Check often for understanding, use verbal clarification techniques
Cultural Competence: Respect the patient's culture and beliefs, take the patients' faith and cultural background into account. This may affect how they interpret what you say, clarify limitations of care if they apply to religious and cultural beliefs, be aware of your own biases and preconceptions, and know your limitations in addressing medical issues across cultures
Trust: Recognize that self-disclosure may be difficult for some patients; Consciously work to establish trust, trust should be established as early as possible and maintained throughout your relationship with the client. (The L.E.A.R.N. and R.E.S.P.E.C.T. Models of Cross–Cultural Communication)

Towards effective communication

This article mainly focuses on basic communication skills, and communication with patients/ service users and their relatives. In order to provide effective communication between patients/ patients' relatives and the service provider or health care personnel, those skills are required. When communicating with the patient and family or relatives, the health care personnel need to respect and maintain their dignity. Effective communication facilitates in understanding the situation better and clearer because it makes the environment comfortable and friendly, and remove the barriers between the patient/ patient's relatives and health care professionals; this will also facilitate in moving onto additional processes, such as the interview and assessment of the patient's medical history and his/her background information, which are the basic and most important aspects in the treatment process.

Similarly, another important aspect is addressed in this article about group discussion skills and communication with colleagues, and its importance especially in health care or clinical settings among the health care professionals, which is vital in the shift handover and take-over process in health care settings. Likewise, it will also help to gain knowledge, develop skills and changes in the attitude/behavior of the health care team to communicate effectively, empathetically with the clients/ client's relatives in comprehensive situations like mistake and apologies, hope and breaking bad news, grief and expressing condolences in critical situations or at the time of death and dying conditions.

This article is beneficial for the readers/ nursing students and entire health care team, which is basic to every individual in a cultural diversity situation. After reading this article, the teacher can plan a pedological learning approach to the students, so that students can directly participate in role play during simulation scenarios in the skill lab to practice and demonstrate their communication skills in comprehensive situations in different health care settings, which will facilitate a better learning environment.

REFERENCES

Baile, W. F., Buckman, R., Lenzi, R., Glober, G., Beale, E. A., & Kudelka, A. P. (2000). SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. *The Oncologist, 5*(4), 302–311. https://doi.org/10.1634/theoncologist.5-4-302

The 4 Basic Communication Skills | Communication Skills Activities. (n.d.). Retrieved October 31, 2022, from https://www.communicationskillsactivities.com/the-4-basic-communication-skills/

The LEARN and RESPECT models of Cross-Cultural Communication | Center for International Rehabilitation Research Information and Exchange. (n.d.). Cirrie-Sphhp.webapps.buffalo.edu. http://cirrie-sphhp.webapps.buffalo.edu/culture/curriculum/resources/models.php

Vestal, K. W. (1995). Nursing management. Concepts and Issues. Lippincott.

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COMMUNITY MEMBERS' PARTICIPATION IN COMMUNITY DEVELOPMENT

Community development is a core component of social work practice and education. Participatory approach is an important factor for sustainable community development. Sustainable community development based on dignity has an important role in promoting the well-being of all. This present article aims to increase our understanding of the community development subject.

Community

The word community came from the Latin word "communitas," which means common (Community Development Strand, 2012). It can be defined as a social unit or a group of people living with a common attachment to their place of residence or in the same area, or in a particular geographical area, having the same culture, religion or race, sharing common living accommodations and goods, or sharing a common language (Tanahu Hydropower Project, 2012; Community Development Strand, 2012; Dinbabo, 2003). Community is a group of people or families with diverse characteristics linked by social ties, sharing common perspectives, or engaging in joint action in social behavior, cultural aspects, or geographical locations or settings (Mohinuddin, 2018). There are some fundamental values and needs that bind people together in the community, e.g., the need for friendship, security, employment, spiritual and cultural values and needs (Dinbabo, 2003; Community Development Strand, 2012).

Community development

Community development can be defined in different ways in different contexts. It can be defined as a change in the community, which improves the lives of community members (Community Development Strand, 2012). It can also be defined as 'the process of increasing the strength and effectiveness of communities'. It is

the gradual positive change among people within a given geographical area, towards self-determined ideals, with minimal outside interference. It aims to enable people to participate in decision making, improving people's quality of life, and to facilitate and empower communities in improving their physical and social environments, promote social justice and equity, reduce social exclusion, improve social structures and social attitudes, values and behaviors, and entail communities in the strategic assessment and decision-making processes that impact their local circumstances (Community Development Strand, 2012; Schutte, 2016). Community development can be easier and sustainable if the community identifies a problem or need, and implements changes to solve the problem or meet the need, and is managed by the community. Community development occurs best when people of the community are involved throughout the development, from deciding what they really need and how they want to achieve it (Schutte, 2016).

Community development is possible; it will be long-lasting and successful if we focus on the participation of local people, which means listening to their voices and assisting them in developing their own community, and empowering their participation in community-based programs with appropriate ways to involve themselves if they choose to become involved; by implementing socially inclusive programs, overcoming the challenges of various interventions and capacity-building through information, education, and sharing knowledge, leading to their empowerment (Tanahu Hydropower Project, 2012).

To create a sustainable and long-lasting community development and to bring positive changes, a participatory approach to reach the level of stakeholder involvement is crucial at each stage of the community development. The use of participatory approach in planning and implementing the programs for development encourages community ownership, allows information to flow between the community, the development organization, and policy makers, which ultimately enhances accountability between organizations and the community (Flanagan, 2015).

Community development should be basically focused on the values of human rights, i.e., dignity, equality, inclusion, social justice, and respect for diversity. It should take care of the rights of the community to make their own choices and decisions (Mohinuddin, 2018). The community development will be sustainable if the principles of equity, justice, and dignity will be followed, which includes: active participation of all community members regardless of culture, religion, sex, or age; making sure that people's access to information are available in ways they can understand; providing access to the community's resources, and communi-

ty members are not being disadvantaged or denied their democratic rights from any form of community development (Community Development Strand, 2012; Schutte, 2016).

Basic elements of community development

Community developments should cover various dimensions for overall developments, such as: economic empowerment dimension, social dimension, environmental dimension, political dimension, health dimension, and services and facilities dimension, etc. (Kim, 2021). Basic elements that are required for long-lasting community developments are:

- The community development should involve the community members in planning and executing the development work
- It should be a Bottom-up development approach
- It should be able to Address the basic real needs of the community initiated and planned by the community members
- It should promote the human development of the groups, with which it works
- The development process should be driven and executed by the community members
- The development process should accommodate local knowledge, cultures, norms, and values
- The development process should be timely executed
- It should focus on inclusion, empowerment, and sharing power
- It should help the community members to recognize and develop their ability and potential, and engage themselves to respond to their problems and needs, and seek the empowerment of local communities (Schutte, 2016; Mohinuddin, 2018)

Participatory approach in community development

Participatory approach can be defined as the development method where project stakeholders participate in the development process, which will be effective in identifying community projects and planning, executing and monitoring the development (Diluxshana et al., 2020). It is commonly understood as a collective involvement of local people in the development process by assessing their needs,

and organizing strategies to meet those needs, which brings the sense of belongingness and working together for community empowerment (Naku et al., 2021).

The basic principle of the community's participation in community development is to give the opportunity to local people to be a part of the programs, influence or contribute to the decision-making process, and actively participate in the issues that concern them. The main purpose of people participating in all stages of the development process is that when grassroots people participate for the common good of a shared purpose, they obviously benefit from it and that is one objective of community development. Therefore, the participatory approach became popular and widely adopted for implementing various projects in the developing world (Rashied & Begum, 2016). Local people have more experience and insight into what works, what does not work, and why it doesn't work. This fundamental relevance of the community's participation in community development is further stressed as a gate pass for achieving sustainable development in any community (Naku et al., 2021).

There might be some obstacles that affect the application of participatory approaches, such as some political influences, lack of technical knowledge among the community members, different casts and ethnic groups in the communities, and conflict between the members in the community (Diluxshana et al., 2020). To overcome these types of problems, some important principles of empowering participation within local people must be implemented, which include: listening, questioning, respecting local knowledge, and using local talent for the development programs (Tanahu Hydropower Project, 2012; Community Development Strand, 2012). Moreover, stages of participation can be studied under the following processes:

1. Initiation: 1st stage in which the project goals and scopes are defined.
2. Planning: This stage deals with working out the project details, budgeting, and the identifying resources.
3. Design: In this stage, details are further developed.
4. Implementation: the actual execution of the development process is done in the Implementation stage.
5. Maintenance: The maintenance or management is required for the long run of the development process, or for the sustainable development (Rashied & Begum, 2016).

Levels of participation

As it has been said, one of the key aims of community development work is to enhance the participation of community members during different stages of the project cycle. There are several typologies showing the different levels of participation. The most known typology is Sherry Arnstein's (1969) ladder of participation (Figure 1), in which she shows how participation may range from non-participation to a high level of citizens' participation and power. In her model, therapy and manipulation represent forms of non-participation, whereas consultation, information, and placation are examples of tokenism, only symbolic efforts to involve people in decision-making. On the other hand, partnership, delegated power, and citizens' control are forms of high-level participation.

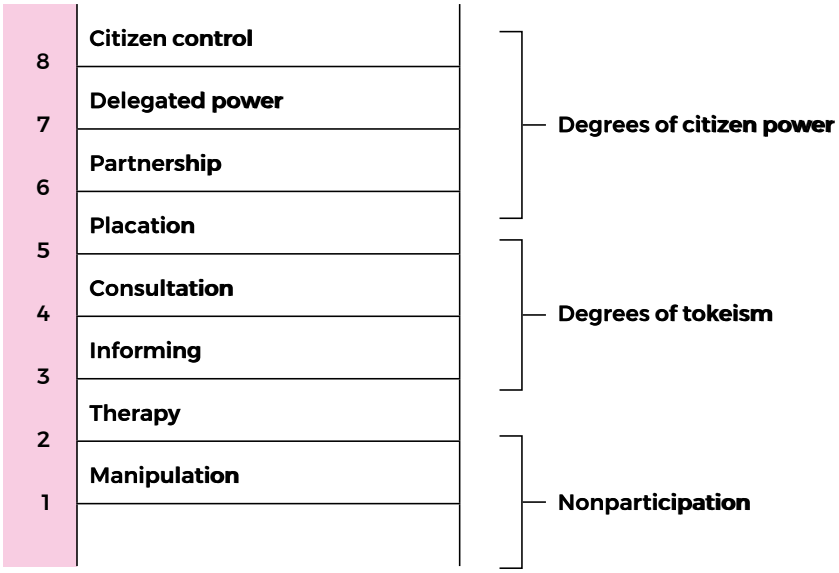

Figure 1: Amstein's ladder of participation (Amstein, 1969).

Sustainable development is essential for community development

In earlier days, development was seen as an economic growth, which commonly depended upon an ever-increasing consumption of energy and nonrenewable natural resources. But nowadays, people are more aware that this type of development cannot be long-lasting or tends to be unsustainable. An alternative type of development is qualitative development with minimal inputs and outputs and maximum reusing and recycling, and very little or no growth in the throughput (Schutte, 2016).

While we work towards building communities, we need to ensure that our processes are inclusive and sustainable. The basic elements of a sustainable community development are community participation, collaboration, capacity building, and empowerment (Matarrita-Cascante et al., 2020). The 17 sustainable development goals set by the United Nations remind us that all developmental activities that take place must keep in mind the well-being and dignity of all. They tell us that all developmental activities should be oriented towards promoting a more equal, just, and humane society, ecological justice and care for our planet, and a sustainable future for all. Sustainable development is necessary for economic sustainability in the country; the development should be targeted to the alleviation of poverty and inequality, and environmental management within national and global levels (Schutte, 2016).

Developments that benefit only a handful undermine our dignity as human beings, and they are detrimental to our own future. Community development becomes holistic only when it is sustainable by ensuring the well-being and dignity of all.

REFERENCES

Arnstein, S. (1969). A Ladder of Citizen Participation. *Journal of the American Institute of Planners,* 35(4), 216–224, DOI: 10.1080/01944366908977225

Community Development Strand. (2012). *Unit 1: Introduction to Community Development. Module: 1.1 Understanding Community Development. Lecturer Support Material.* Academia. https://www.academia.edu/38739055/Community_Development_Strand

Dinbabo, M.F. (2003). Development theories, participatory approaches and community development. Unpublished paper. Bellville: Institute for Social Development, University of the Western Cape.

Diluxshana, T., Nanthagopan, Y., & Thirugnanasampanthar, S. (2020). Participatory Approaches in Community Development Projects: An exploratory study of NGOs in Northern Province. 3rd Research Conference on Business Studies (RCBS). http://drr.vau.ac.lk/handle/123456789/2612

Flanagan, B. (2015). *Participatory Methods and Tools in Community Development. ECHO Summary of MEAS Participatory Methods documents.* Echo Community. https://www.echocommunity.org/resources/53f99bb6-f532-4606-8229-0327c16dbd3c

Kim, J. (2021). What Kind of Community Development System Can Effectively Support Citywide Philanthropic Efforts to Promote Community Well-Being? *International Journal of Community Well-Being* (2021). https://doi.org/10.1007/s42413-021-00135-5

Matarrita-Cascante, D., Lee, J.H., & Nam, J.W. (2020). What elements should be present in any community development initiative? Distinguishing community development from local development, *Local Development & Society, 1*:2, 95–115. DOI: 10.1080/26883597.2020.1829986

Naku, D., Kihila, J., & Mwageni, E. (2021). Community Participation Methods and their Influence on Effective Community Participation in Development Programs in Tanzania. *International Journal of Social Science Research and Review, 4*(4), 104–126. 10.47814/ijssrr.v4i4.131.

Mohinuddin, Md. (2018). *Community Development in Social Work.* SWEduCareBD. https://www.sweducarebd.com/2018/08/community-development-in-social-work.html

Rashied, M., & Begum, H. (2016). Community Participation in Development Projects in a Low Income Community. Jahangirmagar *University Planning Review, 14* (June 2016), 65–76. DOI:10.13140/RG.2.2.28120.32008.

Schutte, D. W. (2016). *Community development and community participation: A Conceptual Revisit.* Unpublished. DOI:10.13140/RG.2.2.22723.81443.

