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Healthcare Communication

2025 CMAI Healing Ministry Week

HEALING MINISTRY WEEK 9th - 15th February 2025
HEALING MINISTRY SUNDAY 9th February 2025
CMAI DAY OF PRAYER 12th February 2025

www.CMAI.org

"IN THEIR HEARTS HUMANS PLAN THEIR COURSE,
BUT THE LORD ESTABLISHES THEIR STEPS" - PROVERBS 16:9

"INSPIRE TO ASPIRE"

EMPOWERED TO HEAL

CMAI Comms

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LETTERS TO THE EDITOR

Dear Members and Readers,

I invite you on behalf of CMAI to share feedback and views and make the CMJI interactive, relevant and vibrant. As you read this edition and each issue of CMJI, we would like to know what comes to your mind?

Please share your thoughts to help guide the Editorial team. E-mail your responses to: communication@cmai.org

Online Editions: Kindly visit our website www.cmai.org to view and download the past editions. Fill up a simple form and enjoy reading! Click here: https://www.cmai.org/publications/cmji.html

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Regards
Lead - Communication Department

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GUIDELINES FOR AUTHORS & CONTRIBUTORS

SPECIAL ARTICLES: CMAI welcomes original articles on any topic relevant to CMAI membership - no plagiarism please.

- Articles must be not more than 1500 words.
- All articles must preferably be submitted in soft copy format. The soft copy can be sent by e-mail; alternatively it can be sent in a printed copy or CD by post. Authors may please mention the source of all references: for e.g. in case of journals: Binswanger, Hans and Shaidur Khandker (1995), 'The Impact of Formal Finance on the Rural Economy in India', Journal of Development Studies, 32(2), December. pp 234-62 and in case of Books; Rutherford, Stuart (1997): 'Informal Financial Services in Dhaka's Slums' Jeoffrey Wood and Ifftah Sharif (eds), Who Needs Credit? Poverty and Finance in Bangladesh, Dhaka University Press, Dhaka.
- Articles submitted to CMAI should not have been simultaneously submitted to any other newspaper, journal or website for publication.
- Every effort is taken to process received articles at the earliest and these may be included in an issue where they are relevant.
- Articles accepted for publication can take up to six to eight months from the date of acceptance to appear in the CMJI. However, every effort is made to ensure early publication.
- The decision of the Editor is final and binding.

GENERAL GUIDELINES

- Authors are requested to provide full details for correspondence: postal and e-mail address and daytime phone numbers.
- Authors are requested to send the article in Microsoft Word format. Authors are encouraged to use UK English spellings.
- Contributors are requested to send articles that are complete in every respect, including references, as this facilitates quicker processing.
- All submissions will be acknowledged via Email

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EDITORIAL

Healthcare communication sits at the heart of patient safety, satisfaction, and outcomes. Care and compassionate communication builds trust and understanding between healthcare providers and patients, including their loved ones. Active listening and empathy ensure patients feel heard, respected, and involved in their treatment decisions. However, miscommunication remains one of the leading challenges at our medical institutions, yet, effective and clear communication strategies are also one of the most correctable and dynamic solutions. Advancements in telehealth, artificial intelligence, and wearable technologies, the ways we share information has evolved but so has the risks of information overload.

In this edition, we have tried to bring to our readers varied perspectives of how the member organisations within and outside our network are contributing to healthcare communication. Please write to me at communication@cmai.org with your feedback and comments on the articles.

As we approach the 48th Biennial Conference this year, it's an opportune moment to showcase on one of the most pressing pillars in healthcare today and that is the Healthcare Professionals. That is why the biennial conference aims to bring together all of us for a time of sharing our achievements and challenges.

The 48th Biennial Conference is more than just a meeting of minds; it is a call to action. Held under the theme "Inspire to Aspire" – Empowered to Heal from Proverbs 16:9 the gathering will spotlight the need for resilient, human-centered leadership strategies that transcend barriers of regions, experiences, culture, and technology.

I urge all members of CMAI to further encourage their network across mission hospitals and sections and even beyond, to participate, support and collaborate.

As a long-standing member of CMAI or maybe a first-time attendee, your voice and presence matters. Come, join us for the 48th Biennial Conference 2025 to be held in Kochi, Kerala from 6th-8th November 2025. Let us work together and harness the collective wisdom of our community and ensure that healing ministry is not an afterthought but a foundational element of quality care of our country.

Visit www.cmai.org/48BC.html for more details.

Dr Christopher D. Moses
Editor

Christian Medical Association of India

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NOTICE OF THE CMAI GENERAL MEETING 2025

GS/ND/2025/3474
8th April 2025

To,
All Members of CMAI in Full Standing (Regular Members)

This is to inform you that the General Meeting of the Christian Medical Association of India will be held on Thursday 6th November 2025 at 6:30 pm and Saturday 8th November 2025, at 11:00 am, as two Business Sessions, at Gokulam Convention Centre, Banerji Road, Kaloor, Kochi, Kerala - 682107

All members are requested to attend. The proposed agenda is given below.

PROPOSED AGENDA

Thursday 6th November 2025
Business Session 1, Time: 6:30 pm

1. Opening Prayer
2. Roll Call
3. Appointment of Recording Secretaries
4. Condolences
5. Confirmation of Minutes of General Meeting held on 22nd & 23rd November 2023
6. Matters Arising
7. Report of the General Secretary, Treasurer, Editor
8. Formation of Nomination Committee
9. Any other matter
10. Closing Prayer

Saturday, 8th November 2025
Business Session II, Time:11:00 am

1. Reports of Sectional Meetings
2. Election of Executive Committee and other Committees of the Association for 2025 – 2027
3. Venue for the Next Biennial Conference 2027
4. Any Other Business with the permission of the Chair
5. Vote of Thanks & Closing Prayer

Thanking you,
Yours sincerely,

Dr Priya Letitia John
General Secretary

THEME
"INSPIRE TO ASPIRE:
EMPOWERED TO HEAL"
PROVERBS 16:9

Christian
Medical
Association of
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DR D W MATEGAONKAR Award 2025

NOMINATIONS ARE INVITED FOR DW MATEGAONKAR AWARD 2025

In 1990 CMAI instituted National Awards to publicly recognize members who have made a significant contribution to the mission of the Church in India in the ministry of health, healing and wholeness. The award (up to 5 per year) shall be presented during the 48th Biennial Conference in November 2025. Members are requested to send suggestions/nominations to cmai@cmai.org addressed to the General Secretary, CMAI by 30th June 2025.

For Nomination Form: https://www.cmai.org/48th-biennial-conference-2025.html

YOUNG MEDICAL MISSIONARY Award 2025

NOMINATIONS ARE INVITED FOR YOUNG MEDICAL MISSIONARY AWARD 2025

CMAI instituted Young Medical Missionary Awards to publicly recognize young doctors below the age of 40 who have served in rural mission hospitals for more than 10 years and made a significant contribution to the mission of the church in India in the ministry of health, healing and wholeness. The award shall be presented during the 48th Biennial Conference in November 2025. Members are requested to send suggestions/nominations to cmai@cmai.org addressed to the General Secretary, CMAI by 30th June 2025.

