**COMMUNICATION**

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**INTRODUCTION**

The term communication comes from a Latin word ‘Communis' which signifies to share or to take part.Two-way process of reaching mutual⎫comprehension, where the participants share insights, updates, thoughts, and emotions.

**Definition:**

* **Webster**defines communication as a method through which information is shared among individuals via a shared system of symbols, signs, or actions.
* **Millet** defines communication as **“collective comprehension of a common objective”**

**PURPOSES OF COMMUNICATION**

* To obtain information
* To influence others
* To collect assessment data
* To initiate intervention
* To evaluate outcome of intervention
* To start a transformation that aids in enhancing well-being
* To implement actions aimed at avoiding legal issues related to nursing practice
* To examine elements influencing the health team.

**LEVELS OF COMMUNICATION**

**LEVEL - 1
 (Conventional acquaintances)**

* ***An individual interacts with unfamiliar people to form informal connections on a basic level.***
* **Example:** Initial meeting between nurse and client. Dialogue at this stage is quite detached. In this context, efforts are made to: maintain politeness, occupy silence, establish familiarity, ease tension/stress, and communicate trivial information.

**LEVEL - 2
 (exploratory associates)**

* ***Conversation is usually impersonal.***
* **Example:** Relationship with colleagues and neighbours etc.
* The relationship stays at this level for numerous years.
* The relationship is amicable but lacks a high level of self-disclosure. For instance, providing health education to the community.

**LEVEL - 3
 (participate friends)**

* ***Engage friends signifies that individuals converse with themselves***
* ***Group is involved in self-disclosure.***
* ***In this instance, the individual conveys his personal emotions, recounts his own experiences, and shares his own thoughts.***
* Nurse - a patient can attain this level solely if they have established a positive reputation

**LEVEL - 4
 (intimacy:- closest friends)**

* ***At this stage, individuals show who they are, but they do not disclose themselves deeply in a manner that entails risk.***
* ***Close relationships are defined by the sharing of emotions and a profound sense of mutual comprehension.***
* **Example:** two close friends

 **KINDS /TYPES OF COMMUNICATION**

**A. Based on relationship**

* + Formal communication
	+ Informal communication

**B. Others**

* + visual
	+ Telecommunication
	+ Meta-communication

**C. Based upon Flow**

* + Downward
	+ Upward
	+ Horizontal
	+ One way
	+ Two way

***FORMAL COMMUNICATION***

* **It refers to the interaction among officials holding different roles within any organization or institution.**
* **Example: b/w nursing supervisor and staff nurse**
* **It entails conveying formal communication either internally or externally within the organization.**

***INFORMAL COMMUNICATION***

* **It refers to the interaction between two individuals, whether in a social setting or within an organization**
* **Example: interaction b/w two close friends**
* It includes casual conversations with individuals.
* It is very simple.
* No one can be deemed accountable for any communication**.**

***UPWARD COMMUNICATION***

* Communication takes place from the ground up. It can manifest as proposals, grievances, reports, and so on.
* It can be spoken or in written format**.**
* **Examples: leave request, recommendations from nursing staff to the Nursing Superintendent for enhancing the quality of care in the hospital, Incident reports.**

**Downward COMMUNICATION**

* It is the communication that takes place from higher levels to lower levels, such as the transmission of information (circulars), directives (policies, rules, and regulations), and commands (transfers, promotions, etc.) from supervisors to their subordinates.
* **ExampleFrom Nursing director to personnel nurses.**

***HORIZONTAL COMMUNICATION***

* **The interaction occurs laterally among equivalent tiers of hierarchy.**
* **Example: Interaction between coworkers, educators, nursing staff, and clinical trainers.**
	1. *One way communication:* from sender to receiver
	2. *Two way communication:* from both to each other

***VISUAL COMMUNICATION***

* **In this communication, information is expressed through symbols like charts, maps, posters, paintings, etc., which is also referred to as symbolic communication.**
* **Example: showcased models at the exhibition, showcased posters on the wall.**

***TELECOMMUNICATION***

* It is the process of communication toremote locations with the assistance of electromagnetic devices.
* **Example: television, radio, internet etc.**

***META COMMUNICATION***

* **This interaction takes place on a more profound level. It communicates meaning underneath the surface message, and so on.**
* **Example: one woman is expressing admiration for her daughter-in-law.**
* One friend is showering compliments on her companion. In this context, the genuine emotions of both the mother and the friend must be examined.
* In this type of communication, the client’s verbal and non-verbal signals might or might not align.