Tanahu Hydropower Project (2012). *Community Development Strategy.* NEP: Tanahu hydropower project. (RRP NEP 43281). https://www.adb.org/sites/default/files/linked-documents/43281-013-nep-oth-02.pdf

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TOOLS AND TECHNIQUES FOR COMMUNITY DEVELOPMENT

The participation of local community members is essential in community development. Participation should be an inherent part of any community development project from start to finish. In other words, participation should be encouraged and guaranteed in all stages of the community work: in the 'needs' assessment, implementation, and evaluation. There are several obstacles to participation. One of them is tokenism, where people may be asked for advice or given information, but they lack real power to make decisions that affect their lives. This article focuses on tools and techniques for encouraging community members to participate in community development.

Towards active participation

It should also be noted that reaching a high level or active participation is not automatic, as the long-lasting process requires plenty of time (Ife, 2016, p. 159). Jim Ife (2016, pp. 160–161) points out that there are ways, in which participation can be supported. Firstly, community members are likely to participate if the matter or an activity is meaningful for them. Therefore, it is important to let the community members determine the needs and strengths of their community. Secondly, community members should feel that their participation will actually influence the status quo of their community. Thirdly, as people may participate in many different ways, diverse forms of participation should be appreciated. Community members should participate in ways that are "natural" to them. Furthermore, participation should be made possible and all obstacles – whether they are related to time, location, or accessibility – that hinder the participation should be removed. Finally, the structures and processes in community development should be inclusive, and the community members should be able to determine the type of structures and processes they find most convenient.

In discussing the participatory rights of children provided by the United Nations Convention on the Rights of the Child, Laura Lundy (2007) identifies four key factors that should be considered when talking about participation:

Space – participants should be provided a possibility to express their views,
Voice – the expression of opinions and views should be facilitated
Audience – the views should be listened to, and the views should be taken seriously
Influence – actions should be taken based on the views

Lundy's (2007) views are also applicable for our article even though our focus is community members and marginalized groups in general. In this article, we will look at three different tools – participatory mapping, walking interviews, and photovoice – that can be used to encourage the participation of community members in assessing and defining the needs and strengths of their communities, and to support their participation in decision-making.

Participatory mapping

A map can be defined as a visual representation or a symbolic depiction that represents a region or place by showing the various features. It can be defined as symbolic representations of reality or the subject of framing, coding, and graphic design in the conception, execution, and projections that involve choices of inclusion and modes of depiction by the mapmakers.

In participatory mapping, the members of a community take part in creating maps that represent their views and experiences of their community. With the help of participatory mapping, the participants are able to identify and map a diverse set of elements in their environment. They may map places that are functional, useful, or add to their wellbeing, and other places that are seen as negative or even potential disaster risks. Participatory mapping thus enables the community members to voice their views and participate in knowledge creation. As a visual tool, it easily generates communication between community members and decision-makers. It therefore allows members of the community to participate in decision-making, which in turn empowers the participants. Participatory mapping is versatile and can be facilitated with relative ease. It is a playful and stimulating tool, and people often derive fun, fulfillment and pride from their participation while constructing maps in a group (International Fund for Agricultural Development, 2009; Panek & Vlok, 2013).

In participatory mapping, two types of maps can be used:

1. **mental maps or cognitive maps** are subjective representations about the environment by the community members. Therefore, the spatialization and the scale are present in the mind of the individual or groups of people.
2. **proper maps,** i.e., those that are fixed cartographic manifestations of spatial relations by using various types of materials (Di Gessa, 2008; Götz & Holmén, 2018).

Mental or cognitive maps can be very useful to express the feelings of the community members about their views on social -spatial hierarchies that structure the world, and how individuals orient themselves in the environment, or to understand how one perceives the world. It is a methodology that collects a broad range of ideas from a population, and organizes and assigns values to the ideas, which creates a picture of how different ideas are related to each other (Flanagan, 2015). This technique could be an effective way to express an understanding of the person about dignity, and these maps often represent a step toward grassroots empowerment for better access and tenure security (Di Gessa, 2008; Götz & Holmén, 2018).

Characteristics of participatory mapping

Participatory mapping is also known as community mapping. It is a general term that can be used to define a set of approaches and techniques that may combine the tools of locally available things to modern cartography with participatory methods to represent the spatial knowledge of local communities (Bhandari et al., 2015; International Fund for Agricultural Development, 2009; Panek & Vlok, 2013). It is well established as a tool of development intervention. These are compelling tools that give visual expression to realities that are perceived, desired, or considered valuable, thus providing means for communicating information beyond the realms of those who produce them. The maps contain place names, symbols, scales and priority features of a community and represent local knowledge systems (Di Gessa, 2008). Participatory mapping can be implemented in both developing and developed countries for the creation of maps ranging from simple to advanced by local communities; including the small-scale participation involving the members of the communities, to a large-scale participation like the involvement of supporting organizations including governments at various levels, non-

governmental organizations (INGO's), universities, and other actors engaged in development planning. Different types of maps can be prepared by the community people like: Ground mapping, Stone mapping, Sketch mapping, Mapping on aerial Photos or satellite images, GPS mapping, and Drone mapping etc (Le Dé et al., 2020; Paradza et al., 2020).

Participatory mapping is multidisciplinary. It provides valuable visual representation about the perception of the people in the community. It focuses on providing the skills and expertise for the members in the community to create the maps to represent their knowledge, ideas, and planning via the maps (Di Gessa, 2008). The availability of various tools and local equipment make this mapping method highly flexible and valuable in development initiatives.

This type of preparing maps by the involvement of the community members can contribute to building community cohesion, help stimulate community members to engage in land-related decision making, and raise awareness (Di Gessa, 2008). Participatory mapping plays a major role in giving voice to minority groups, and can also express history that is often unheard and a means by which marginalized and oppressed people seek recognition and justice. It also helps in securing indigenous rights and property, and Empowerment is often an objective of community-based and participatory mapping (Cochrane et al., 2014).

It can provide detailed information about the area layout and infrastructure like rivers, transport, location of houses, some institutions, roads, etc., information about the natural resource distribution, and for improving collaborative natural resource management, and for cross-sectorial planning, to facilitate the management of these resources, and to support community advocacy on land-related issues. It can be used as a tool for advocacy, and as a way to enhance community cohesion in the face of land-related challenges (Di Gessa, 2008).

These types of maps are not only confined to simply presenting the geographic feature information, but they can also illustrate important social, cultural and historical knowledge, ethno-linguistic groups, health patterns, and health service facilities, etc., which ultimately plays a role in empowering local communities and their members in the planning for the community development by visualizing the present scenario and possibilities of future planning in the maps. Somehow, this technique can also help to enhance dignity by expressing people's feelings in the form of the map even if they are not able to express it by saying the words. i.e., participatory mapping can empower the voiceless and can perpetuate existing inequalities by favoring the voices, perceptions, realities, and spatial languages of those that are already privileged and reflect the full bundle of rights (Di Gessa,

2008; Weyer et al., 2019). It is a very useful tool that allows remote and marginalized people or communities to represent themselves, and bring their knowledge and perspectives to the attention of governmental authorities or decision makers. These types of maps can act as a way to identify their rights and dignity, a way to make customary tenure relations and rights apparent for outsiders, and a way to facilitate the official administrative recognition of their rights and dignity.

Uses of participatory mapping

Maps can exist in various forms, represent different ideas, and can be used for many purposes. Nowadays, Participatory maps have a wide application and scope. Nearly anything can be mapped like Heritage, language, community planning, conservation, curriculum, economic development, and many more.

Based on the purpose, participatory mapping can be broadly categorized into the following types (Cochrane et al., 2014):

1. To get insight into a current situation, and explore and assess a situation where a development process should take place.
2. To get information about the perception, and archive local knowledge of the community members.
3. To provide information and ideas on the local perspectives of available resources in the area or to access the services/facilities.
4. To articulate and communicate spatial knowledge to the outsiders
5. To plan for the use of land and resource management
6. To advocate for change
7. To address resource related conflict
8. To increase capacity within communities.

Maps provide information in a simple and visual way. It helps us to be creative, and engage the community members to work in a collaborative manner. This method helps reinforce the importance of working together, across differences, and ensures that the voices of even the most marginalized members of communities are heard.

Walking interviews

In community development work, it is important to find out about both the needs and assets of the community. One way of finding out about these is to interview the community members. Often, the interviews carried out with community members are sedentary; in other words, they are carried out while both the interviewee and the interviewer sit and stay in the same location for the duration of the interview. Sometimes the interviews are done by only handing out questionnaires to the community members without having any further conversation between the two. Even though these methods provide the worker with some information about the strengths and needs of the community, they also have some impediments. One of the downsides is that they tend to maintain the rigid power relationship between the interviewer and the interviewee, and thus prevent the participation of community members instead of reinforcing it. Therefore, these types of interviews do not necessarily improve the sense of dignity for the community members. To deconstruct the uneven division of power and to strengthen the participation of the community members, a different approach to interviews should be adopted. Interviews that are done on the move, especially walking interviews, offer a suitable solution here. Not only do walking interviews enable the participation of community members and the collaboration between them and the community development workers, but they also give room to the multiple voices within the community. To be able to express one's opinions and be heard, and to be able to participate on an equal footing with others, is a key factor in building dignity. In this chapter, we will look more closely at the walking interviews, which are beneficial tools if you want to treat community members with dignity.

Types of walking interviews

As the name implies, walking interviews are interviews that are done while the interviewer walks with the interviewee in the surroundings where the community is located. James Evans and Phil Jones (2011, pp. 850) note that there are various types of walking interviews, which differ from each other based on two different variables. The first variable pays attention to who determines the route to be walked. Is the route to be walked determined by the interviewee or by the interviewer? The second variable focuses on how familiar either the interviewee or the interviewer is with the area to be walked. Based on these two variables, Evans and Jones have created a continuum on which the different types of walking interviews can be situated (see Figure 1).

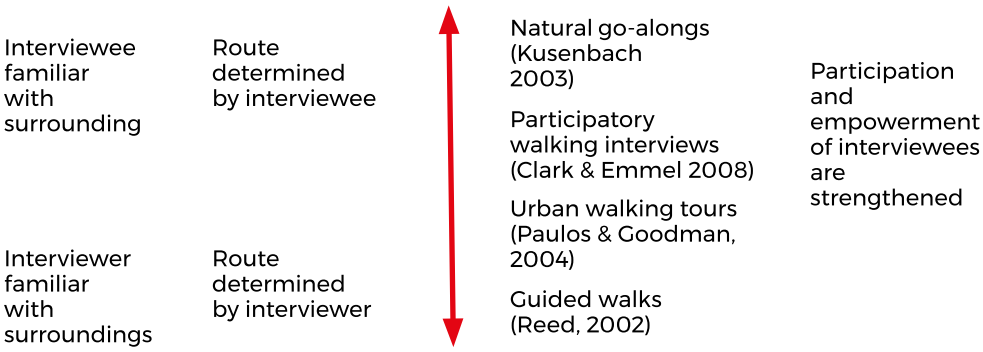

Figure 1. Continuum of walking interviews (adapted from Evans & Jones 2011).

At one end of the continuum, there are walking interviews where the route is determined by the interviewer and who, at the same time, is familiar with the surroundings. The interviewees may not have any experience or knowledge of the area where the walking interview takes place. Examples of these types of walking interviews are, e.g., so-called guided walks (Reed, 2002 as cited in Evans & Jones, 2011) or urban walking tours (Paulos & Goodman, 2004 as cited in Evans & Jones, 2011). These kinds of walking interviews are suitable and valid if the interviewer is interested in how community members experience or feel about a specific area or place in their environment (see Evans & Jones, 2011). However, walking interviews, where the route is determined by the interviewer, do not necessarily provide a sense of empowerment nor agency to the interviewees. Thus, they may end up maintaining the imbalance of power between the interviewer and the interviewee (see Evans & Jones, 2011).

At the other end of the continuum, there are walking interviews where the route to be walked is determined by the interviewee who is also familiar with the route and the surroundings. Evans and Jones (2011) mention Kusenbach's (2003) natural go-alongs and Clark and Emmel's (2009) participatory walking interviews as examples of these types of walking interviews. As Kusenbach (2003) notes, in the natural go-alongs, the interviewers follow the interviewees "into their familiar environments" and "to their natural outings" (Kusenbach, 2003). This means that the interviewer accompanies the interviewee on their daily walking routes during the times of the day that they would walk anyways, be it on their way to do grocery shopping, on their way to work, school, or hobbies, or just to take the dog out for a walk. While conducting go-alongs, the interviewer will observe, ask questions, and listen to the interviewees about their "experiences and practices as they move through, and interact with, their physical and social environment,"

(Kusenbach, 2003). In participatory walking interviews, the interviewee walks to different places with the interviewer.

Why walking interviews? The pros and cons of walking interviews

The use of both walking interviews and go-alongs have several advantages. As it has already been mentioned, when applied properly, they may help overcome the power relations between the interviewer and the interviewee that are often inherent in sit-down interviews (Anderson, 2004; Roy & al., 2016). This in turn may strengthen the participation of community members in decision making, and create opportunities for a collaborative partnership between community workers and community members. Thus, the method is empowering and gives the community members a sense of agency.

When, for example, exploring the relationship of community members to their physical and social environment, the problem with sedentary and static interviews is that they focus primarily on talking (Kusenbach, 2003). On the other hand, walking interviews provide more personal information about the interviewees' experiences, feelings, and attitudes about their living environment (Evans & Jones, 2011). It also makes it possible for the interviewer to observe the "spatial practices in situ while accessing their experiences and interpretations at the same time" (Kusenbach, 2003). In addition, walking interviews embrace the idea that the place, person's experiences, and perceptions of place strongly impact their identity. It is important to point out here that 'place' and 'identity' not only influence one another, but also constitute one another (Anderson, 2004). By engaging in walking interviews, it is easier to understand the interrelatedness of the place and person's identity. This in turn will help the interviewers better understand the daily lives of the interviewees (Anderson, 2004; Roy & al., 2016).

Walking interviews can, e.g., provide us with information about how the community members are engaged, included, or excluded in their social and physical environments, or how accessible their environment is to them. It can reveal which places add to the wellbeing of members of communities, or which places are feared by them. During the walking interviews, the members of communities may also share ideas of improvement. When applied to the community development work, walking interviews help us in understanding the assets and needs of community members that they encounter on a daily basis.