For Nomination Form: https://www.cmai.org/48th-biennial-conference-2025.html

"DO YOU WANT TO BE MADE WELL?" JOHN 5:1-9

DR REV ARUL DHAS

How can a healthcare professional communicate like Jesus?

When Jesus was in Jerusalem, this healing miracle happened. Jesus healed a sick man and towards the end, the man was made well. If I am open to the promptings of the Spirit of God, I can learn from this passage few important things regarding communication.

1. Observation as the beginning of communication: *Jesus saw him (John 5:6):* Before communicating anything, observation of the surrounding and the person/ things around us is absolutely essential. It may be true that we have a burden to communicate, we have an important matter to communicate, even we may sense an urgency to communicate. Whatever be the situation, if we don't know how to see what/who is in front of us, true communication is not possible. In the clinical setting we see the healthcare professionals do a thorough clinical examination before they begin to communicate anything important. This requires close, non-judgmental observation. Sometimes, we don't see because we don't look.

We are familiar with the question, 'do you see what I see?' When a new person approaches the reception desk, the person at the desk often feels in his/her mind, "Oh, one more person with many questions and doubts, how do you I 'dispose' him/her soon". Recently, I visited a mission hospital. When I approached

the reception desk, the lady at the counter with a smiling face asked me “may I help you?” I felt welcome, accepted and respected there. There was some peace, expectation, cordiality. I thought for a moment that the whole hospital is there to help me. In John 5, Jesus saw in that 38 year old sick person ‘the image of God’. Jesus saw him lying there. These are the initial observations.

Can I learn to see others as they are before I start communicating? There is no burning urgency to change the other person as I am. Sometimes, I see others in a condescending manner. I see that I am far better than the other. ‘I didn’t mess up my life as the other person has messed up his/her life’. ‘I am very close to God than the other’. ‘If God had been with him/her, s/he won’t be in this pathetic condition’. ‘I have made use of my talents and opportunities so well, this person has wasted all his opportunities’.

True communication can happen when there is respect, love and genuineness. It is not surprising to note that in counselling discipline, respect, empathy and genuineness are considered as core conditions for a counsellor. Good communication is the beginning of a therapeutic relationship.

2. Autonomy at the forefront of communication: The question of Jesus “Do you want to be made well?” (John 5:6) considers the person’s dignity, choice, preference very important. At the outset it looks as if this is an unnecessary question. This question has two impacts.

One on the questioner and another on the listener.

The questioner understands the beauty of giving importance to the listener. How could we assume that a sick person doesn't want to be healed? But the purpose of this question seems to be to confirm and ascertain the desire of the person concerned. Others thought that this man needed healing, but Jesus wanted to know the deeper desire of the sick person.

Paternalism is common and natural in the healthcare discipline. We know what is good for the other person. As healthcare professionals, we are learned, equipped, expertised to handle different health situations of the people. Therefore, we don't bother to ask the persons in trouble what they exactly need. We do those things as we like and not necessarily how the other person needs it. The time, manner, pattern we do our role is so dominated with our own will and desire. Rarely, we incorporate the recipient's will, considerations and desires into our service/ministry. Often, those who are in need of healing service/ministry are at the mercy of the health providers. Would I dare asking this question to the recipient of my service?

This type of question also helps to bring clarity on the mind of the recipient. It leads the person to go deeper in thoughts and motives. As a sick person, what is my objective in my life? What do I need? Do I need some contributions from my sympathizers OR something deeper than that? Often my immediate 'need' obfuscates my true need. I am in need of healing & wholeness. However, I become complacent as soon as I get some items in my life fulfilled. In this manner, Jesus' question: "Do you want to be made well?" helps both the health care provider and health care recipient.

3. Beyond the feelings of the healthcare provider: "Jesus said to him, "Stand up, take your mat and walk" (John 5:8). When Jesus wanted to heal the sick person, he had the power/resources needed to bring forth healing. The sick person underestimated the power and ability of Jesus. It is possible that someone in the place of Jesus would have felt humiliated, unrecognized. It is also possible to be angry about the sick person for the distracted nature of answer he gave – "Sir, I have no one to put me into the pool …".

Jesus asked whether the person wanted to be healed, but he is putting the blame on others for his being ill. He did not answer the question of Jesus. Being upset, angry, being distracted are definite possibilities under those circumstances. However, we see Jesus going beyond all possible negative feelings and providing healing and wholeness to the sick person.

The sign or miracle (as the other evangelists called it) was in this interplay. Miracle is experiencing wholeness and healing in the midst of power of God, need of people and the misunderstanding of many in the process. Often, the healing ministers themselves become blocks for the healing of the sick persons. Our communication is blocked due to some feelings we have in the ministry itself. When the communication is complete it leads us towards healing and wholeness. Both the minister and the sick experience wholeness.

Communication starts with empathetic, non-judgmental observation. Identifying the heartfelt desires of the sick person is the central focus of healing. When the healers go beyond the hurt feelings they themselves go through, the miracle of healing happens through the power of God. Jesus was such a therapeutic communicator from whom healing flowed to those who came into contact.

Lord of love, make us therapeutic communicators in our institutions and families. Amen.

Dr Rev Aruldas is former Chaplain of CMC Vellore

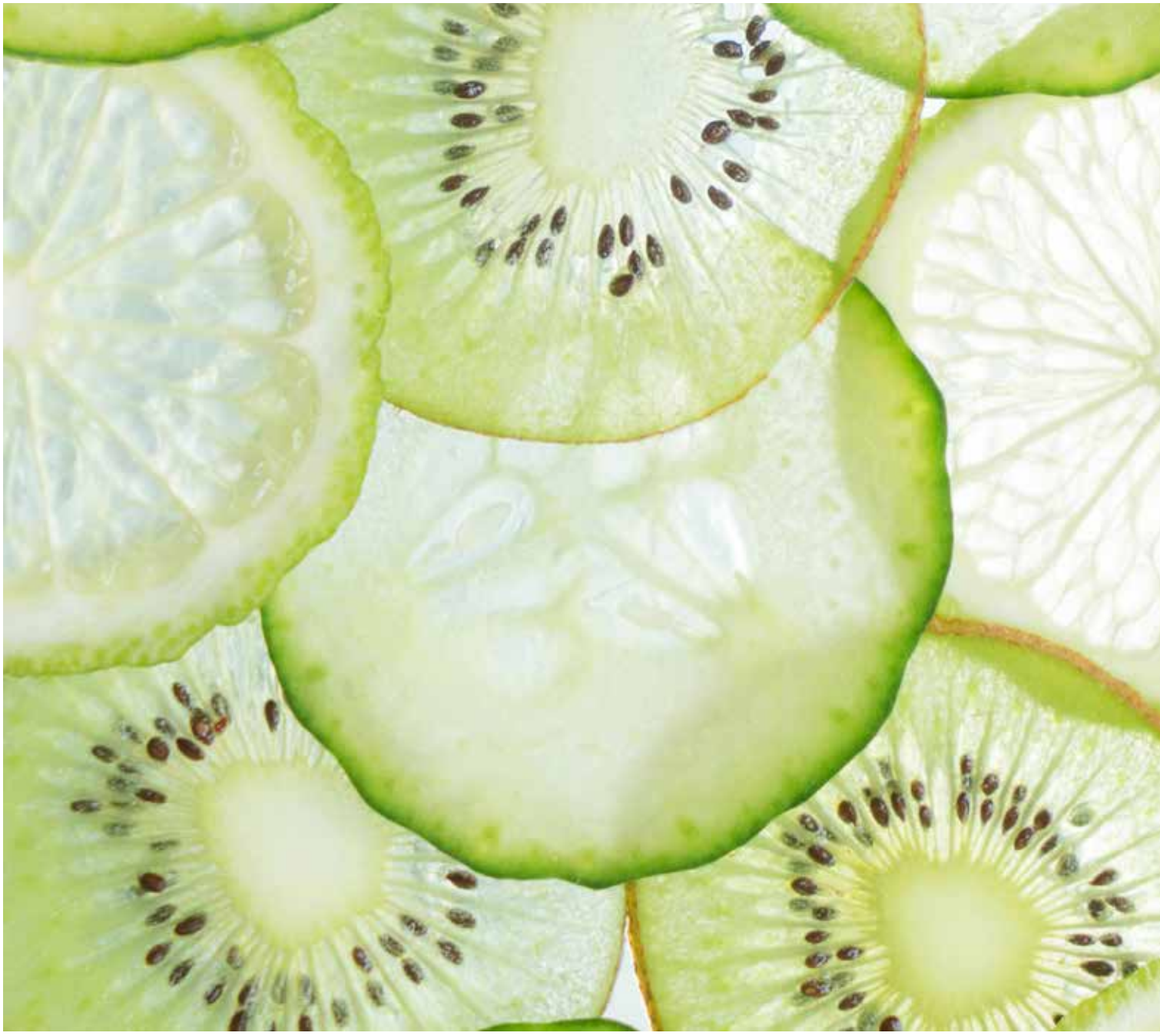
LIFESTYLE DISEASES AND BEHAVIOUR CHANGE

JACOB C. VARGHESE

LIFESTYLE DISEASES AND BEHAVIOR CHANGE COMMUNICATION: CHALLENGES AND OPPORTUNITIES.

Lifestyle diseases are rapidly increasing in India. A recent webinar organised by the Kerala chapter of the Christian Medical Association of India (CMAI), in collaboration with Believers' Church Hospital, Thiruvalla, highlighted four focus areas: 1) Preventing chronic illness in a modern world; 2) Nutritional management of lifestyle diseases; 3) Impact of positive mental health on lifestyle diseases; 4) Unlocking health through physical activity. They were well-presented and very informative. I strongly encourage the healthcare community to develop more such valuable programmes to enhance their reach and impact.

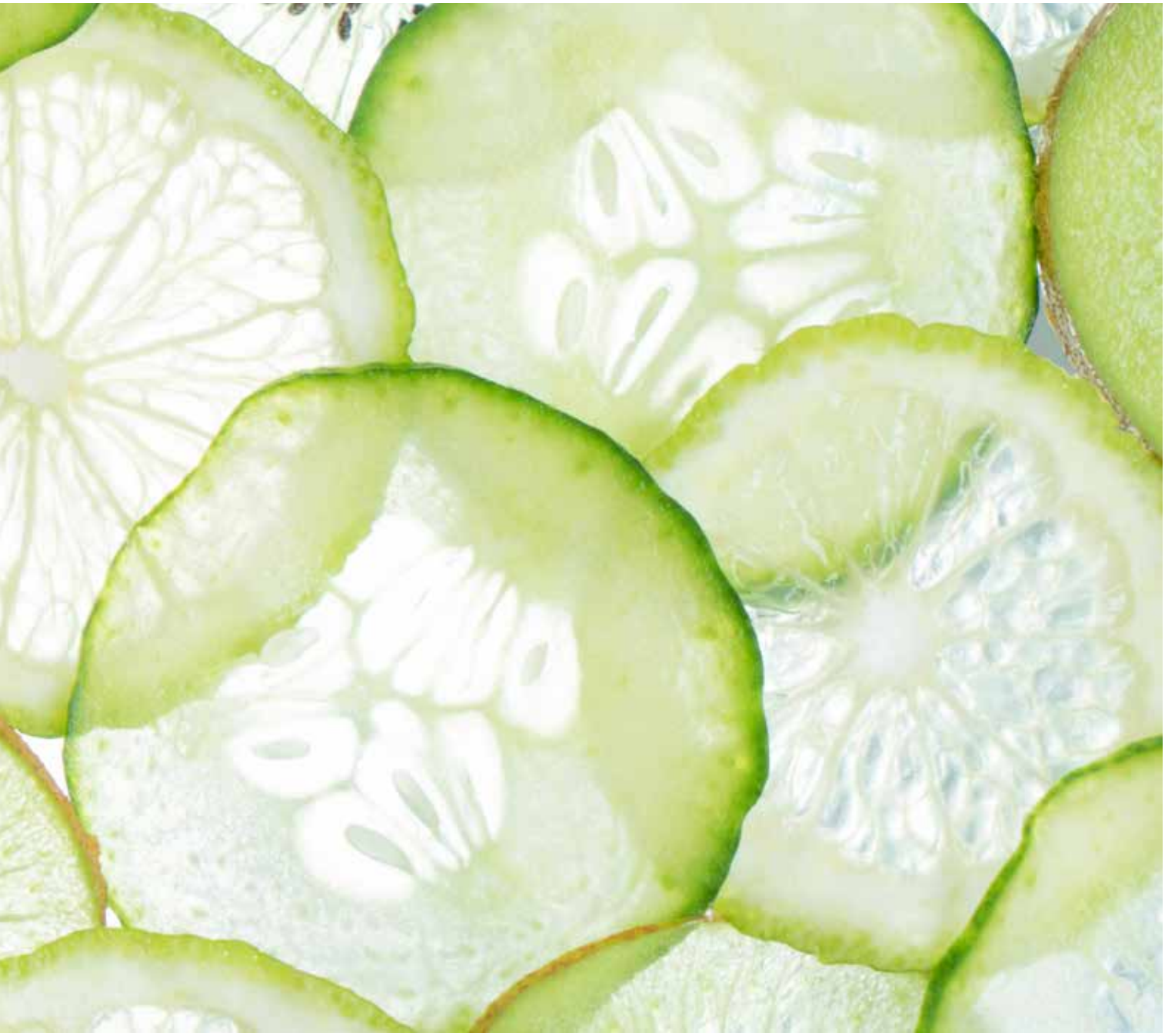
Being diabetic for the past 25 years, I am pained to see my country hurtling toward an undesirable distinction: the diabetes capital of the world. India is not far behind in the alarming rise of chronic kidney, heart, and liver diseases. Beneath our clothes, many Indians—predominantly South Asians—display what



is medically termed the “Asian Indian phenotype,” commonly known as the skinny-fat body type: thin limbs with a soft, fatty midsection. Combined with sedentary lifestyles, this contributes to a silent but severe health crisis.

What is Behaviour Change Communication?