How to prepare for the participatory walking interview

If you want to conduct go-alongs or participatory walking interviews, it is important that you give information about the chosen method to the community members, those being interviewed. You should at least talk about the following:

1. *Why you are doing the interview, and what you are interested in finding out.* You may, for example, tell that you are interested in finding out how the interviewees experience the geographical and social surroundings of their community, what they are pleased with, and what they would like to improve in their environment. Are there places they like to spend time in or places that they would like to avoid?
2. *Who decides the route to be walked and the length of the walk?* Tell the interviewees that they may take you anywhere they wish during the walk, and that you will walk along with them. They may walk along their daily routes, or take you to places they consider worth walking to and showing to you. You may also let them know that the length of the walk depends on them, but that you are ready to walk for as long as needed. Remember to reserve enough time!
3. *How is the interview conducted?* The idea in walking interviews is to let the interviewees talk freely about the route they have chosen to walk, and about their experiences, feelings, and attitudes about different places and social environments along that route. Remind them that you may ask them clarifying questions while you are walking. However, as Lenette and Gardner (2021) point out, it is important to remember that the interviewer should focus on listening to the stories told by the interviewees. The interviewees may also stop to take photos of places that are important and meaningful to them. Tell that you will also observe their practices and social interactions that might take place during the walk.
4. *How ethical matters are taken into consideration.* Informed consent should always be asked from the interviewees before the walking interviews take place. If you use a recording device, ask for permission to use it. Let the interviewees know that all information they share with you is confidential and that their anonymity is guaranteed. Inform them how, and for what purposes, you will use the interview material that you have collected. Of course, a good idea in community development is to collaborate with the interviewees, and discuss and analyze the collected material with them.

Materials needed for the walking interview

1. It is important to *document the route* that you have walked. You can do this by using GPS. If it is not possible, you may also draw the route on the map afterwards.
2. It is equally important to *document the interviews*. You may do this by using *a recording device*. In this case, make sure that the interviewees give their consent for recording the interview. Also, make sure that the device will be able to record the interviews while walking outdoors. In case you do not have a recording device, you may take notes and write important quotations on a *notepad*. This may, however, distract your attention from the interview.
3. As the interviewees may stop to take photos of meaningful places during the walking interview, it is important to make sure that the interviewees have *a camera* in their use. If possible, they may use their mobile phones. If they do not have mobile phones, you can give them disposable cameras.

After the interviews, it is important to locate on the documented route where the photos are taken by the interviewees along the walking route and their accounts of these places. You may, e.g., synchronize your GPS and the recording device in order to do this, or you may do this afterwards manually.

Photovoice

Another method that advocates for the strong participation and empowerment of community members is photovoice. With photovoice, community members – or more generally, those lacking power – are given cameras to take pictures and document their everyday lives and the needs and strengths of their social and physical environment within the community. The photos – and the experiences, strengths, and needs that they represent – will then be discussed and critically reflected in group discussions with other members of the community. Finally, the experiences, concerns, and needs are communicated to the general public and policymakers in order to achieve social change, and to improve the situation of those living in the community.

From the above definition, the three important goals of photovoice can be drawn (Wang & Burris, 1997):

1. **Voice:** By allowing the community members to document their lives and the positive and negative aspects of their community with cameras, photovoice gives the participants an opportunity to voice their opinions. Photovoice acknowledges that even though people may lack power, they still should be considered as experts of their own communities and environments that others, including professionals, outside their communities lack (Wang and Burris, 1997).
2. **To enhance critical consciousness:** When engaging in a dialogue and critically reflecting the photos with their peers, it is possible for the participants to realize that what they thought was their private and trivial experience is, in fact, caused and maintained by unequal power structures.
3. **Social change:** In photovoice, it is important to disseminate the information gathered via photos and critical dialogues in the groups to the general public and the policymakers. The idea is to influence the policymakers in order to achieve social change and improve the quality of life for community members.

Underlying theories

Photovoice was developed by Caroline Wang and Mary Ann Burris while they worked in a Ford-Foundation-supported research project that focused on the reproductive health of rural women in Yunnan (see a detailed description of the photovoice project, e.g., in Wang & Burris, 1994 and Wang & Burris, 1997). Wang and Burris asked the women to record "the spirit" of their everyday lives with cameras, and made efforts to achieve changes and improve the lives of these women.

Photovoice is a form of participatory action research method and echoes its four pillars: participation, action, research, and social change (Liebenberg, 2018). The theoretical basis of photovoice can be found in critical pedagogy & critical consciousness by Brazilian educator Paulo Freire, feminist research and documentary photography (Wang & Burris, 1994; Wang & Burris, 1997; Liebenberg, 2018; Breny & McMorrow, 2021). All these approaches also share the same value base that is built on equality. The Freirean critical pedagogy and critical consciousness, seeks to dismantle the hierarchical relationship between the teacher and the student. Its idea is to democratize this relationship and turn it into a reciprocal relationship that contains mutual respect. This approach allows both parties to

participate in producing and creating knowledge, and thus advocates for the co-creation of knowledge. The Freirean model is also called a problem-posing education. It uses photos as triggers and focuses on topics that are meaningful in the everyday lives of the students. Instead of offering ready-made answers, the teacher engages the participants in a critical dialogue. Through the critical and collective dialogue, the participants will be able to find common themes that define their lives. They will also be able to identify the diverse social and political factors that influence their lives. Following these ideas, photovoice points out that the everyday experiences of participants, that at first seem to be private and trivial, are, in fact, shared and socially and politically constructed. Photovoice helps examine and deconstruct these structural inequalities and the processes that maintain them (Wang & Burris, 1997; Liebenberg, 2018; Coemans & al., 2019).

In a similar vein, critical feminist research emphasizes the idea that the power relationship between the researcher and the research participant should be re-assessed. Those being researched should not be considered as mere objects of research, but should be granted a more active role. Accordingly, the research participants should be made co-researchers, and they should be engaged in the research process from the beginning. Moreover, along with feminist research, many other critical theories, cultural studies, and post-colonial studies also aim at questioning the taken-for-granted discourses about – and promoting critical awareness of – women or any other marginalized groups (Liebenberg, 2018).

The influence of documentary photography on the photovoice method has also been acknowledged. In documentary photography, the lives of members of different communities or marginalized people are represented via photos. However, by deciding what to photograph and how to represent everyday life in communities, the photographer practices a form of power. Contrary to documentary photography, in photovoice, the cameras are given to the hands of the community members who can take pictures based on their own choice, thus being able to represent their community in their own right (Wang & Burris, 1997; Liebenberg, 2018; Coemans & al., 2019; Breny & McMorrow, 2021).

Who is it used with

Photovoice is often used with people who lack power, or who are seen as marginalized, and whose voices are not heard nor taken into consideration in decision making. The fundamental goal of photovoice is to give the participants an opportunity to have control of their lives and living conditions. Here are just a few examples of

recent publications where photovoice has been used. It has been used with a variety of people, e.g., with ethnic minorities (Le & Yu, 2021), children with autism (Ha & Whittaker, 2016), with immigrants (Tinh Trinh, 2020), refugees (Lumbus & al., 2021; Namutebi & al., 2021), homeless people (Cheng, 2021), when examining sexual and reproductive health (Le & Yu, 2021), and with youth (Delgado, 2015).

Steps in photovoice

Photovoice has a clear structure, which should be followed carefully. Photovoice requires careful pre-planning and organizational skills from those conducting the photovoice method.

1. **Participants, research questions** – you may start your photovoice project by first defining either the participants or the research question. In either case, you should discuss and define the final topic and research questions with the participants. It is important to give a safe space for the participants to discuss the topic and research question.
2. **Learning about photovoice** – before implementing the photovoice project, it is important to go through the elements and goals of photovoice.
3. **Learning about the technique and ethics of photographing** – before the photo shooting sessions, it is important to practice how to use cameras and give some practical tips, such as not taking pictures against the sun or using flash in the dark. However, it is not advisable to give too detailed instructions in order not to stifle the creativity of the participants. The ethics of taking the photos should also be discussed with the participants. No one should be photographed without their consent even if they cannot be recognised. The privacy and self-determination of those being photographed should always be respected. The ownership of the photos, and what happens to the photos after the photovoice process is over, should be discussed. Instead of giving instructions to the participants, these themes could be discussed and reflected with the participants. It is important to receive informed consent from the participants.
4. **Taking pictures** – when the participants are ready to take the photos, some guidelines about the duration of the photoshoot (hours or days) and the number of photos (limited or unlimited) to be taken should be discussed. It is crucial that you trust the participants and do not follow the photo shootings, as this may hinder their creativity. After the photos are taken, they will be developed by the researcher.

5. **Discussing and reflecting on photographs & experiences in small groups** – participants join group discussions to discuss and reflect their photos. Each participant may choose a few meaningful photos that they want to share with others. They will then be supported in contextualizing their photos. A set of SHOWeD questions could be used in order to raise critical consciousness of their situation, and in creating ways to improve their situation (Wang, 1999).

   – What do you See here?
   – What is really Happening here?
   – How does this relate to Our lives?
   – Why does this situation, concern, or strength exist?
   – What can we Do about it?

   The dialogue about the photos may give rise to three levels of analysis: issues, themes, or theories, and may generate diverse meanings for single photos (Wang & al., 1997).

6. **Writing/dictating narratives** – the participants should be given a chance to write or dictate their stories related to the photos. A remark has been made that in this way the participants become narrators instead of being interviewees (Chan, 1994 cited in Wang et al., 1997).
7. **Choosing photographs & photo exhibition** – the final stage of photovoice is about disseminating the findings to the decision-makers and those who hold the power to make the changes happen.

Why photovoice? Pros and cons of photovoice method

Photovoice has many positive elements. As it has been stated earlier, if implemented carefully, the method is truly participatory. It gives credit to local knowledge and offers the participants an opportunity to express their views about their situations. It may be easier to communicate the difficult situations in one's life with the help of photos. Being able to communicate the experiences of one's everyday life may be empowering or therapeutic even. If a photovoice project disseminates the results to the decision-makers, doing so also guarantees an audience of people who will listen to the voices of the participants. At best, this will lead to improving the lives of the participants. This would offer them a sense of control over

their own lives. Photovoice, if implemented properly, is time-consuming, and it requires good organizational and networking skills. It is not guaranteed that any social change will take place due to the photovoice project, which may lead to disappointment in the participants. Participants may be equally disappointed if no follow-up is done after the project has ended.

Accepting and internalizing the ethos of community development work

We have presented three different tools that can be applied in community development work with different types of communities, be they geographically determined or interest-based communities. Each of these tools can help the community development worker to reach a high level of citizen's power and participation as mentioned in Sherry Arnstein's ladder of participation (see previous article, Arnstein, 1969). All the tools are built on partnership; at best, they help delegate power to the community members who will then be able to take control of their lives. However, it is important to point out here that the methods themselves do not guarantee a high level of participation. Instead, the workers need to accept and internalize the spirit or ethos of community development work – accept the idea of change from below, respecting and valuing local knowledge, skills, cultures, resources, and processes – if the community members truly want to participate – (Ife, 2016, pp. 126–136) and treat them with dignity.

REFERENCES

Anderson, J. (2004). Talking whilst walking: a geographical archaeology of knowledge. *Area,* 36, 254–261. https://doi.org/10.1111/j.0004-0894.2004.00222.x

Arnstein, S. (1969). A Ladder of Citizen Participation. *Journal of the American Institute of Planners.* 35(4), 216–224, DOI: 10.1080/01944366908977225

Bhandari, A., Lamichhane, D., & BC, K.R. (2015). *Participatory Mapping: A Case Study of Hazard Analysis in Panauti, Kavreplanchok, Nepal.*

Breny, J. M., & McMorrow S. L. (2021). *Photovoice for Social Justice. Visual Representation in Action.* Qualitative Research Methods. Volume 59. Sage.

Chan, S. (Ed.) (1994). *Hmong Means Free: Life in Laos and America.* Temple University.

Cheng, Y.-W. (2021). Sleepless in Taipei: The application of photovoice method to explore the major challenges perceived by homeless people facing multifaceted social exclusion. Critical Social Policy, 41(4), 606–627. https://doi.org/10.1177/0261018320981849

Clark, A., & Emmel, N. (2009). *The Methods Used in Connected Lives: Investigating networks, neighbourhoods and communities.* ESRC National Centre for Research Methods. NCRM working Paper Series 06/09. https://eprints.ncrm.ac.uk/id/eprint/800

Cochrane, L., Corbett, J., & Keller, C.P. (2014). Impact of Community-based and Participatory Mapping. Working paper. DOI: 10.13140/RG.2.1.4522.5360

Coemans, S., Raymakers, A.-L., Vandenabeele, J., & Hannes, K. (2019). Evaluating the extent to which social researchers apply feminist and empowerment frameworks in photovoice studies with female participants: A literature review. *Qualitative Social Work,* 18(1), 37–59. https://doi.org/10.1177/1473325017699263

Delgado, M. (2015). *Urban Youth and Photovoice: Visual Ethnography in Action.* Oxford University Press.

Di Gessa, S. (2008). *Participatory Mapping as a Tool for Empowerment. Experiences and Lessons Learned from the ILC Network.* The ILC 'Knowledge for Change' Series, no. 5. International Land Coalition.

Evans, J., & Jones, P. (2011). The walking interview: Methodology, mobility and place. *Applied Geography,* 31(2), 849–858. https://doi.org/10.1016/j.apgeog.2010.09.005

Flanagan, B. (2015). *Participatory Methods and Tools in Community Development. ECHO Summary of MEAS Participatory Methods documents.* ECHO Community. https://www.echocommunity.org/en/resources/53f99bb6-f532-4606-8229-0327c16dbd3c

Götz, N., & Holmén, J. (2018). Introduction to the theme issue: "Mental maps: geographical and historical perspectives". *Journal of Cultural Geography,* (35)2, pp. 157–161, DOI: 10.1080/08873631.2018.1426953

Ha, V. S., & Whittaker, A. (2016). 'Closer to my world': Children with autism spectrum disorder tell their stories through photovoice. *Global Public Health, 11*(5–6), 546–563. https://doi.org/10.1080/17441692.2016.1165721

Ife, J. (2016). *Community Development in and Uncertain World. Vision, analysis & practice. Second edition.* Cambridge University Press.