To define it briefly, BCC is a strategic approach aimed at influencing and sustaining positive health behaviours by addressing people’s knowledge, attitudes, and practices through targeted communication. A webinar or an instructive lecture might help with the first aspect—knowledge. However, it doesn’t necessarily lead to a change in attitudes and behaviour. Slogans like Smoking is Injurious to Health have done little to alter smokers who have hooked on to the habit at an early age. There was a time when smoking among health professionals was not frowned upon. It wasn’t a lack of knowledge that led people to become addicted to nicotine



or other substances.

Today, our task is to discourage unhealthy eating habits and encourage regular physical activity, both of which are key contributors to the early onset of lifestyle diseases. This is where real challenges emerge. A habit is a regularly repeated behaviour or action that often becomes automatic over time. Habits, good or bad, are formed through repetition and reinforcement, creating strong associations between specific situations and actions.

Communication Strategy

"Do you really think you are diabetic?" my physician sardonically asked when he enquired about my daily routine as the HbA1C level had touched 14. I felt like an alcoholic confessing: "Yes, I admit, I am guilty." What followed was a scathing admonishment about my neglect of diet and exercise. At 67, I limited my movements and indulged in the finest of foods. I was deeply ashamed—especially because I had spent 20 years in public health, many

of them as a communication specialist. The fear tactic, in this instance, worked for me. I resolved not to see my doctor again until I had made significant lifestyle habits: increasing exercise time without strain and carefully portioning food into my daily routine. These efforts paid off; my sugar levels dropped considerably, and I started enjoying my days better than ever.

However, during the HIV/AIDS crisis, we consciously removed fear-based messaging, as it often led to depression, suicide, and social ostracism.

Many Indians, like myself, remain in denial, unwilling to change attitudes or behaviours. BCC is not just about providing information; it is about motivating people to act and empowering them with the skills to do so. 'Intentionality matters'. Lack of awareness is not the sole barrier to improving one's lifestyle. Change requires a conscious resolve and must be supported by a conducive ecosystem. Maintaining healthy behavior is challenging without proper support systems; family meals must adapt, and routines and time management require adjustments and consistent adherence.

What can hospitals do?

Many hospitals today are actively engaged in conducting medical camps focused on various illnesses and raising awareness about lifestyle diseases. While this is commendable, there should be a greater emphasis on reaching out to schools and colleges. These formative environments are ideal for promoting healthy habits, such as balanced nutrition and regular exercise. Moreover, involving parents in these efforts is crucial, as the home remains the primary setting where lifelong habits are developed. The growing trend of eating out should be discouraged, as it often leads to poor dietary choices and contributes to a sedentary lifestyle.

Hospitals can offer fitness messages at government and private offices, conduct healthy eating campaigns and provide preventive health screenings to reduce absenteeism and burnout. In Japan, a few firms supply pedometers and body composition analysers to monitor employee health. These tools have proven effective in weight management and reducing health risks. The affordability of gadgets may raise concerns among our countrymen. However, considering the high out-of-pocket costs for treating major diseases can help individuals make informed choices about

investing in such devices.

In their routine interactions with patients—whether outpatients or inpatients—doctors, nurses, and paramedical staff should take time to offer compassionate, practical counseling on lifestyle changes. Hospitals must display informative posters in strategic areas and conduct public lectures to raise awareness. Leadership within hospital management must support and actively promote such interventions to ensure sustained impact.

Another valuable initiative hospitals can undertake is the formation of peer support groups for individuals at different stages of managing lifestyle diseases. These groups can offer encouragement, shared experiences, and accountability. Across all communication efforts, the central themes must be DIET and EXERCISE—repeated, reinforced, and remembered.

Behaviour Change Communication Challenges

So, what are the core challenges of BCC in combating the rise of chronic lifestyle diseases, and how do we overcome these hurdles?

• Lack of sustained awareness campaigns for conditions like hypertension, diabetes, and organ diseases. Governments, private hospitals, corporate offices, non-profits, and institutions must use multiple communication channels (both media and interpersonal) to disseminate standardised, repeated messaging.

Notably, consistent anti-smoking and anti-drinking campaigns, backed by policy changes, have brought some visible behavioural shifts. Laws enforcing helmets, seatbelts, and speed control in vehicles have seen success. Similar approaches are needed for promoting physical activity and controlled food intake.

• Maintaining consistent community engagement is vital yet challenging. BCC must continuously reinforce positive behaviour through accessible, culturally attuned messaging.

• Social norms and cultural beliefs often hinder the adoption of healthy lifestyles. For example, India's overdependence on carbohydrates requires systemic changes in food habits. Incorporating millets and protein-rich foods into regular family diets is essential. Involving community leaders and adopting culturally sensitive messaging can help overcome such barriers.

• Environmental barriers such as pollution, lack of access to nutritious foods, and absence of safe public spaces for exercise also impede lifestyle change. Policy advocacy and community interventions are needed to create supportive environments.

• Frontline workers like Anganwadi and ASHA workers are doing commendable work in promoting nutritional awareness among rural women. While lifestyle diseases were once limited to the middle and upper classes, they now affect all socio-economic groups. However, limited healthcare access, especially in rural regions, still hampers effective management.

• BCC programmes often lack systematic evaluation of their communication efforts and behavioural outcomes. To be effective, BCC must rely on robust data and continuous assessment. A shining example is the USAID-AIDS Prevention and Control Project (APAC), managed by Voluntary Health Services, Chennai. Over eight years, it conducted longitudinal studies to track behavioural changes among specific cohorts. This data-driven, evidence-based approach became a model for India's successful fight against HIV/AIDS.

In conclusion, BCC strategies must be holistic, integrating community-level interventions with systemic policy changes. The fight against lifestyle diseases cannot be won with information alone. It requires inspiration, intention, and infrastructure—woven into the fabric of everyday life.

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Jacob C. Varghese is a communication consultant for non-profit organisations.


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COMMUNICATION CAMPAIGNS, COMMUNITY & AWARENESS

DR. LAVANYA SUNEETHA

Nireekshana (AIDS, action Care, Education & Training) is a community-based care centre based in Hyderabad, India, dedicated to the compassionate care and support of people infected and affected by HIV/AIDS, Leprosy, and other Neglected Tropical Diseases. We take a holistic approach to our care, looking beyond the illness to better health and life by supporting children in education and empowering women through various rehabilitation programs.

Founded in 2004 by Dr. Sujai and Dr. Lavanya, Nireekshana has a rich history spanning 20 years. CMJI's Editorial Team interacted with Dr Lavanya to get a glimpse of how Nireekshana ACET's healthcare communication activities and priorities.

We found that launching a campaign on communicable diseases is vital in public health, especially in vulnerable communities. Such campaigns help raise awareness and educate public on effective prevention methods such as vaccination, sanitation, and safe practices. It encourages early detection and timely treatment, which are crucial for controlling spread.

Furthermore, by promoting community engagement and responsible behaviour, the campaign can significantly slow the spread of infections. It also helps break stigma around certain diseases, making it easier for individuals to seek help. Overall, a well-executed campaign on communicable diseases strengthens public health infrastructure, empowers communities with knowledge, and builds resilience against future health crises.

CMJI: What inspires Nireekshana to launch a campaign that integrates work into its mission priorities?

Nireekshana ACET is motivated by the call and desire to contribute to healthier and more resilient communities affected and infected by HIV/AIDS, leprosy, and neglected tropical diseases. This is carried out by collaborating with local partners and stakeholders to address pressing health and social issues. Nireekshana started small, and the campaign to integrate HIV and leprosy was initially spread by word of mouth. It later expanded through meetings, partnerships with other organizations, and writing project proposals to secure funding for gap areas. Communication efforts included activity pictures and short videos. Most of our initial startup funds came from partners who visited the work firsthand and felt it was worthwhile to invest in improving the lives of the people we serve. Communicating consistently via email and face-to-face meetings is also the key to integrating work within the organizational vision priorities.

CMJI: Can you share some of Nireekshana's key campaigns?

Nireekshana ACET has initiated several key campaigns, including:

One of the recent campaigns focused on building a health and empowerment centre in a semi-urban area on the outskirts of Hyderabad. It was a college intern in the laboratory who inspired his uncle to donate the land space for this project. The vision was shared and spread through

word of mouth, site visits, and discussions about the project's potential. Meanwhile, progress and financial reports were sent to all partners and friends, who asked about sustainability and the future of the project. In parallel, we developed a website and improved our monitoring, evaluation, and reporting systems, which further supported the campaign.

3. How do you believe the communication materials were relatable to the wider community?

After decades of experience, we recognized that communication materials such as the website, WhatsApp, phone calls, and face-to-face meetings with partners and stakeholders all play a vital role in connecting with those engaged in similar work.

4. What types of art (visual, performing, digital, etc.) are being used in this campaign, and how are they being incorporated into your work and activities?

Nireekshana integrates visual elements into its campaigns through PowerPoint presentations, manuals, simple healthcare teaching posters, videos, skits, and role plays. For example, the skit on immunity reduction and CD4 decline effectively demonstrates to the community how HIV gradually progresses to AIDS when medication is not taken consistently. This visual representation helps the community grasp the seriousness of the topic more effectively.

5. Who are the primary stakeholders or communicators involved in this project, and what backgrounds do they bring to the campaign?

The primary stakeholders in the campaign were individuals affected by leprosy and HIV, who played a central role both as beneficiaries and active participants. These individuals were not only the focus of awareness, support, and intervention efforts, but in many cases, they were also directly or indirectly involved in shaping and implementing the campaign activities. Their lived experiences brought authenticity and urgency to the message, helping to humanize the issues and reduce stigma within communities. Some took on roles as peer educators, volunteers, or advocates, sharing their personal journeys to inspire others to seek diagnosis, treatment, and social acceptance. Others contributed indirectly by participating in surveys, community meetings, or support groups that informed the campaign's strategies and outreach. Their involvement ensured that the campaign was grounded in real needs, culturally appropriate, and more effective in reaching others facing similar challenges. By engaging affected individuals as stakeholders, the campaign not only empowered them but also promoted inclusivity and sustainability in its impact.

6. What role does digital communication (such as social media and video) play in outreach?

Short videos, activity reports, and spontaneous everyday life stories have proven to be powerful tools in showcasing the real-world impact of our work, significantly enhancing our reach and credibility among partners and collaborators. These formats offer an engaging and authentic glimpse into the communities we serve, allowing stakeholders to witness firsthand the positive changes resulting from our initiatives. Short videos can visually capture moments of transformation, community engagement, and success stories in a way that is emotionally compelling and easy to share across digital platforms. Activity reports provide structured updates on progress, outcomes, and challenges, reinforcing transparency and accountability. Meanwhile, everyday life stories—shared spontaneously by beneficiaries or team members—add a deeply human element that builds trust and emotional connection. Together, these storytelling tools create a

dynamic narrative that not only highlights our impact but also encourages ongoing collaboration, investment, and support from current and potential partners.

7. Are there any specific partnerships or collaborations with other organizations or groups that have contributed to shaping the development of this campaign?

Corporate Social Responsibility (CSR) initiatives from companies interested in healthcare and women's empowerment have been invaluable partners, helping us strengthen our organizational systems and meet due diligence requirements. The Christian Medical Association of India (CMAI) has played a significant role in aligning us with current trends and evolving needs while ensuring we uphold our core values of compassionate care and professional excellence. Various online and face-to-face meetings have encouraged us to continuously upgrade our knowledge and apply it practically at multiple levels, including administration, medical professionals, paramedical staff, and accountants.

Dr Lavanya currently is the Executive Director for Nireekshana ACET, India.

ENHANCED COMMUNICATION FOR NURSES

MS GLORY PAUL & MS VEDA LEENA

Enhancing communication involves the intentional use of various available communication methods to achieve clarity and understanding. It is crucial to acknowledge the limitations and perspectives of others, as this recognition significantly contributes to effective interactions. By carefully incorporating a diverse range of verbal, non-verbal, written, and digital communication techniques, individuals can foster an environment that promotes the clear exchange of ideas. This refined approach not only strengthens interpersonal relationships but also cultivates a culture of respect for diverse viewpoints, ultimately facilitating more productive and constructive dialogues.

Nurses often find themselves in multiple scenarios involving critical aspects of patient care, including instances of patient death, adverse events, change in medical conditions, and modifications to treatment protocols. Additionally, they are frequently tasked with explaining planned procedures or surgeries, as well as addressing patients' requests for clarity regarding treatment protocols and investigative results. In such situations, the nursing professional is obliged to inform the patient or their family members that counseling will be provided by the treating consultant.

Subsequently, the nurse must effectively communicate this requirement to the consultants to facilitate an appropriate resolution.

Improving communication skills is vital for establishing a healthy and productive work environment. Nurse Leaders can cultivate a culture of effective communication within their teams by employing strategies such as active listening, articulating clear messages, promoting open dialogue, utilizing effective non-verbal communication, providing regular feedback, and integrating technology effectively.

Strategies to Enhance Communication Skills

1. Active Listening: Focus fully on what your patient is trying to convey. Respond thoughtfully and show that you understand their message. This builds respect and understanding.

2. Clear and Concise Messaging: Communicate clearly and simply. Avoid jargon and complicated language. Use clear language so that everyone can understand your message.

3. Open and Honest Dialogue: Create a culture where team members/Patients and their relatives feel safe sharing their ideas and feedback. Address problems directly to prevent misunderstandings and build trust within the team.

4. Non-Verbal messages: undoubtedly, it is extremely important to pay attention to body language, facial expressions, and tone of voice, as these affect how your message is received. Make sure your non-verbal cues match your spoken words to avoid confusion.

5. Regular Feedback: Give regular, constructive feedback to help patients see their strengths and areas for improvement. Encourage your patients to give regular feedback too.

6. Use Technology Wisely: Use communication tools to enhance teamwork and stay connected, especially when working remotely. Make sure

everyone uses these tools effectively to communicate well.

Benefits of Better Communication

1. Clear Understanding: Clear messages reduce misunderstandings and conflicts.

2. Better Teamwork: Effective communication helps people work together more efficiently.

3. Stronger Connections: Good communication builds stronger relationships.

4. Effective Problem Solving: Improved communication helps people resolve problems and conflicts more effectively.

Situation that required enhanced communication are:

- Breaking bad news/ Death
- Handling aggressive patient/family
- Handling adverse events
- Reconciliation of medicine

Breaking bad news/Death:

Bad news is information that negatively impacts how someone sees their future. This includes serious diagnoses such as death, cancer, renal failure, and heart failure. These conditions are important for patients and their families to understand so they can make informed choices. While the treating doctor is responsible for delivering this news, nurses provide support to both patients and their families throughout the entire process.