International Fund for Agricultural Development. (2009). Good Practices in Participatory Mapping. A review prepared for the International Fund for Agricultural Development (IFAD). (https://www.ifad.org/documents/38714170/39144386/PM_web.pdf/7c1eda69-8205-4c31-8912-3c25d6f90055)

Kusenbach, M. (2003). Street Phenomenology: The Go-Along as Ethnographic Research Tool. *Ethnography*, 4(3), 455–485. https://doi.org/10.1177/146613810343007

Le, T. M., & Yu, N. (2021). Sexual and reproductive health challenges facing minority ethnic girls in Vietnam: a photovoice study. *Culture, Health & Sexuality,* 23(8), 1015-1033. https://doi.org/10.1080/13691058.2020.1753813

Le Dé, L., Gaillard, J.C., Gampell, A., Loodin, N., & Cadag, J. (2020), Participatory mapping 2.0: new ways for children's participation in disaster risk reduction, *Australian Journal of Emergency Management,* 35(2), 34–42.

Lenette, C. & Gardner, J. (2021). Short Take: Walking Interviews with Refugee-background Women. Field Methods. 33(3), 305–312.

Liebenberg, L. (2018). Thinking Critically About Photovoice: Achieving Empowerment and Social Change. *International Journal of Qualitative Methods.* 17(1), 1–9.

Lumbus, A., Fleay, C., Hartley, L. K., Gower, S., Creado, A., & Dantas, J. A. (2021). "I want to become part of the Australian community": Challenging the marginalisation of women resettled as refugees in Australia–Findings from a photovoice project. *Australian Journal of Social Issues.*

Lundy, L. (2007). 'Voice' is not enough. Conceptualising the Article 12 of the United Nations Convention on the Rights of the Child. *British Educational Research Journal.* 33(6), 927–942.

Namutebi, L., Nakyazze, O. C., Bamuwayira, A., Huber, A., & Krasniqi, S. (2021). "Life in the camps makes you sick." Results of a photovoice project with refugees in Munich, Germany. *European Journal of Public Health,* 31(Supplement_3), ckab164–395.

Panek, J., & Vlok, A.C. (2013). Participatory mapping as a tool for community empowerment – a case study of community engagement in Koffiekraal, South Africa.

Paradza, G., Mokwena, L., & Musakwa, W. (2020). Could Mapping Initiatives Catalyze the Interpretation of Customary Land Rights in Ways that Secure Women's Land Rights? *Land.* 9(10):344. https://doi.org/10.3390/land9100344

Paulos, E., & Goodman, E. (2004). The familiar stranger: anxiety, comfort, and play in public places. Proceedings of the SIGCHI Conference on Human Factors in Computing Systems.

Reed, A. (2002). City of details: interpreting the personality of London. *Journal of the Royal Anthropological Institute,* 8, 127–141.

Roy, A., Hughes, J., Froggett, L., & Christensen, J. (2016). Using Mobile Methods to Explore the Lives of Marginalised Young Men in Manchester. In L. Hardwick, R. Smith & A. Worsley (Eds.), *Innovations in Social Work Research. Using Methods Creatively.* Jessica Kingsley Publishers (pp. 155–172).

Tinh Trinh, E. (2020). Photovoice in a Vietnamese Immigrant Family: Untold Partial Stories behind the Pictures. *Genealogy, 4*(3), 67. MDPI AG. Retrieved from http://dx.doi.org/10.3390/genealogy4030067

Wang, C. (1999). Photovoice: A Participatory Action Research Strategy Applied to Women's Health. *Journal of Women's Health.* 8(2), pp. 185.192.

Wang, C., & Burris, M. (1994). Empowerment through photo novella: portraits of participation. *Health Education Quarterly,* 21, 171–186.

Wang, C., & Burris, M. (1997). Photovoice: concept, methodology, and use for participatory needs assessment. *Health Education and Behavior,* 24, 369–387.

Wang, C., Yi, W.K., Tao, Z.W., & Carovano, K. (1997). Photovoice as a participatory health promotion strategy. *Health promotion international,* 13(1), 75–86.

Weyer, D., Bezerra, J.C., & De Vos, A.D. (2019). Participatory Mapping in a Developing Country Context: Lessons from South Africa. Land, 8(9), 134; https://doi.org/10.3390/land8090134

IV
HOLISTIC WORK
IN CONDITIONS OF DISTRESS

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DISASTERS – RISK REDUCTION AND MANAGEMENT

Dealing with crises and disasters is, in many ways, a global condition of living. Crisis can hit individuals in every corner of the world and change lives for people and their near and dear. Larger crises, often named disasters, can also strike and hurt societies or communities. Sometimes disasters hit globally, like the COVID-19 pandemic that started in 2019 and spread worldwide during the years 2020–2022. In this article, we will look further into how crises and disasters impact people differently, and how needs are assessed, described, and planned for in global strategies, as well as at regional, national, and local levels.

What is a disaster

The WHO defines disasters as "an occurrence disrupting the normal conditions of existence and causing a level of suffering that exceeds the capacity of adjustment of the affected community," (WHO/EHA, 2002). Disasters are often linked to hazards, and the risk for disaster is often described as the function of hazard, exposure, and vulnerability (Palliyaguru et al., 2014).

A more formal definition of disaster risk is "the potential disaster losses, in lives, health status, livelihoods, assets and services, which could occur to a particular community or a society over some specified future time period," (UNDRR, 2022). The probability of a hazard leading to a disaster increases when a community is largely exposed to the hazard and has a vulnerable population. Vulnerability is a complex concept, often described as determined by the degree of exposure and susceptibility and coping capacities. Recent research emphasizes that vulnerability is dynamic, and a result of the interactions between individual, social-structural, and situational factors that may vary over time (Hansson et al., 2020).

Hazards can be natural or man-made. Natural hazards are extreme and severe weather events that occur naturally in all parts of the world. Natural hazards become natural disasters when people's lives and living conditions are destroyed or

radically disturbed. Man-made (i.e., anthropogenic, or human-induced) hazards are defined as those "induced entirely or predominantly by human activities and choices." This term does not include the occurrence or risk of armed conflicts and other situations of social instability or tension, which are subject to international humanitarian laws and national legislation (UNDRR, 2022). The activity or events leading up to a man-made hazard may be the result of deliberate or negligent human actions. Technological hazards are normally considered a subset of man-made hazards. Technological hazards refer to hazards that stem from technological or industrial conditions. Examples of technological hazards include industrial pollution, nuclear radiation, toxic wastes, dam failures, transport accidents, factory explosions, fires, and chemical spills (UNDRR, 2022).

International organizations involved in disaster risk reduction

Disasters have important consequences for communities experiencing them. They also have a large impact on development, and can reverse development gains in vulnerable communities. Strategies to reduce the risk of disasters occurring and to minimize the consequences of disasters that happen are produced on many levels.

In 1999, the United Nations created a special office for Disaster Risk Reduction, UNDRR (formerly UNISDR), which convenes partners and coordinates activities. An important goal for UNDRR is to create safer, more resilient communities. The Sendai Framework for Disaster Risk Reduction (named after Sendai, a large city in Japan that hosted the meeting), was the first major agreement between UN member states to recognize the strong connection between development and disasters (United Nations 2015 Sendai Framework). The Sendai Framework is a 15-year voluntary people-centered approach to disaster risk reduction. The Sendai Framework is an agreement on concrete actions to prevent disasters to be implemented between 2015 and 2030. The framework is connected to the Sustainable Development Goals (United Nations 2015, SDG), and has the following priority areas:

Priority 1: Understanding disaster risk
Disaster risk management needs to be based on an understanding of disaster risk in all its dimensions of vulnerability, capacity, exposure of persons and assets, hazard characteristics and the environment.

Priority 2: Strengthening disaster risk governance to manage disaster risk
Disaster risk governance at the national, regional, and global levels is vital to the management of disaster risk reduction in all sectors, and ensures the coherence of national and local frameworks of laws, regulations, and public policies that, by defining roles and responsibilities, guide, encourage, and incentivize the public and private sectors to take action and address disaster risk.

Priority 3: Investing in disaster risk reduction for resilience
Public and private investments in disaster risk prevention and reduction through structural and non-structural measures are essential to enhance the economic, social, health and cultural resilience of persons, communities, countries and their assets, as well as the environment. These can be drivers of innovation, growth and job creation. Such measures are cost-effective and instrumental to save lives, prevent and reduce losses, and ensure effective recovery and rehabilitation.

Priority 4: Enhancing disaster preparedness for effective response, and to «Build Back Better» in recovery, rehabilitation and reconstruction
Experience indicates that disaster preparedness needs to be strengthened for a more effective response and ensure capacities are in place for effective recovery. Disasters have also demonstrated that the recovery, rehabilitation and reconstruction phase, which needs to be prepared ahead of the disaster, is an opportunity to «Build Back Better» through integrating the disaster risk reduction measures. Women and persons with disabilities should publicly lead and promote gender-equitable and universally accessible approaches during the response and reconstruction phases (United Nations 2015 Sendai Framework).

International strategies targeting health

The Sendai Framework adopts an all-hazards approach, including health emergencies (United Nations 2015 Sendai Framework). It also highlights the importance of building resilient health systems and integrating DRR into all levels of the health sector. A part of this is the aim of developing an increased understanding of disaster risk within health workers at all levels and the capacity to implement disaster risk management approaches in their health work.

The World Health Organisation has also contributed to developing strategies for disaster risk reduction and disaster management related to health. The WHO worked together with the UNDRR, and developed the so-called Bangkok princi-

ples in 2016 (named after a meeting in Bangkok) (WHO, 2016). The main point in the Bangkok principles is the recognition of the benefits of a multisectoral approach to address disaster risk reduction. The health sector and the disaster sector cannot work separately, but need to collaborate. The Bangkok principles led to the development of a WHO Emergency and Disaster Risk Management Framework (EDRM) (WHO, 2019). The vision of Health EDRM is the "highest possible standard of health and well-being for all people who are at risk of emergencies, and stronger community and country resilience, health security, universal health coverage and sustainable development." The expected outcome of Health EDRM is that "countries and communities have stronger capacities and systems across health and other sectors, resulting in the reduction of the health risks and consequences associated with all types of emergencies and disasters," (WHO, 2019). The main idea of the EDRM is to make a contribution to a change from a single-hazard-focused approach based on the response, reactivity, single and separate responsibility to a vulnerability-focused approach highlighting risk management, proactivity, all-hazards and shared responsibility focusing on society as a whole. Instead of planning for the community, the approach emphasizes the importance of planning with the communities (WHO, 2019). A key element is the EDRM slogan 'Everyone's business' accentuates the collective responsibility that all organizations, institutions, and all human beings have to work on emergency preparedness and disaster risk reduction and management.

The health EDRM has a focus on research, and one of its actions is to establish a research network with the aim to strengthen research and evidence for managing health risks associated with all types of emergencies and disasters. This is to be done through global collaboration among academia, government officials, and other stakeholders (WHO, 2019).

Disaster risk reduction at regional, national and local levels

The UN and WHO offer global initiatives to prevent, prepare for, and address disasters that occur both locally and globally. These initiatives are providing resources to be used globally, and they are common resources. In addition to these initiatives, a lot of other plans and strategies exist adapted to specific problems and conditions in local contexts. Let's use Asia, South-East Asia, and the country of Nepal as an example: In South-East Asia, the regional strategy for managing disaster from a health perspective has been elaborated with the acronym AADMER

(ASEAN agreement on disaster management and emergency response) from 2021 to 2025 (ASEAN, 2020), highlighting the co-existing hazards the region is exposed to and the co-existing risks and vulnerabilities. A particular challenge in the South-East Asian region is the so-called seasonal risks or hazards, such as seasonal floods and landslides, cyclones, heatwaves, and infectious disease outbreaks. The AADMER states the challenge in the following way:

The ASEAN (Association of ten South-East Asian Nations – Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Vietnam) *"region is vulnerable to natural disasters such as typhoons, floods, drought, earthquakes, and volcanic eruptions, among others; and these disasters are undeniably increasing in intensity, frequency, and unpredictability due to such factors as rapid urbanization, population growth, degradation of the natural environment, and climate change* (ASEAN, 2020)."

The ASEAN Vision 2025 on Disaster Management aims to move towards a people-centered, people-oriented, financially sustainable, and networked approach by 2025. It identified three (3) strategic elements for the implementation of the AADMER through 2025, which also serve as the guiding principles for this AADMER Work Program 2021–2025, namely:

- Institutionalisation and Communications
- Finance and Resource Mobilization
- Partnerships and Innovation

Let's use the country of Nepal as an example: In Nepal, the government has created a specific web portal presenting Nepal Disaster Risk Reduction policies and activities (http://drrportal.gov.np/). This platform presents both global and national strategies and national and local actions regarding risks, such as monsoons, COVID-19, and others. This is also a platform for recruiting volunteers.

In Nepal, the National disaster risk reduction 2018 policy aims to ensure safe, adaptive, and sustainable country-building by reducing existing risks and preventing new and potential risks. It has also taken national needs and international agreements and obligations as concerns, disaster risk reduction, sustainable development and climate change into account. (Khanal, 2020.) To be able to achieve the goals, an action plan has been elaborated, which is the so-called 'Disaster Risk Reduction National Strategic Plan of Action 2018–2030' framed within the objectives of the Sendai Framework (SFDRR). The plan takes forward strategic priorities and actions that guide disaster risk reduction initiatives in Nepal. Nepal is

a signatory country to SFDRR 2015–2030, and has expressed a commitment to achieve the SFDRR goals by 2030.

So far, Nepal has submitted two SFDRR progress-monitoring reports. It has clearly prepared the priorities through its action plans and has started their implementation phase. The majority of damages and losses reported have been water-induced disasters. Other seasonal disasters, such as fires more concentrated in urban areas, have incurred significantly higher costs. Therefore, attention needs to be paid especially in establishing disaster risk management, including funding and actions at sub-national and local levels (Khanal, 2020).

Local ownership and engagement in DRRM functions are crucial to the success of these strategies! These functions include, but are not limited to disaster risk mapping, risk reduction, risk monitoring and early warning, disaster response, and relief and recovery. The provinces should also prepare or adopt federal guidelines on managing different hazards and vulnerable sectors to prevent risk, and to effectively manage disasters. Recently, each province prepared a DRRM Policy and DRR Strategic Action Plan, with support from UN Agencies. These documents require endorsement by their respective provincial cabinets (Bhandari et al., 2020). The Nepalese government formulated a delineation of DRRM roles and responsibilities between federal, provincial, and local levels for all types of disaster risks, such as earthquakes, floods, landslides, and fires.

Addressing disasters holistically at all levels

As we stated in the beginning of this article, dealing with crises and disasters is, in many ways, a global condition of living. Strategies and actions for disaster risk reduction and management is therefore a global focus. However, global strategies and goals are not useful if they are not transformed and adapted to local situations and stimulate engagement and activities locally. The idea that all sectors of society have a role in DRRM is fundamental, and highlights the importance of understanding and addressing disasters holistically at all levels of the society. As professionals, it is important to get insight into strategies and plans at many levels, and understand the implications of these strategies in our local work context and community.

REFERENCES

ASEAN. (2020). *ASEAN Agreement on Disaster Management and Emergency Response (AADMER) Work Programme 2021–2025.* Retrieved April, 5, 2022, from https://asean.org/wp-content/uploads/2021/08/AADMER-Work-Programme-2021-2025.pdf

Bhandari, D., Neupane, S., Hayes, P., Regmi, B., & Marker, P. (2020). *Disaster risk reduction and management in Nepal: delineation of roles and responsibilities.* Available from https://www.opml.co.uk/files/Publications/a1594-strengthening-the-disaster-risk-response-in-nepal/delineation-of-responsibility-for-disaster-management-full-report-english.pdf

Hansson, S., Orru, K., Siibak, A., Bäck, A., Krüger, M., Gabel, F., & Morsut, C. (2020). Communication-related vulnerability to disasters: A heuristic framework. International *Journal of Disaster Risk Reduction, 51,* Article 101931. https://doi.org/10.1016/j.ijdrr.2020.101931

Khanal, B.N. (2020). *Nepal: A brief country profile on disaster risk reduction and management.* The Asian Disaster Reduction Center (ADRC). Available from https://www.adrc.asia/countryreport/NPL/2019/Nepal_CR2019B.pdf

Palliyaguru, R., Amaratunga, D., & Balfry, D. (2014) Constructing a holistic approach to disaster risk reduction: The significance of focusing on vulnerability reduction. *Disasters 38*(1), 45–61.

United Nations. (2015). *The Sendai Framework for Disaster Risk Reduction.* Retrieved April, 5, 2022, from https://www.preventionweb.net/files/43291_sendaiframeworkfordrren.pdf

United Nations Office for Disaster Risk Reduction (UNDRR). (2022). *Terminology guide.* Retrieved April, 5, 2022, from https://www.undrr.org/terminology

United Nations Department of Economic and Social Affairs Sustainable Development. (2015). *Sustainable Development Goals.* Retrieved April, 5, 2022, from https://sdgs.un.org/goals

WHO/EHA. (2002). *Disasters & emergencies definitions. Training Package.* Panafrican Emergency Training Centre, Addis Ababa. Retrieved April, 5, 2022, from https://apps.who.int/disasters/repo/7656.pdf

WHO. (2016). *The Bangkok Principles for the implementation of the health aspects of the Sendai Framework for Disaster Risk Reduction 2015–2030.* Retrieved April, 5, 2022, from https://www.who.int/hac/events/2016/Bangkok_Principles.pdf

WHO. (2019). *Health Emergency and Disaster Risk Management Framework.* Retrieved April 5, from: https://www.who.int/hac/techguidance/preparedness/health-emergency-and-disaster-risk-management-framework-eng.pdf

Bodil Tveit, Shanti Awale and Shobha Laxmi Bajracharya

VULNERABILITY AND RISK IN DISASTERS

Lately, the concept of vulnerability has been contested and debated. Some scholars state that the concept can create stigma and be used to oppress people or groups. There is a need for focusing on the dynamic aspects, and the fact that vulnerability changes over time and may vary depending on the relation between individual factors and context. In this chapter, we will look further on the concept of vulnerability, what it means and what it may involve being labeled as vulnerable, and how the concept of vulnerability can be understood and used in different ways.

Vulnerability and risk in disasters as concepts

The risk for disaster is often described as the function of hazard, exposure, and vulnerability (Palliyaguru et al., 2014). Disasters do not affect people equally. The level of vulnerability is often described as the key to understanding risks related to disasters. However, the concept *vulnerable/vulnerability* is used in many different ways. What does it mean? Sometimes it is used to characterize countries, regions, or sites. Other times, it is used on material resources, such as buildings or infrastructure. Other times, it refers to societies, groups or individuals. The word can be linked to the economic status of individuals, communities, and nations, emphasizing that poor people are more vulnerable to disasters than richer people because they lack the resources to build solid structures and put measures in place to protect themselves from hazard exposure. The word has also been linked to age, gender, and health situations, implying that women, children, old people, and people with chronic diseases sometimes are more vulnerable to disasters than the rest of the population.

Vulnerability is defined in many ways. The dictionary Merriam Webster describes vulnerability as historically referring to people's capability of being physically wounded. Often, the potential of people to be emotionally wounded is included in the understanding, and 'openness to attack or damage' also has been

stated as a possible definition (https://www.merriam-webster.com/thesaurus). In disaster literature, regions, countries, communities, and infrastructure are often included in the definition. And a common disaster-related definition of the concept is that vulnerability means the extent to which changes/events/hazards can harm a person or a system (Palliyaguru et al., 2014).

Understanding vulnerability by causes and strategies

Heijmans (2004) describes how the understanding of vulnerability in relation to disasters has evolved and enlarged, and depicts three different views on vulnerability related to the cause of vulnerability, resulting in three different strategies: a) nature as cause, b) cost as cause, and c) societal structures as cause (Heijmans, 2004).

a) Natural disasters often cause vulnerability. The reports of giant fires, massive landslides, floods, droughts, as well as typhoons and hurricanes, have become much more frequent due to climate changes. When nature causes people's vulnerability, technological and scientific solutions are often pointed to as the answer.
b) Prediction and mitigation technologies and measures are costly. Although scientific capacities exist and technology has been developed, it does not mean that early warning technology is available or that safety systems are built up. The lack of economic capacity to put measures in place consequently mean that people in poor countries and regions are more vulnerable, and exposed to and suffer more from hazards.

The view that nature and cost as the main elements of causing vulnerability has led to a focus on relief and disaster prevention, humanitarian aid, and financial support as the way to address potential victims or people in crisis. But according to Heijmans (2004), there is also a third position:

c) Vulnerability can also be seen as caused by societal structures. This view highlights the connection between vulnerability and social orders and politics. Socio-economic and political processes generate vulnerability because they affect the community's ability to respond to and recover from disasters (Heijmans, 2004).

Understanding vulnerability by depicting vulnerable groups

Vulnerability to hazards is often discussed as a feature of specific groups in society, such as children, old people, women, and people with chronic diseases, etc. Depicting vulnerable groups can be a strategy to direct measures and strategies in order to protect specific risk groups towards specific hazards.

Age as vulnerability

Age has often been connected to vulnerability. Children are often depicted as a particularly vulnerable group when disasters happen whether they are caused by forces of nature, such as floods, hurricanes, and earthquakes; technological accidents, such as oil spills and chemical releases; or terrorism, war, and other willful acts of violence (Peek, 2008). Due to their physiological size, children are more vulnerable to all types of hazards and they are physically vulnerable to death, injury, illness, and abuse. They are more vulnerable to environmental hazards due to heavier exposure to toxins in proportion to their body weight; they have more years of life ahead of them, in which they may suffer long-term effects from early exposure. Children are also psychologically vulnerable, and may develop post-traumatic stress disorder or related symptoms. Disasters may also often cause disruptions or delays in their educational progress. All this implies that children often have special needs and may require different support than adults. However, according to Peek (2008), children also often have the capacity for resilience during disasters; they can contribute to disaster preparedness, response, and recovery activities.

Older adults have often been designated as a particularly vulnerable age-group. One example is the recent COVID-19 pandemic outbreak, where older age was depicted early as an important potential risk factor of severe illness and death from COVID-19. The danger of creating stereotypes on aging and aging processes has been voiced by several researchers in the wake of the COVID-19 pandemic (Ayalon et al., 2021). Despite the clear connection between risk and age discovered in the pandemic, there are also deep problems related to the common practice of associating aging with vulnerability, decline, and loss. Canadian researcher Martine Lagacé found that older people were usually absent or silent in the debates and public discourses during the pandemic. She argues that if older people are positioned as people *to fight for* rather than *to fight with,* there is a risk not only for ageism, but also that important resources become unused (Lagacé et al., 2021).

Gender as vulnerability

Many researchers have highlighted that gender plays an important role in disaster vulnerability, emphasizing that the number of female victims to natural hazards-induced disasters is much higher than the number of male victims (Neumayer & Plümper, 2007). Women are also more likely to die in disasters than men, especially in developing countries. It is important to keep in mind that female vulnerability is increased by factors and conditions that stems from women's general position in society, and is often connected to the lack of education and information, limited access to resources, such as economic and cultural issues leading to an unequal distribution of power and workload (United Nations, 2016).

Arora-Jonsson (2011) addresses what she calls 'the virtues and vulnerability' of women in relation to *climate changes,* highlighting how gender is presented in climate debates. There seems to be a widespread agreement between experts that women in the global south will be more affected than men in the same area by the effects of climate changes, and that women in the north generally contribute less to the climate changes. Arora-Johnson argues that such generalizations about women's vulnerability and virtuousness can lead to an increase in women's responsibilities instead of reducing inequalities. She argues for a more contextual understanding of women and climate change to be able to deal reliably with the unequal effects of climate change; the main cause of women vulnerability is related to economic inequality between men and women, and the fact that women represent a disproportionate share of the people in the world living below the threshold of poverty.

Disability as vulnerability

People with various forms of disabilities are often depicted as more likely to be physically, psychologically, sociologically, and materially affected by environmental hazards and disasters. The affections imply a larger likeliness to die, being injured, traumatized, or displaced due to hazards (Abbott & Porter, 2013). Realizing the fact that a large proportion of the global population are living with some form of disability (WHO considers around 15 % of the global population to live with some form of disability, but the number in some places like the USA is higher, up to 25 %), this is a considerable aspect of discussions around disasters and vulnerability. Having a disability can imply that the person has serious difficulty with

walking and climbing stairs, difficulties with hearing or seeing, and mental difficulties with remembering, concentrating, or making decisions. All these impairments are often considered aspects that make it difficult for people to act quickly enough during a hazardous event and escape, climb into a boat, seek shelter, adapt to a transformed landscape, or generally be in a position to be rescued. Connon & Hall (2021) criticizes that common research tends to blame the increased vulnerability of disabled people during disasters and hazards on the impairment of the individuals. Rather, they suggest looking at limitations of policies and inadequate emergency responses (Connon & Hall, 2021).

Our common condition of vulnerability

According to French scholar Michel Foucault, naming or designation is a way of exercising power, and naming is therefore not a neutral act (Foucault, 2001). This implies, according to Norwegian theologist Sturla Stålsett (2020), that it is necessary to critically reflect how we use language to characterize groups or people. Naming groups or people as vulnerable, even when it is well-intended, may have negative implications. It may create a problematic distinction between helpers and those being helped, which can create a dichotomy or an underlying structure of "us" and "them" (Stålsett 2020). He uses the example from the ongoing COVID-19 pandemic where children, older people, homeless, asylum-seekers, refugees, people with a disability and people who experience mental health issues are depicted as vulnerable groups in Europe. Such naming may fuel stereotypes and stigmatization between "us" and "the others." Stålsett refers to Springhart & Thomas (2017), who distinguishes between two dimensions of human vulnerability, one that can be identified as *fundamental* and one that can be identified as *situated*. **Fundamental vulnerability** points to the reality that in a sense, vulnerability is a condition of our humanity, a part of just being human. And vulnerability is closely linked to our dependency on each other. We are all dependent on other people for our well-being and our lives as humans.

Situated vulnerability focuses on the fact that some groups or people can be seen as particularly vulnerable because of the context they live in, and their life circumstances and situations (Springhart, 2017).

Vulnerability is not weakness

American researcher Brené Brown (2015) has authored well-known research on the topic of vulnerability. She argues that vulnerability is not weakness, but our greatest measure of courage. She states: *"The definition of vulnerability is uncertainty, risk, and emotional exposure […] When the barrier to vulnerability is about safety, the question becomes: 'Are we willing to create courageous spaces so we can be fully seen?"* (Brown, 2015). In our understanding about vulnerability in disasters, it is important to recognize vulnerability as a fundamental human condition. At the same time, it is important to understand the dynamic aspects of vulnerability, and enhance knowledge, increase awareness, and develop insights into the fact that vulnerability changes over time and may vary, depending on certain life circumstances and the relation between individual factors and context.

REFERENCES

Abbott, D. & Porter, S. (2013) Environmental hazards and disabled people: from vulnerable to expert to interconnected. *Disability Soc., 48*(6), pp. 839–852.

Arora-Johnson, S. (2011) Virtue and vulnerability: Discourses on women, gender and climate change. *Global Environmental Change, 21,* 744–751.

Ayalon, L., Chasteen, A., Diehl, M., Levy, B.R., Neupert, S.D., Rothermund, K., Tesch-Römer, C., & Wahl, H-W. (2021). Aging in Times ofthe COVID-19 Pandemic: Avoiding Ageism and Fostering Intergenerational Solidarity.: *The Journals of Gerontology: Series B, 76*(2), e49–e52. doi:10.1093/geronb/gbaa051

Brown B. (2015). *Daring Greatly: How the Courage to be Vulnerable Transforms the Way We Live, Love, Parent, and Lead.* Penguin.

Connon, I.L.C., & Hall, E. (2021). 'It's not about having a back-up plan; it's always being in back-up mode': Rethinking the relationship between disability and vulnerability to extreme weather. *Geoforum, 126,* p. 277–289.

Foucault, M. (2001), L'ordre du discours: Leçon inaugurale au Collège de France prononcéele 2 décembre 1970, Paris: Gallimard.

Heijmans, A. (2004). From Vulnerability to Empowerment. In: G. Bankoff, G. Frerks, & D. Hilhorst (Eds.). *Mapping vulnerability: Disasters, development and people* (Chapter 8, pp. 115– 127). Routledge.

Jason, L., & Glenwick, D. (2016). *Handbook of methodological approaches to community-based research: Qualitative, quantitative, and mixed methods.* Oxford University Press.