The nurse supports patients and their families in these ways:

1. Setting Up the Space: The nurse makes sure the environment is comfortable and private. To reduce distractions, the nurse limits access to the counseling room to only those who need to be counseled and the consultants. The nurse also keeps the area quiet.

2. Offering Emotional Support: After sharing important information, recipients may need time to process their feelings. The staff nurse shows empathy by recognizing these emotions and providing comfort as needed. The counselling team is notified to assist patients and their families in the grieving process. The nurse should prepare the family sensitively by providing assistance in obtaining the death certificate and clearing the final bills.

Handling aggressive patient/ family:

Healthcare providers face various scenarios on a daily basis and must be prepared to navigate unexpected situations effectively. This includes managing instances where patients or their relatives may become angry or frustrated. It is essential for treatment teams to remain vigilant for signs of discontent or distress and to address these early warning signs to prevent escalation. During duty hours, if a patient or their attendants become disturbed and engage in argumentative behavior with staff, the nurse should contact the supervisor.

Effectively handling an angry patient or relative involves two key stages:

1. De-escalating: The first step is to de-escalate the anger by actively employing strategies to diffuse the situation.

One effective approach is the LOWLINE model:

L - Listen: Actively listen to the patient. This can help them de-escalate their anger. -

O-Offer: Provide brief reflective comments and repeat key phrases expressed by the patient. This allows them to articulate their feelings and frustrations. -

W - Wait: Give the patient some time to express themselves. Avoid using unnecessary words to fill the silence. -

L - Look: Maintain good eye contact, but avoid staring in a way that could be perceived as unpleasant. -

I - Incline: Slightly incline your head towards the patient to indicate a non-threatening posture and show that you are engaged. -

N - Nod: Nod appropriately to demonstrate that you are paying attention. -

E-Express: Express empathy and summarize

the conversation to ensure understanding. Using these strategies can help create a more constructive interaction and support the patient's emotional needs.

2. Resolving: The second stage of the approach involves allowing the patient to express their feelings and explore options to meet their unmet needs. It is important to acknowledge the patient's anger and explain the steps that will be taken to resolve the issue and a time frame should be established for resolution.

Handling adverse events

Adverse events can include complications related to anesthesia, medication, procedures, or surgeries. The first crucial step in managing adverse events is identification. During procedures, nurses monitor the patient's condition and promptly inform the clinician of any deviations. After the procedure, the nurse must communicate with the patients and their relatives, advising them to be vigilant for any post-procedure complications and to notify the nurse immediately if any arise.

When an adverse event occurs, the nurse must act quickly to minimize the patient's injury. The nurse should respond promptly and with a caring demeanor to emphasize the urgency of the situation, but without causing additional distress to the patient. For example, in the

case of a transfusion reaction, the nurse's first action should be to immediately disconnect the IV lines. To effectively manage the situation, the nurse should seek assistance from colleagues and notify the supervisor. If an adverse event arises due to an error, such as a medication error, the nurse should immediately communicate this to the clinician so that appropriate corrective actions can be taken. To prevent panic, this conversation should take place separately, without involving the patient or their family members.

The nurse will ensure that all recommended actions are implemented and will then monitor and assess their effectiveness. Any questions or clarifications raised by the patient or their relatives should be directed to the clinician and addressed promptly. Once the risk has been resolved, the nurse will document all actions taken. The supervisor will then investigate and analyze the incident by communicating with the relevant staff to achieve an effective resolution.

Reconciliation of medicine

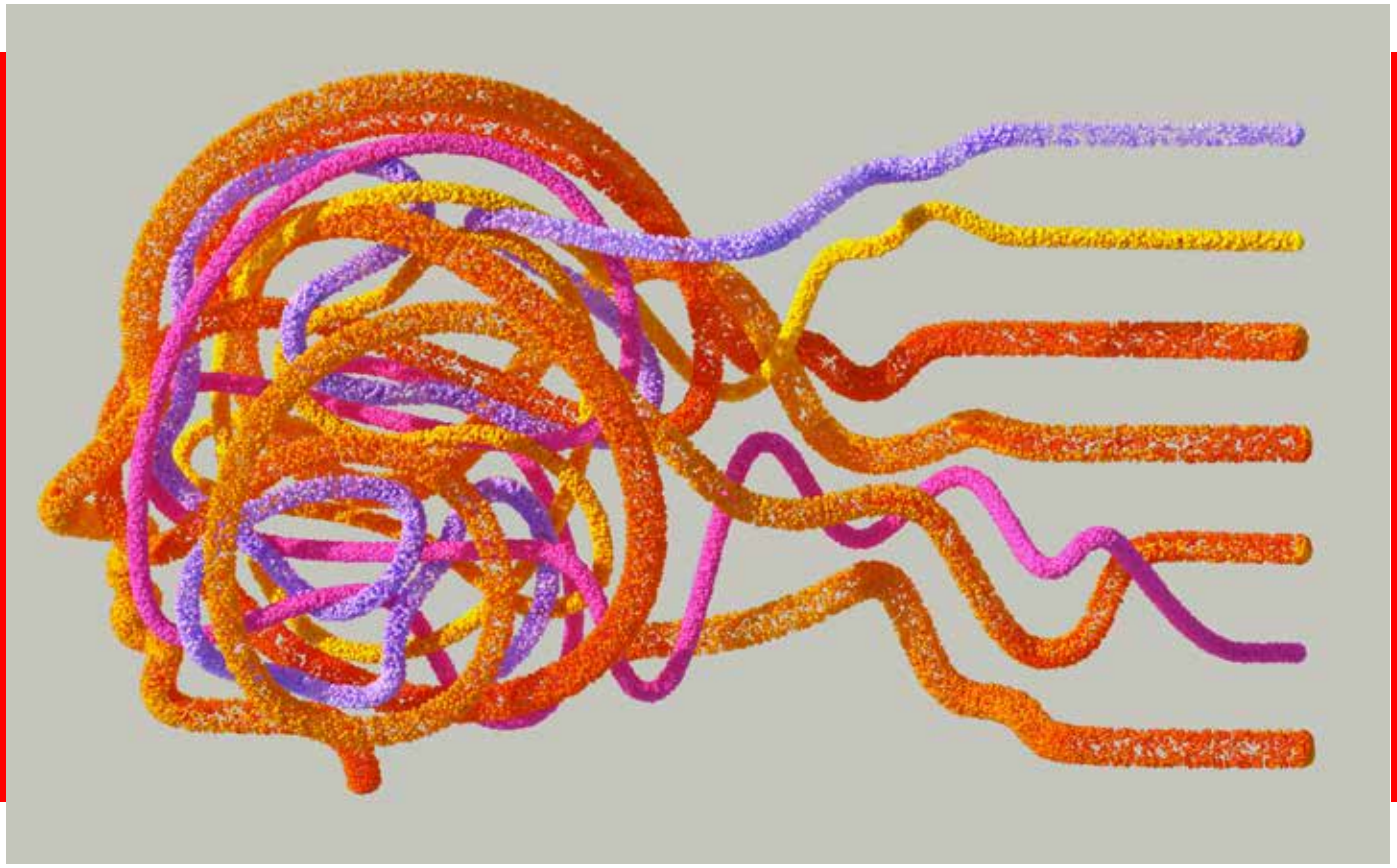
Medication reconciliation is the process of ensuring that a patient's medication list is complete and up to date in relation to their previous medical conditions and current care plan. Prescribed medications are verified for accuracy during key transition points, such as when the patient is admitted, transferred between wards or departments, or discharged. During the admission process, the nurse reviews the patient's medical history and records any prior medications in the Nursing Initial Assessment. The nurse will ask the patient for a list of their regular medications and instruct them not to self-medicate, as all necessary medications will be administered by the nurse according to the doctor's orders.