Lagacé M., Doucet A., Dangoisse P. and Bergeron C.D. (2021) The "Vulnerability" Discourse in Times of Covid-19: Between Abandonment and Protection of Canadian Francophone Older Adults. *Front. Public Health 9:662231.* doi: 10.3389/fpubh.2021.662231

Merriam-Webster Thesaurus. Retrieved 7. april 2022 from: https://www.merriam-webster.com/thesaurus/vulnerability

Neumayer, E., & Plümper, T. (2007). The Gendered Nature of Natural Disasters: The Impact of Catastrophic Events on the Gender Gap in Life Expectancy, 1981–2002. *Annals of the Association of American Geographers, 97*(3), 551–566, DOI: 10.1111/j.1467-8306.2007.00563.x

Palliyaguru, R., Amaratunga, D., & Baldry, D. (2014) Constructing a holistic approach to disaster risk reduction: The significance of focusing on vulnerability reduction. *Disasters 38* (1), 45–61.

Peek, L. (2008). "Children and Disasters: Understanding Vulnerability, Developing Capacities, and Promoting Resilience – An Introduction." *Children, Youth and Environments 18*(1), 1–29.

Springhart, H., & Thomas, G. (2017). Exploring vulnerability, Gottingen: Vandenhoeck & Ruprecht.

Stålsett, S. (2020). Naming Vulnerability: A Diaconal Dilemma of Designation. *Diaconia 11*(2), 125–140. https://doi.org/10.13109/diac.2020.11.2.125

United Nations. (2016). *Gender and Climate Change. Gender, adaptation and disaster risk reduction.*

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ISBAR – COMMUNICATION TOOL FOR CLINICAL HANDOVER

Communicating critical information about the patient every time he or she is transferred is essential, whether the transfer is from one care provider to another, from one level of care to another, or from one facility to another, including the discharge to home. On the other hand, sharing incorrect or omitting information can have harmful or life-threatening consequences for patients. Therefore, clinical handover and communicating critical information can be a high-risk process in healthcare. The communication problem commonly identified with clinical handovers that has received the most attention is that information is incomplete and/or unstructured. The ISBAR (Introduction, Situation, Background, Assessment, Recommendation) tool presented in this chapter is a mnemonic created to ensure safety in the transfer of patient information through improving communication with teamwork among health care workers.

Factors affecting communication

Several factors either promote or hinder effective communication of critical information, such as situations, the method of communication, location, and participants involved (Australian Nursing & Midwifery Federation, 2021):

The situation: what and why are we needing to communicate? Is it a shift handover? Is it urgent or non-urgent? Are there any distractions or potential disruptions? Do you have time to plan what you want to say? It's ok to write what you want to communicate first, provided it is not a time-critical conversation.
The method: is it face to face? Is it verbally over the phone? Is it written in a page or email?
The location: is it at the bedside? Is it at a meeting? Is it in the staff/handover room?
The participants: is it nurse/midwife to nurse/midwife? Is it to other members of the multidisciplinary team? Is the patient and their family involved? (Australian Nursing & Midwifery Federation, 2021)

Indeed, communication breakdowns are a leading cause of medical errors. Between 1995 and 2004, communication problems were the primary cause of 65% of sentinel events, according to the Joint Commission. In 2005, a Joint Commission analysis found that 70% of sentinel events were caused by communication breakdowns, half of which occurred during handoffs. To address the problem, the Joint Commission instituted a National Patient Safety Goal in 2006, calling on hospitals to implement a standardized approach to patient handoffs (Runy, 2008).

Clinical handover is defined as "the exchange between health professionals of information about a patient accompanying either a transfer of control over, or of responsibility for, the patient," (Cohen & Hilligoss, 2010). Effective clinical handover is an essential component of safe patient care to ensure reduction in errors, patient harm, and improve continuity of care. With rapidly changing work patterns within the healthcare workforce, excellence in clinical handover is increasingly important. It is essential that healthcare leaders and professionals from across the health disciplines work together to ensure good clinical handover practices are developed and maintained. Protected teaching time and resources are essential to support the staff and students in these endeavors. While a number of tools have been developed to improve the handover, we have found the well-researched ISBAR to be an ideal tool for effective clinical handovers (Burgess et al., 2020).

ISBAR was originally used by several industries outside of healthcare, such as maritime and airline sectors. Healthcare adapted the SBAR tool to be more patient-centered by adding the ***Identify*** component. ISBAR is one of several frameworks for communication between healthcare personnel in relation to patient situations. The usage of the ISBAR instrument improves patient safety through more structured, focused and concise communication among healthcare personnel. The US healthcare system implemented ISBAR around 2003, and its overarching goal in patient safety (Moi et al., 2019).

What is the ISBAR tool

To ensure all healthcare professionals are communicating effectively, the ISBAR communication tool was developed. ISBAR stands for identification, situation, background, assessment and recommendation (Table 1.)

Table 1. Explanation of the acronym 'ISBAR'

Identify	Identity of nurse and patient • Who are you? • Where are you? • Patient's name, age, gender, and department.
Situation	Reason for contact • Reason for call. • Change in patient's condition/symptoms. • Patient's vital signs: temperature, pulse, respiration rate, blood pressure, O2 saturation and other significant laboratory values.
Background	Background • Date of admission and diagnosis. • Relevant past medical history. • Relevant problems, treatments/interventions to date. • Allergies.
Assessment	Assessment and action • What is your diagnosis/impression of the situation? • What have you done so far?
Recommendation	Response and rationale • What do you want done? • Treatment/investigation/ nursing action underway or that need monitoring. • Review: by whom, when, and of what? • Plan depending on results/clinical course.

(Thompson et al., 2011; Moi, et al., 2019)

Identify: Nurse/health personnel should report his/her identity and role followed by the patient's identifier – bed number, name, age, sex, date of admission, and diagnosis. Refrain from referring to the patient by their location "the patient in bed 5."

Situation: Nurse/health personnel have to say clearly what is going on, and what the reason is for calling this health person. She also should mention the patient's condition, vital signs, and any incident, e.g., severe pain, vomiting, high BP, fall, or refusal of care.

Background: Nurse/health personnel should report the patient's date of admission and relevant past clinical history. To make it more clear about the patient, she can report shortly the main diseases of the patient, relevant clinical history, and the risk data (e.g., allergies).

Assessment: Nurse/health personnel have to provide details of observations, procedures, and treatments thus far. What do you feel that needs to be done or changed?

The patient's vital signs and other observations may be normal, but their behavior or appearance seems different compared to his or her previous assessment, which should be clearly said.

Response/recommendations: It must be said how urgent it is to require a response from this person. OR set a deadline for when you would like your request acknowledged (e.g., "could you please write the name, dose, route of pain killer now?").

Nurse/health personnel should be clear about what she is suggesting – it can be care instructions (2 hourly position change/ maintain intake and output) or that she needs a medical doctor to come see the patient (Joint Commission International, 2018).

Table 2. Example of good bedside handover using ISBAR.

Introduction	– Nurse A: This is Uma Shrestha. – In bed number 50, the patient's name is Hari Maya Magar, female, 65 years. Date of admission: 2021, September 5th. – She has been admitted with a history of a fractured left Neck of Femur (NOF) post-mechanical fall at home.
Situation	– Hari Maya is currently mid night NPO (Nil per Oral) for operation today. – Her pain has been well controlled with the regular analgesics as per the medication chart.
Background	– She has a history of osteoarthritis (OA) and dementia. – She is a high fall risk and has a documented allergy to Morphine, which causes hallucinations.
Assessment	– Her vital signs have been within normal limits throughout the shift. – Hari Maya is currently mid night NPO (Nil per Oral) for operation today. – All investigation reports are ready. – Blood two units are ready with cross-match. – Needed/ordered orthopedic implants are ready and sent to OT. – IV fluid – Normal Saline is continuing 6 hourly.
Recommendation	– Consent has not been done yet – Her son will come this morning and will give consent. – She needs to change hospital clothes prior to going to OT. – "Did you have any questions in regards to Hari Maya's care?"

ISBAR can be used in shift changes, intra-hospital transfers, inter-hospital transfers, discharge to community services and critical situations, such as medical emergencies or evacuations. Because ISBAR focuses on the issue at hand, it means that people of different disciplines will speak the same language. This allows more effective communication between the same discipline members (e.g., physician to physician communication, nurse to nurse communication) and between members of different disciplines (e.g., nurse-physician communication (Aldrich et al., 2009).

The use of ISBAR has several advantages. ISBAR ensures the completeness of information and reduces the likelihood of missed data. ISBAR is an easy and focused way to set expectations for what will be communicated. ISBAR ensures that a recommendation is clear and professional. ISBAR gives confidence in commu-

nication and focuses not on the people who are communicating, but on the problem itself (Burgess, 2020).

The significance of using the ISBAR protocol is shown to be evident in communication, teamwork, and patient safety. Although the ISBAR is considered as a useful tool that guides nurses to structure clearer handover communication, which could in turn help improve the quality of handover practice. A study finding by Pun (2021) suggested that nurses' perception of ISBAR was not an essential predictive factor for the quality of handovers. Instead, the quality of handover practices depends on the degree of nurses' understanding of the patient care plan. Further, to obtain a complete understanding of the patient care plan, providing the opportunity to ask as many questions as required to have updated information about a patient's condition is highly recommended for enhancing the quality of handover practices among nurses (Pun, 2021).

Four primary themes pertaining to ISBAR, communication, and patient safety were extracted from the results of an integrative literature review (Stewart, 2016):

1. **Utilization of SBAR creates a common language for communication of key patient care information:** Minimizing the hierarchical communication barrier that exists in the healthcare field maintains the integrity of the information exchanged by allowing patient-care briefings to take place openly and remain unrestricted, regardless of the superior status or position of the receiving individual. Improving the flow of information between healthcare providers in this manner helps to ensure that every patient-care decision made is based upon the available information, which subsequently enhances the best patient safety (Stewart, 2016).
2. **Utilization of SBAR increases the confidence of the speaker and the receiver of the handoff report:** Understanding when to expect which type of information allows the receiver of the handover report to withhold questions regarding information that has not yet been communicated, and anticipating that the information will be covered in the remaining duration of the handover report. It will also be helpful to find out that should the patient-care information be mistakenly skipped over by the speaker, the information is easily identified as missing, pointed out, and then requested by the receiver of the report (Stewart, 2016).
3. **Utilization of SBAR improves the efficiency, efficacy, and accuracy of the handoff report:** There was a 5% decrease in the rate of patient falls, a 31% decrease in the rate of restraint use, and a 34% decrease in the rate of catheter-

associated urinary tract infections (CAUTIs) following the implementation of the SBAR communication tool. SBAR usage between nurses and physicians in another quasi-experimental study resulted in improvements in medication reconciliation and reductions in adverse events stemming from miscommunication (Stewart, 2016).

4. **Utilization of SBAR improves the perception of effective communication between the healthcare staff and promotes a culture of patient safety in healthcare organizations:** Utilization of the SBAR tool promotes a higher culture of safety by creating shared expectations for reporting among all users, increasing confidence in the efficacy of handoff reports, and establishing a common trust between healthcare providers. In a quasi-experimental study utilizing the Hospital Survey of Patient Safety Culture, utilizing the SBAR framework had a positive effect on interdisciplinary team communication, resulting in improvements in the safety culture of the team (Stewart, 2016).

Effectiveness of ISBAR tool in clinical handover

Clinical handover is a high-risk activity, and ineffective handover practice constitutes a risk to the patient's safety. The use of ISBAR can be applied to improve safety in nursing assessment and healthcare. Working with this communication tool brings us the opportunity to understand the clinical decisions and treatments. Teamwork is the key to giving our patients the safety and quality they deserve; therefore, one might say that using tools like ISBAR in our everyday lives can make us better in clinical practice. An effective communication flow is a vital factor in providing safe patient care. It can reduce the adverse events related to communication errors, and can bring us the opportunity to be better at our work and make better decisions for the patients' treatments (Gadea & Budia, 2019).

The implementation of the ISBAR tool in the handovers of patients between the operating room and the postoperative anesthesia care unit PACU improves the quality and safety of patients. Because handovers followed a logical structure, the available documentation was used, and all relevant information was communicated after implementing the ISBAR tool, the health personnel's experiences improved. The experience of the overall patient handover quality increased from 82.6% to 93.3%. Moreover, personnel found it easier to establish contact at the beginning of the handover, ambiguities were resolved, and documentation was more complete (Leonardsen et al., 2019).

ISBAR is a reliable and effective handoff communication tool to promote patient safety, and nurses generally have a good perception and compliance with ISBAR tools. Hence, achieving good perception and compliance regarding the ISBAR tool is extremely vital for nurses in order to prevent communication error, and improve staff satisfaction and patient safety (Chiew et al., 2019).

In addition to health professionals, the use of ISBAR principles is a good way for nursing students to learn shift handovers, and can help improve students' self-confidence, as well as better understanding the patient's condition (Pang, 2017). The students become more aware of their own communication structure when using ISBAR in clinical practice. When using the ISBAR tool, they also may feel more confident about their own expertise and communication, and they are able to obtain a quicker overview of patient situations. (Moi et al., 2019).

ISBAR for patient safety

The use of the ISBAR tool, as described previously, is a simple and effective method for bringing about systemic change in healthcare communication, which leads to improvements in the safety of the healthcare system. While miscommunication errors are not the fault of any one individual, it is unacceptable for patients to continue to be harmed by a system from which they seek aid when effective solutions like the ISBAR communication template have been identified. As ISBAR is a reliable and effective handoff communication tool to promote patient safety, it should be implemented on a systematic and pervasive basis in order to begin the process of healing healthcare communication and creating a safer healthcare environment for people who seek care.

REFERENCES

Aldrich, R., Duggan, A., Lane, K., Nair, K., & Hill, K.N. (2009). *ISBAR revisited: identifying and solving barriers to effective clinical handover in inter-hospital transfer – public report on pilot study.* Hunter New England Health.