Medication reconciliation is the process of ensuring that a patient's medication list is complete and up to date in relation to their previous medical conditions and current care plan.

Conclusion

Improving communication skills is crucial for fostering a healthy and productive work environment. By practicing active listening, delivering clear messages, encouraging open dialogue, using effective non-verbal communication, providing regular feedback, and utilizing technology, nurses can cultivate a culture of effective communication within their teams.

Ms. Glory Paul, Nurse Supervisor/ Educator and Ms. Veda Leena, Chief Nursing Officer with Bangalore Baptist Hospital



SCIENCE OF PEER REVIEW PROCESS IN RESEARCH BASED ARTICLES

CHRISTIAN MEDICAL JOURNAL OF INDIA

The editorial review and peer review processes are crucial pillars of academic publishing and research dissemination. They help ensure the quality, credibility, and reliability of research-based articles. Peer review involves subject matter experts (peers) evaluating a manuscript before it is published in a journal. These reviewers assess the work's validity, originality, significance, and clarity. It ensures Quality & Accuracy as peers critically examine the research methodology, data analysis, and conclusions, helping to catch errors or flaws that the author might have missed. Validated research is accepted by the experts' lending credibility to the research and meeting the standards of the field. Furthermore, the process improves the manuscript and brings constructive feedback helping the authors to refine their arguments, improve clarity, and correct weaknesses. Maintaining scientific integrity is of prime importance, hence, the process filters out unsubstantiated claims, bias, and pseudoscience, protecting the integrity of the academic record.

Editorial review is conducted by a journal's editorial board and often precedes or accompanies peer review. Editors check for scope, formatting, language quality, and initial scientific soundness. Editors ensure

that the manuscript aligns with the journal's aims, follows ethical guidelines, and meets structural requirements. By screening out low-quality or off-topic papers early, editors save reviewers' time for higher-quality submissions.

The review process at is managed by an Editorial Board, which is composed of experts in various fields of medicine, healthcare, and ethics. The Editorial Board provides oversight and governance to the journal's operations, ensuring that it maintains its high editorial standards and integrity.

The Review Committee comprises the following members:

1. Editor-in-Chief: The Editor-in-Chief holds the highest responsibility for the journal's editorial policy and overall scientific quality. This person is usually a senior healthcare professional with experience in research and publication. The Editor-in-Chief is responsible for guiding the peer review process, making final decisions on the acceptance of manuscripts, and ensuring the quality and integrity of content published in CMJI.

2. Associate Editors: The Associate Editors assist the

Editor-in-Chief by managing the peer review process, acting as intermediaries between reviewers and authors, and providing editorial feedback. They are specialists in different medical disciplines, allowing the journal to cover a wide range of medical topics.

3. Reviewers/Peer Reviewers: Peer reviewers are healthcare professionals, researchers, and academicians who are experts in the relevant field of the submitted manuscript. Reviewers evaluate the scientific merit of the paper, its relevance to the journal's focus, and its adherence to ethical standards. They play a critical role in ensuring that the papers meet the necessary criteria for publication.

4. Advisory Board: The Advisory Board consists of distinguished members from the fields of medical research, theology, and Christian healthcare ethics. These individuals provide guidance on the journal's thematic direction and ensure that the content of the journal adheres to Christian values and ethical guidelines.

The Peer Review Process

The peer review process is central to ensuring that the publication publishes high-quality, scientifically sound, and ethically rigorous papers. The review process consists of several stages that help to evaluate a manuscript's validity, relevance, and contribution to the field.

Stage 1: Submission of Manuscript

The first step in the review process is the submission of the manuscript by an author or group of authors. The manuscript is submitted through the journal's online submission platform, which helps streamline the review process. Authors must submit their research with a cover letter detailing their manuscript's objectives, methodology, and outcomes, as well as any ethical considerations taken during the research process.

Along with the manuscript, authors must provide relevant documents such as:

- Ethical approval from an institutional review board or ethics committee
- Informed consent statements for clinical studies involving human participants
- Conflict of interest disclosures

The editorial team ensures that the submission aligns with the journal's scope and guidelines. Submissions that do not meet the required ethical or thematic standards are usually rejected at this stage.

Stage 2: Initial Assessment by the Editor-in-Chief

Once a manuscript is received, the Editor-in-Chief conducts an initial assessment to determine its suitability for peer review. This includes evaluating whether the manuscript fits within the journal's scope, its scientific and ethical soundness, and its contribution to the field. The Editor-in-Chief also assesses the clarity of the paper, its relevance and its potential impact.

If the paper passes this initial screening, it is then sent for peer review.

Stage 3: Peer Review by Subject Matter Experts

The peer review process involves independent evaluation by experts in the field to ensure that the research is robust, well-designed, and properly executed. The peer reviewers provide critical feedback on various aspects of the paper, such as:

1. Scientific Validity: Does the research methodology follow accepted scientific standards? Are the conclusions supported by data?

2. Relevance: Is the topic relevant to the field of Christian healthcare, medical ethics, and current global health challenges?

3. Clarity and Structure: Is the paper well-written, organized, and free from unnecessary jargon?

4. Ethical Considerations: Has the research been conducted in an ethical

manner, adhering to standards set for human subjects, and does it reflect the Christian principles of compassion, dignity, and respect for life?

Originality: Is the research novel and does it contribute significantly to advancing knowledge or understanding in the medical or healthcare field?

Reviewers may recommend one of the following outcomes for the manuscript:

- **Accept:** The paper is accepted for publication without revisions.
- **Minor Revisions:** The paper requires slight adjustments or additional clarification before acceptance.
- **Major Revisions:** The manuscript has significant issues that require substantial changes before it can be considered for publication.
- **Reject:** The paper does not meet the necessary criteria for publication.

Stage 4: Feedback and Revisions

Following the peer review process, the authors receive feedback from the reviewers, along with recommendations for revision. Authors are expected to address all comments and concerns raised during the review process, and they may be asked to provide a detailed response to the reviewers' feedback.

If major revisions are required, the manuscript is sent back to the reviewers for further evaluation once the authors have submitted their revised version. Minor revisions may be handled by the Editor-in-Chief or the Associate Editors, depending on the scope of changes needed.

After all revisions have been made, the final decision on whether the manuscript will be accepted or rejected is made by the Editor-in-Chief.

After all revisions have been made, the final decision on whether the manuscript will be accepted or rejected is made by the Editor-in-Chief. If the manuscript is accepted, it undergoes a final editorial check to ensure compliance with the journal's formatting and style guidelines. Accepted manuscripts are then scheduled for publication.

The review and peer review processes are fundamental to upholding the scientific, ethical, and values that the journal stands for. By involving experts from various fields, high-quality research is scientifically valid. The rigorous process of peer review helps to safeguard the integrity of the publication.

HEALTH EDUCATION COMMUNICATION THEORIES FROM A RURAL INDIA

C.M.E. MATHEWS

In this paper I would like to give some examples of the application of health education theories, from the experience I have had living in a village about fifteen miles from Vellore. I lived there for nearly two and a half years to study village life and culture, because I think it is important before starting health education to understand the beliefs and customs of the people who are to be educated.

Communication depends upon common knowledge, needs and attitudes. Perception is selective and distorting.

Communication between Doctor and Patient

Communication is difficult between people whose cultural background and knowledge, needs and attitudes are different. It is often not realized that perception (hearing, seeing, etc.), is not just purely objective. It is selective since we only pay attention to a small fraction of all the stimuli reaching our eyes and ears from the environment. Not only this, but what is seen and heard may also be distorted. The following experiment can demonstrate this. One person sees a picture, and has to tell the next person, who has not

seen it, what is in the picture. This person then tells another, and so on for about 10 people altogether. Only the first person sees the picture. The last person to hear the description gets a very distorted message. Much is left out, some details are overemphasized, and extra meaning may be added or details distorted to fit a particular idea. Such problems of communication may be clearly seen between doctor and patient. They come from different cultural backgrounds and do not have common knowledge, needs, or attitudes. I send patients from my village to both the primary health centre and to the CMC centre Kavanur, and when they come back I would ask them: 'What did the doctor say? 'Almost always they would say : 'He said nothing; he just gave me medicine'. Even when something was said it did not mean anything to them and they did not take it in. Since they had no idea of when to go back, how long they should take the treatment for, how soon they could expect to be cured or whether it was a serious disease or not, it is not surprising that often they did not get much benefit from their visit to the Health Centre. Much treatment is wasted as people did not return and some lost faith in allopathic medicine because they were not cured as quickly as they expected to be.

One example of distortion was when a mother took a child with anemia to the health centre. She came back and told me that the doctor had told her to give the child sugar instead of jaggery. He had of course in fact said the opposite, since jaggery contains iron, but the mother did not expect this. In her opinion jaggery could cause overheating in the child and give it a cough; also, the sugar is what richer people eat and has more prestige. So she heard the message the wrong way round.

To improve communication, we must increase the shared knowledge, needs and attitudes. We cannot expect the patient to immediately learn the knowledge which the doctor has and adopt his attitudes, and so it seems essential for the doctor to study the knowledge, needs and attitudes of the patient.

Perception is influenced by frame of reference. Hierarchy of needs: higher needs only when lower needs are satisfied.

Attitude of patients to visiting health centre. Attitudes to preventive health measures.

A person's 'frame of reference' depends on their attitudes, previous experience, mental set or saliency (i.e., what is important to them and in the foreground of their minds at that particular moment). What is perceived is made to fit into a larger whole, which is their frame of reference.

Needs are said to form a hierarchy, and if lower needs are not satisfied then higher needs do not appear. The hierarchy of needs is as follows; Physiological, safety, belongingness, esteem, self-actualization.

Examples of this may be seen in the village. According to the villager's frame of reference, based on past experience many diseases get better by themselves without anything being done. Therefore, they do not feel like making the effort required to go to the health centre, since this may involve a long walk, losing a days' wages, and paying fees (if it is not a government centre). They do not know there is a certain risk of more serious complications if the disease is not treated.

Also, they have so many more urgent needs, such as getting enough food for today, that they cannot think about preventive health measures which may help only in the remote future. To ask them to do this would be like asking people in Vellore not to risk crossing the street as they might run over. It is a small risk, and we accept it because otherwise we could not meet other immediate needs.Learning experiences are important for behavioral change.

Demonstration of effect of nourishing foods for pre-school child leads to the change in the diet given.

An actual experience is much more effective in changing attitudes and behavior than merely being given information, e.g., through seeing a film or hearing a talk.

This principle could be seen in educating mothers of children with malnutrition (marasmus, kwashiorkor or Vit. A deficiency). When it was possible to arrange for a mother and a child to be admitted at Kavanur where the child was well fed or when the child was given supplementary food in the village, the mother was impressed by the effect on the child. After that she was more interested to look after her child and feed it as well as she could. The same thing happened with a number of mothers. Later when it was possible to start a nursery school with extra feeding, mothers wanted their children to attend and get the food supplement since they had already seen that this would help.

Changes in cognitive, motivational, and action structures are required to change behaviour.

Cognitive education alone is not effective. In family planning lack of cognitive education impedes progress.

A person's cognitive structure is the knowledge and logical information he has. To change his cognitive structure we give him more information and logical reasons for the change. However, even the cognitive structure is very hard to change due to distortions in perception, as already discussed.

The motivational structure depends on the goals or needs of a person has. To change this, we must make the person see the required action as a way of reaching one of his goals. For example, if one of his goals is to achieve social status or social approval, he may imitate the leaders, and so he can be influenced through the leaders.

To change the action structure we must make it easy for the person to take some specific action. It is more effective to say 'Bring your child to the centre in your village at 9 a.m. on Wednesday for immunization', than to say merely 'You should get your child immunized'.

We should remove barriers to action by ensuring that time and place are convenient.

Many health education programmes include only cognitive education – giving information by means of talks, etc. This is usually not very effective.On the other hand, it seems that in the family planning programme little cognitive education is given. Efforts are made to motivate by means of financial reward and action is made easy, particularly in drive period. But people do not really understand what sterilization is and often are not really convinced that they should have it but do it mainly to get the money. Afterwards they may regret it, may get psychological complications, and tend to blame any subsequent illness on the operation. This leads to rumors of bad effects such as weakness and inability to work, and in the long run retards the programme.

Hence a balanced health education programme is needed including all these three components.

Social norms and social pressure have much influence on people. It is therefore important to work through leaders.

Certain indigenous practitioners have much influence and can be educated.

Social influence through family, caste groups, village leaders is important in changing people's behaviour. Studies have been made of how doctors adopt the use of a new drug and farmers adopt the use of new strain of corn. It was found that although mass media can be effective in the early stages to create awareness and interest, in the later stages personal influence is needed

for actual adoption of the new methods. [9, 10]

An example of the influence of a small kinship or neighbourhood group could be seen in the pattern of family planning acceptance in the village where I lived. Nearly all acceptors of sterilization could be divided into a few small groups of people who were either related or close neighbours and who had all adopted either tubectomy or vasectomy over a period of a few years through the influence of a particular leader. There was a group of women of one caste who had tubectomy following the wife of a village leader in this group. Another group of men of a different caste had vasectomy at a different time through the influence of another village leader. Thus, education for family planning might be usefully done in small groups, or with groups of leaders of these different family/neighbourhood groups.

The above are only a few of the many examples which could be given of the application of health education theories.

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