Australian nursing & Midwifery Federation. (2021). *Communication - using ISBAR for clinical handover.* https://otr.anmfvic.asn.au/articles/communication-using-isbar-for-clinical-handover

Burgess A., Diggele, C.V., Roberts, C., & Mellis, C. (2020). Teaching clinical handover with ISBAR. *BMC Medical Education, 20*(Suppl 2), 459. https://doi.org/10.1186/s12909-020-02285-0

Chiew, L., Bakar, S.B.A., Ramakrishnan, S., Cheng, P.C.L., Karunagaran, Y., & Bun-yamam, Z.B. (2019). Nurses perception and compliance on identification, situation, background, assessment and recommendation (ISBAR) tools for handoff communication in tertiary hospital, Dammam (Saudi Arabia). *Malaysian Journal of Medical Research. 3*(4). 26–32. doi: 0.31674/mjmr.2019.v03i04.004

Cohen, M.D., & Hilligoss, P.B. (2010). The published literature on handoffs in hospi-tals: deficiencies identified in an extensive review. *Quality & safety in health care 19*(6), 493-7. doi:10.1136/qshc.2009.033480

Gadea Company, P., & Budía Alba, A. (2019). Patient safety and ISBAR. *JOJ Nursing & Health care 11*(1), 0031–0032. DOI: 10.19080/JOJNHC.2019.11.555808

Joint Commission International. (2018). *Communicating clearly and effectively to patients: how to overcome common communication challenges in healthcare.* https://store.jointcommissioninternational.org/assets/3/7/jci-wp-communicating-clearly-final_(1).pdf

Leonardsen, A.C., Moen, E.K., Karlsoen, G., & Hovland, T. (2019). A qualitative study on personnel's experience with patient handovers between the operating room and the postoperative anesthesia care unit before and after the implementation of a structured communication tool. *Nursing Reports, 9*(1), 8041. doi:10.4081/nursrep.2019.8041

Moi, E.B., Soderhamn, U., Marthinsen, G.N., & Flateland, S.M. (2019). The ISBAR tool leads to conscious, structured communication by healthcare personnel. *Sykepleien forskning, 14,* 74699. DOI: https://doi.org/10.4220/Sykepleienf.2019.74699

Pang, W.I. (2017). Promoting integrity of shift report by applying ISBAR principles among nursing students in clinical placement. ERPA 2017. *SHS Web of Conferences 37(1),* 01019. https://doi.org/10.1051/shsconf/20173701019

Pun, J. (2021). Factors associated with nurses' perceptions, their communication skills and the quality of clinical handover in the Hong Kong context. *BMC Nursing, 20*(1), 95. https://doi.org/10.1186/s12912-021-00624-0

Runy, L.A. (2008). Patient Handoffs. Hospital and health networks. Saint Joseph's Online 7/21/2010. https://forum.ahme.org/discus/messages/21/Patient_Handoffs_-_2008_Article-2338.pdf

Stewart, K.R. (2016). *SBAR, communication, and patient safety: an integrated literature review.* Honors Theses. Retrieved https://scholar.utc.edu/honors-theses

Thompson, J.E., Collett L.W., Langbart, M.J., Purcell, N.J., Boyd, S. M., Yuminaga, Y., Ossolinski, G., Susanto, C. & McCormack, A. (2011). Using the ISBAR handover tool in junior medical officer handover: a study in an Australian tertiary hospital. *Postgraduate Medical Journal, 87*(1027), 340–344. Doi:10.1136/pgmj.2010.105569

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PSYCHOLOGICAL FIRST AID (PFA)

Psychological First Aid is the practice of recognizing, responding and assisting people experiencing disaster-related stress in the immediate aftermath of disasters and humanitarian crises. Individuals respond physically, psychologically, emotionally, or behaviorally to any kind of disaster. Ways of coping with the disaster and subsequent events also vary individually. This chapter introduces the main points of Psychological First Aid (PFA).

Psychological first aid as an intervention

Psychological First Aid (PFA) provides psychological support to recover naturally among survivors (Burke et al., 2013); it helps foster short and long-term adaptive functions in the receiver. However, PFA is not a new intervention (Shultz and Forbes, 2013). It was introduced in the mid-twentieth century. The term PFA was first coined in the 1940s, but its use has increased enormously due to crisis events occurring more frequently. Since 2002, psychological first aid has been recommended as a key part of the provision of psychosocial support following disasters.

Psychological first aid (PFA) provides initial emotional and practical support to someone who has experienced a traumatic event on a varying scale, either individually or in a group. As mentioned in PFA Field Worker's Guide (WHO, 2011) and PFA: Supporting people following crisis events (WHO, 2016), PFA is a 'humane, supportive response to a fellow human being who is suffering and who may need support'. It can be rendered by any staff or volunteers, such as health workers not specialized in mental health and psychosocial support, community health workers, and teachers. It consists of assessing needs and concerns, helping people to address basic needs, and showing them concern and care in a way that respects their wishes, culture, dignity ,and capabilities by listening without pressuring people, comforting people, linking people to information, services, and social supports, and protecting them from further harm (Sijbrandij et al., 2020; Wang, 2021). It is an informed modular approach to help children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism.

The basic principle of PFA is to provide support and promote natural recovery in the immediate aftermath of any traumatic event, anywhere that is considered safe for the helper and affected person, ideally with some privacy as appropriate to the situation. However, a small part of an affected population will require further mental health support to assist recovery. Moreover, it should be kept in mind that PFA differs from professional counseling, clinical or psychiatric intervention, and psychological debriefing. The disaster victims are neither asked to analyze the events, nor are they pressured to tell their story, or asking details about how they feel or what had happened (WHO, 2011; WHO, 2016).

Goals and themes of PFA

As mentioned in Burke et al. (2013), PFA is provided with the assumption that people do better over the long term if they feel safe, connected to others, calm and hopeful; have access to social, physical, and emotional support; regain a sense of control by being able to help themselves during the time of crises. The main aims of PFA are to reduce initial distress, meet current needs, promote flexible coping, and encourage adjustment.

PFA should be provided with the following goals in mind:

- To make people feel calm, give hope, and reduce distress.
- To make people feel safe and secure.
- To identify and assist with current needs.
- To establish human connection.
- To facilitate people's social support.
- To help people understand the disaster and its context.
- To help people identify their own strengths and abilities to cope.
- To assist with early screening for people needing further specialized help.
- To promote adaptive functioning.
- To help people to be able to recover naturally from an event.
- To reduce the risk factors of mental illness as a result of the event, such as post-traumatic stress disorder (Burke et al., 2013).

As mentioned in PFA Field Worker's Guide (WHO, 2011), PFA involves the following themes:

- giving non-intrusive, practical care and support
- assessing needs and concerns
- helping people to address basic needs (for example, food and water, information)
- listening to people, but not pressuring them to talk
- comforting people and helping them to feel calm
- helping people connect to information, services, and social supports
- protecting people from further harm

The American Red Cross (2017) has explained the importance of PFA in the following ways:

- It helps to create a compassionate environment for disaster survivors and first aid providers.
- It helps to identify people's needs at a particular time.
- It guides how to provide immediate support to those in stressful situations.
- It helps them to cope while facing stressful events.

PFA action principles

The World Health Organization (WHO, 2016) has developed a framework, which consists of action principles to assist in the delivery of psychological first aid. The three basic action principles of PFA are Look, Listen, and Link. These action principles will help guide how to view and safely enter a crisis situation, approach affected people, understand their needs, and link them with practical support and information.

Look

The person providing PFA must look for:

1. safety.
2. people with obvious urgent basic needs.
3. people with serious distress reactions.

1. **Look for safety:** The person providing PFA must think of dangers that can be seen in the environment, such as an active conflict, damaged roads, unstable buildings, fire, or flooding. He or she also should think about potential self-harm and harm toward others. If the PFA provider is not certain about the safety of the crisis site, then he/ she should not go to the site. He/ she should try to help people in need. If possible, one should communicate with people in distress from a safe distance.
2. **Look for people with obvious urgent basic needs:** The person providing PFA must look if there is anyone who is critically injured and is in need of emergency medical help and rescuing. He/ she also should look if there is anyone who has obvious urgent basic needs, such as protection from the weather, torn clothing, and protection from discrimination and violence. Another thing that should be kept in mind is to find out if there is anyone to help the PFA provider.
3. **Look for people with serious distress reactions:** The person providing PFA must look if there is anyone who appears extremely upset, not able to move on their own, not responding to others, or in shock. It is important to find out where and who are the most distressed people.

Listen

Listening properly to people is essential for understanding their situation and needs, helping them to feel calm, and being able to offer appropriate help. One should learn to listen with:

– Eyes: giving the person your undivided attention
– Ears: truly hearing their concerns
– Heart: with caring and showing respect

The PFA provider must consider the following points while listening:

1. Approach people who may need support.
2. Ask about people's needs and concerns.
3. Listen to people and help them to feel calm.

1. **Listen carefully while approaching the people who may need support:** the PFA provider should approach people respectfully and according to their culture. He/she should introduce himself/herself by name and organization. He/she should ask about the need for his/her help, and should find a safe and quiet place to talk. PFA provider should help the person feel comfortable as needed; for example, offer water, try to keep the person safe, remove the person from immediate danger, try to protect the person from exposure to the media for their privacy and dignity, and if the person is very distressed, try to make sure they are not alone.
2. **Listen to people's needs and concerns:** the PFA provider should always ask about people's needs and their concerns. He/she should find out about the most important needs of people at the moment, and help them work out their priorities.
3. **Listen to people, and help them to feel calm:** the PFA provider should listen, staying close to the person with a soft voice. If people are very distressed, he/she should help them to feel calm and try to make sure they are not alone.

Link

After establishing their needs and concerns, the PFA provider should search for support services to link them with the individuals by:

1. helping people address basic needs and access services.
2. helping people cope with problems.
3. providing information.
4. Connect people with loved ones and social support.

1. **Help people address basic needs and access services:** the PFA provider should help people to address basic needs, consider the following:
   - Immediately after a crisis event, try to help the person in distress to meet the basic needs they request, such as food, water, shelter, and sanitation.
   - Learn what specific needs people have – such as health care, clothing, or items for feeding small children (cups and bottles) – and try to link them to the help available.
   - Make sure vulnerable or marginalized people are not overlooked.
   - Follow up with people as needed.

2. **Help people cope with problems:** A person in distress can feel overwhelmed with worries and fears, so the PFA provider should help people cope with the problems; being able to manage a few issues will give the person a greater sense of control in the situation and strengthen their own ability to cope by remembering that everyone has natural ways of coping. The PFA provider should encourage people to use their own positive coping strategies and avoid negative strategies, which will help them feel stronger and regain a sense of control.

   Encourage positive coping strategies: the PFA provider should encourage people to use positive coping strategies as follows:

   – Get enough rest.
   – Eat as regularly as possible and drink water.
   – Talk and spend time with family and friends.
   – Discuss problems with someone you trust.
   – Do activities that help you relax (walk, sing, pray, play with children).
   – Do physical exercise.
   – Find safe ways to help others in the crisis and get involved in community activities.
   – Help people identify support in their life, such as friends or family that can help them in the current situation
   – Give practical suggestions for people to meet their own needs (for example, explain how the person can register to receive food aid or material assistance)
   – Ask the person to consider how they coped with difficult situations in the past, and affirm their ability to cope with the current situation
   – Ask the person what helps them to feel better.
   – Encourage them to use positive coping strategies and avoid negative coping strategies by:
   – Account of the person's culture and what is possible in the particular crisis situation.

Negative coping strategies must be discouraged: the PFA provider should discourage people from following negative strategies, such as:

- Taking drugs, smoking or drinking alcohol.
- Sleeping all day.
- Working all the time without any rest or relaxation.
- Isolate oneself from friends and loved ones.
- Neglect basic personal hygiene.
- Be violent.

3. **Give information:** the PFA providers should provide accurate information regarding:
   - the event
   - loved ones or others who are impacted
   - their safety
   - their rights
   - how to access the services and things they need

4. **Connect with loved ones and social support:** the PFA provider should work on linking people with their loved ones and social support as it is an important part of PFA.
   - Help keep families together, and keep children with their parents and loved ones.
   - Help people to contact friends and relatives so they can get support;
   - for example, provide a way for them to call loved ones.
   - If a person lets you know that prayer, religious practice or support from religious leaders might be helpful for them, try to connect them with their spiritual community.
   - Help bring affected people together to help each other. For example, ask people to help care for the elderly, or link individuals without a family to other community members.

Eight core actions of PFA

As mentioned before, PFA is constructed around eight core actions. Most PFA contacts will involve providing most of the actions depending on the context. The choice of action and amount of time spent on each will depend on the needs of survivors and on the context of delivery (Ruzek et al., 2007). The actions are described below:

1. Contact and engagement: Many affected persons will not seek help from providers, and some may not want or need contact. This means that the provider needs to use judgment in when and how to initiate contact. The provider should introduce themselves with his/her first or full name and describe their response role. Importantly, they should ask for permission to talk with the survivor. Initiating contact is likely to be better received if the provider focuses on identifying and helping meet the immediate needs of the person.
2. Safety and comfort: Practical help must start with ensuring immediate physical safety, providing physical or emotional comfort, and promoting a psychological sense of safety. Some individuals may be unsafe themselves or may present a threat to others as a result of physical contamination or behavioral or psychological instability. If there are indications that persons may hurt themselves or others, PFA providers should seek assistance from the medical or security team. It may be important to protect survivors from elements of the situation that may increase their sense of danger: from unnecessary exposure to additional trauma and trauma reminders, from possible violations of their privacy (e.g., reporters, onlookers or attorneys).
3. Stabilization: When survivors are emotionally overwhelmed, it may be important to attempt to calm them and reduce their distress. For the individuals whose reaction interferes with their ability to comprehend the situation or respond to guidance, stabilization may be needed. Such individuals would include those who are unresponsive to questions, crying uncontrollably, hyperventilating, or experiencing intense uncontrollable physical reactions. In such situations, the PFA provider has several options, including enlisting the aid of their family or friend in comforting the distressed person, taking him or her aside to a quiet place or speaking quietly with the person while their family/friends are nearby.

4. Information gathering: current needs and concerns
   Because of its focus on immediate assistance for the survivor, information gathering in the context of PFA focuses most prominently on identifying immediate needs and concerns. Therefore, most discussion will focus on such things as concerns about immediate post-disaster circumstances and ongoing threats, separation from loved ones, or concern about the safety of loved ones and the need for medications, and the nature of severity of experiences during the disaster. However, the provider is also looking for information as to whether there is a need for immediate referral, additional services or a follow up contact. The PFA provider will need to use judgment about how to gather information, how much information to gather, and to what extent the questions should be asked, while remaining sensitive to the needs of the person.
5. Practical assistance: Assisting survivors with current or anticipated problems is a central part of PFA. Ongoing adversities and continuing problems resulting from a disaster can add significantly to the survivor's stress level, distract from self care, and help maintain distress reactions. Most PFA interactions are built around the discussion of immediate needs. In such discussions, the PFA provider can clarify the need, help the survivor, specify the problem, and discuss what can be done to address the need or concern.
6. Connection with social supports: Assistance with re-establishing contacts with primary support persons or other sources of support (e.g., family, friends, community helping resources) is an important PFA action. An immediate concern for most affected persons is locating and contacting their loved ones. The provider should take practical scales to enable the person to make contact with persons important to the survivor. The provider may also help educate survivors about the importance of social support, and how to be supportive to others.
7. Information on coping support: Although PFA is not focused on treating psychological problems, the PFA contact provides an important opportunity to influence the survivor's coping behavior by providing brief education about the unfolding disaster itself, stress reactions, and coping. Disaster-related information might focus on what is currently known about the event, what is being done to assist survivors, and available services. Coping-related information that may be helpful includes information about post-disaster reactions and how to manage them, self-care and family care and coping. It may also be appropriate and helpful to discuss ways of coping and distinguish between positive and negative coping actions.

8. Linkage with collaborative services: Because many survivors will need additional assistance following a PFA contact, the contact is used to help link survivors with needed services. If the survivor is interested in additional services, the PFA provider should do whatever is necessary to ensure effective linkage with the services. PFA should include ways of attempting to create a psychological sense of continuity of care by providing, if feasible, continuing contact information so that the affected person can find the PFA provider if they wish to reconnect, and introducing the survivor to other mental health, health care, family services, or relief workers so that they know several helpers by name.

Special considerations

As mentioned in PFA field worker's guide (WHO, 2011) & War Trauma Foundation and World Vision International (2013), people who are likely to need special attention in a crisis situation are as follows:

Children and adolescents

During the time of crises and thereafter, children and adolescents should be kept together with loved ones. If this is not possible by any means, they should be linked to a trustworthy child protection network or agency. They should not be left unattended or with unauthorized strangers. In the meantime, PFA providers should take steps to find their caregivers or to contact other family members who can take care of them. Children and adolescents alike should be protected from being exposed to any unpleasant scenes like abuse, exploitation, injured people or terrible destruction, hearing upsetting stories about the event, or from the media or people who want to interview them beyond the emergency response. PFA providers should be calm, talk softly, and be kind to the children. They should listen intently, talk, and play with them. They should be ensured that the PFA providers are there to help them.

People with ill health conditions and disabilities

People with ill health conditions and disabilities should also receive good care during the disaster and thereafter. They may need special help to get a safe place, to be protected from abuse, and to access medical care and other services. This may include elderly people, pregnant women, people with severe mental disorders, or people with visual or hearing difficulties. They should be addressed directly, rather than through a caretaker, unless direct communication is difficult in a clear and direct manner. They should be encouraged to be self-sufficient when and where possible. If needed, they should be offered to write down information, and make arrangements for the person to receive written announcements.

People at risk of discrimination

People at risk of discrimination or violence may include women, people of certain ethnic groups, and people with mental disabilities; they may need special protection to be safe in the crisis setting, and may need extra help and support to access available services.

Coping strategies

While dealing with the disaster victims, we need to encourage and help people use their natural and positive coping strategies to regain a sense of control. They should be advised to follow healthy lifestyle habits like getting enough rest, eating a healthy balanced diet and drinking adequate water as regularly as possible. Whenever possible, they should be provided opportunities to talk and spend time with family and friends. If there is any problem, they should discuss the problem with someone they trust. People should be involved in activities that promote relaxation, i.e., walking, singing, dancing, praying, playing with children, etc. They should be involved in regular physical exercise, find safe ways to help others in the crisis, and get involved in community activities. At the same time, we should discourage people from using negative coping strategies, i.e., drinking alcohol, smoking tobacco, using various drugs, sleeping all day, working all the time without any rest or relaxation, isolating oneself from friends and loved ones, neglecting personal hygiene, and being violent, etc. (P WHO, 2011; War Trauma Foundation and World Vision International, 2013).

Communication

Effective communication is the key to successful PFA. After identifying the victim, the PFA provider should first try to find a quiet place to talk with limited outside distractions. Stay near the person, but keep an appropriate distance depending on their age, gender, and culture. Be patient and calm while communicating, and let them know that you hear them. Provide genuine information simply in a way the person can understand. Acknowledge how they are feeling about any losses or important events. Respect the privacy of the person. Shared information should be kept confidential, especially when they disclose very personal affairs. Focus on the person's strengths rather than their limitations, and how they have helped themselves.

However, the PFA provider should take care not to pressurize the person to tell their story if they are not comfortable sharing. Do not interrupt or rush someone's story. The PFA provider should just listen and not give their opinion about the person's situation or judge the situation, behaviors, or their feelings. Never touch the person unless the person's cultural norms allow it. Technical terms should be kept to a minimum as much as possible. The person should not be provided with false promises and reassurances. Self-disclosure of problems should also be avoided (WHO, 2011).

Be aware of the emergency response measures

When hundreds of thousands of people are affected, different types of emergency response measures take place, such as search-and-rescue operations, emergency healthcare, shelter, food distribution, and family-tracing and child protection activities. Try to be aware of what services and supports may be available so you can share information with people you are helping and tell them how to access practical help (WHO, 2011).

Look after yourself and your colleagues

Similarly, according to PFA Field Worker's Guide (WHO, 2011), PFA providers should also consider self-care pertaining to their health and well-being while providing PFA to the victims. As a helper, the PFA provider may be affected by the experience in a crisis situation. It is important to pay extra attention to your own well-being, and be sure that you are physically and emotionally able to help oth-

ers. Take care of your own self so that the best care can be provided for others. If working in a team, be aware of fellow helpers' well-being as well. They also need to take adequate rest, eat and drink regularly, perform relaxing activities like walking, singing, praying, exercising, etc. If any problems arise, they can be discussed with someone trustworthy. However, behaviors like consuming alcohol, drugs, excessive caffeine or nicotine should be avoided.

Need for PFA intervention

The Greek philosopher Heraclitus noted that the only constant is change. We currently live in an era of unprecedented personal, social, economic, and political change. While change can often be uplifting, it can also be distressing. Due to current events, or perhaps life in general, most of us have directly observed another person in psychological distress, such as a friend, family member, coworker, or even a complete stranger. Similarly, those of us who have observed someone in distress have often been motivated to offer some form of support in an attempt to ease the suffering we witnessed. Sometimes our efforts were effective, and sometimes they were not. At other times, despite our best efforts, our actions actually appeared to make matters worse, intensifying the acute distress (George, 2018).

A recommendation in the *American Journal of* Psychiatry stated that shortly after a stressful event, it is important that those affected be provided with empathic, practical psychological support beginning with a compassionate and supportive presence. The American Red Cross, the American Psychological Association, and even the United Nations have recognized the importance of PFA. In its guidelines for mental health responses, the Inter-Agency Standing Committee (IASC) of the United Nations wrote that most people experiencing acute psychological distress after being exposed to stressful events are "best supported without medication" and that "all aid workers, and especially health workers, should be able to provide very basic psychological first aid," (George, 2018).

Nepal has great physical diversity, starting from the Terai plains, landforms rising in succession towards hills and mountain ranges, reaching the great Himalayas. Due to this geographical variation, rapid urbanization, globalization, and various demographic factors, Nepal is prone to disasters, either natural or manmade, which leave millions of people homeless or displaced (Bhusal et al., 2019). Nepal is a disaster-prone country as it faces a lot of disasters every year. On April 25, 2015, Nepal faced a devastating 7.8-magnitude earthquake that took over

9,000 lives. Accidents account for 3.18% of the total mortality rate in Nepal, whereas nearly 10,000 people have been killed by landslides and flooding in the last 45 years. 134 people lost their lives in 2017's South Asian floods in Nepal, which severely affected 18 districts (National Planning Commission, 2017). A fire destroyed Patala, an ancient place in Western Nepal in December 2018 where 87 houses were burnt (The Himalayan times, 2018). Such disaster events leave millions of people affected each year, many of whom are displaced.

Nepal has adopted various plans and policies to tackle disasters and related problems. While Nepal previously adopted a reactive policy for disasters (focusing on response and rescue), the country has now shifted to a proactive policy (focusing more on preparedness and mitigation) (Bhusal et.al, 2019). In light of this, PFA has become more relevant in the Nepalese context as an integral part of disaster preparedness. Henceforth, knowledge and information regarding PFA for individuals from different professions and backgrounds are of immense need in the current hour.

Psychological first aid aims to enhance mental well-being

Psychological first aid (PFA) is an approach for assisting people in the immediate aftermath of disasters and humanitarian crises to reduce initial distress, and to foster short and long-term adaptive functions. PFA is largely intended to be used by helpers in contact with people recently impacted by distressing events. They may include staff or volunteers, such as health workers not specialized in mental health and psychosocial support, community health workers, and teachers.

PFA consists of assessing needs and concerns, helping people to address basic needs, listening without pressuring people, comforting people, linking people to information, services, social supports, and protecting them from further harm. The PFA provider should be prepared with learning about the crisis event, available services and support, safety, and security concerns. They should follow the principles of PFA by looking for people with obvious urgent basic needs and serious distress reactions, listening to people's needs and concerns, helping them to feel calm, linking them with the available services, and connecting people with loved ones and social support. Children and adolescents, and people with ill health conditions and disabilities should be cared for with special considerations.

REFERENCES

Bhusal, R., Machamasi, S., & Nepal, S. (2019). Mainstreaming psychological first aid response during disaster events in Nepal. *International NGO Journal, 14*(6), 70–75. DOI:10.5897/INGOJ2019.0342 https://www.researchgate.net/publication/338834932_Mainstreaming_psychological_first_aid_response_during_disaster_events_in_Nepal

George, S. (2018). *Psychological first aid can help support family and friends through a crisis.* Psychology today. Retrived on https://www.psychologytoday.com/us/blog/when-disaster-strikes-inside-disaster-psychology/201810/psychological-first-aid#:~:text=Psychological%20first%20aid%20can%20help%20support%20family%20and%20friends%20through%20a%20crisis.&text=The%20Greek%20philosopher%20Heraclitus%20of,%2C%20economic%2C%20and%20political%20change.

National Planning Commission. (2015). *Nepal Earthquake 2015: Post Disaster Needs Assessment-Vol. A: Key Findings.* Government of Nepal.

National Planning Commission. (2017). *Post Flood Recovery Needs Assessment.* Government of Nepal. Retrieved from https://www.npc.gov.np/images/category/PFRNA_Report_Final.pdf

Burke, S., Richardson, J., & Whitton, S. (2013). *Psychological First aid: An Australian guide to supporting people affected by disaster* (2nd ed.). Australian Red Cross and Australian Psychological Society. https://psychology.org.au/getmedia/c1846704-2fa3-41ae-bf53-7a7451af6246/red-cross-psychological-first-aid-disasters.pdf

Ruzek, J. I., Brymer, M. J., Jacobs, A. K., Layne, C. M., Vernberg, E. M., & Watson, P. J. (2007). Psychological First Aid. *Journal of Mental Health Counseling, 29*(1), 17–49. https://doi.org/10.17744/mehc.29.1.5racqxjueafabgwp

Shultz, J.M., & Forbes D. (2013). Psychological First Aid: Rapid proliferation and the search for evidence. *Disaster Health 2*(1), 3–12. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5314921/

Sijbrandij, M., Horn, R., Esliker, R., O'May, F., Reiffers, R., Ruttenberg, L., Stam, K., Jong, J.D., & Ager, A. (2020). The Effect of Psychological First Aid Training on Knowledge and Understanding about Psychosocial Support Principles: A Cluster-Randomized Controlled Trial. *International Journal of Environmental Research and Public Health, 17(2)*, 484, 1–11, doi:10.3390/ijerph17020484 https://www.mdpi.com/journal/ijerph

The American Red Cross. (2017). *Psychological First Aid: Helping Others in Times of Stress: Instructor-Led Training Participant Guide* 7–19. The American Red Cross.

The Himalayan times. (2018). *Karnali govt announces Rs. 43.5m cash relief for Patala fire Victims.* Retrieved from https://thehimalayantimes.com/nepal/karnali-govt-announces-rs-43-5m-cash-relief-for-palata-fire-victims/

Wang, L., Norman, I., Xiao, T., Li, Y., & Leamy, M. (2021). Psychological First Aid Training: A Scoping Review of Its Application, Outcomes and Implementation. *Int. J. Environ. Res. Public Health 18(9)*, 4594. https://doi.org/10.3390/ijerph18094594

World Health Organization. (2011). *Psychological first aid: Guide for Field Workers.* https://www.who.int/publications/i/item/9789241548205

World Health Organization. (2014). *Facilitation Manual – Psychological First Aid During Ebola Disease Outbreaks.* https://www.who.int/mental_health/emergencies/psychological_first_aid_ebola_manual/en/

World Health Organization. (2016). *Psychological First Aid: Supporting people following crisis events.* https://www.mhinnovation.net/resources/psychological-first-aid-supporting-people-following-crisis-events

World Health Organization, War Trauma Foundation and World Vision International. (2013). *Psychological First Aid: Facilitators Manual for Orienting Field Workers.*

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DIAKONIA-AMMATTIKORKEAKOULU
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THE ABILITY to cooperate with each other is a crucial skill for people and their propensity for thriving, along with their well-being. When it comes to the well-being of others, it necessitates that humans are approached as integrated human beings and not as loose mixtures of bodily, medical, social, and other elements. Enhancing people's well-being requires cooperation and a holistic approach.

This book offers conceptual and practical tools for the holistic enhancement of wellbeing and dignity in higher professional education, learning, and cooperation. Hence, a multi-professional perspective is the central approach in this publication. Originally, this book was written to offer learning material for professional education in Vietnam and Nepal, but it may well offer usable contents for education elsewhere as well.

The book is divided into four parts: Part one concentrates on utilizing multi-professional teamwork and simulations as a method of teaching and learning it. Part two describes the usage of qualitative research methods for health and social professionals. Part three illuminates how communities can be developed with appropriate methods, co-creation, and innovations, in which the active participation of community members is stressed. Lastly, part four offers practical tools for holistic work in distressing situations.

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