 **METHODS OF EFFECTIVE COMMUNICATION**

**Methods of effective communication include:**

* Attending skills
* Rapport building skills
* Empathy skills
* Physical attending
* All the therapeutic communication techniques
* Motivated
* Critical thinker
* Analytical
* Open minded
* Active listener
* Empathic
* Tactful
* Systematic
* Knowledgeable
* confidentiality

**THERAPEUTIC COMMUNICATION TECHNIQUES:**

* **Using silence**: embracing intervals or quiet moments that might last for several seconds or minutes without any spoken responsesponse. E.g.- Nurse says lessbut still keeps eye contact and shows engagement .
* **General leads:**employing remarks or inquiries that motivate the client to express themselves. For instance - "What happened next?" , "Maybe you'd prefer to discuss this"
* **Stay specific and tentative:**expressing points that are particular instead of broad. For example – You do not care about your health at all.
* **Use of open-ended questions:**inquiries that encourage investigation. For example - What led you to
* **Using touch:**offer suitable types of touch to strengthen feelings of care.
* **Restating:**reiterating the ideas using comparable phrases as expressedby the client. E.g.- Patient- Mr. XYZ am not sure how he wI will take care of the household chores when he arrives. My Wifeanticipate that I'll handle the cooking and cleaning just like always .
* Nurse – Your wifewill anticipate that you handle the cooking and cleaning just as you usually do.
* **Seeking clarification:**clarifying the client's message. For example – Nurse- Allow me to confirm my understanding of this correctly .The price of the medicationkeeping youfrom being capable of taking it every day?
* **Offering self:**indicating an individual's attendance or desire to comprehend the client. E.g.-” I will walk to you”.
* **Giving information:**Presenting accurate information in a clear and straightforward way.
* **Acknowledging:**acknowledging a shift in behavior in an impartial manner, whether through spoken or unspoken communication. For example:.-Commend the individual for their self-care actions.
* **Clarifying time or sequence:**assisting the client with an event, circumstance, or occurrence in relation to time.
* **Presenting reality**: helping the client to differentiate the real from the unreal.

**BARRIERS OF COMMUNICATION**

* If a nurse overlooks the elements that influence communication and communication abilities, these will be seen as obstacles to effective communication.

The subsequent factors may disrupt the communication process:

* *Physiological Barriers*
* *Psychological Barriers*
* *Environmental Barriers*
* *Cultural Barriers*
* *Non-therapeutic communication techniques*
* *Failure to listen*
* *Misinterpreting the client's intended message*
* *Prioritizing the nurse’s requirements over the client’s needs*

**Non-therapeutic communication techniques**

Theseare the methods that obstructbarriers to effective communication are referred to as communication obstacles.

* **Stereotyping:**providing broad and overly simplistic opinions regarding groups of individuals that stem from experiences that are insufficient to be legitimate. For instance -”its“for your own benefit” or distinction between girls and boys as perceived by society
* **Agreeing and disagreeing:** giving judgmental response that client is right or wrong. E.g.-”This is right” and this is wrong”
* **Being defensive:**working to safeguard an individual or health care services from unfavorable remarks. For instance.-"This hospital has a strong reputation."

**IEC**

 Information ,Education and Communication are inter related to each other. Information is the knowledge derived from study, experience or instruction or it is a collection of facts or data and education is the both acquisition of knowledge and experience and as well as the development of skills, habits and attitudes which help the person to lead a full and worthwhile life in this universe and communication is the interaction between two or more persons that involve exchange of information between sender and receiver. So these three are related to health i.e. information of health related events, education to people regarding health and communicate this in proper way.

**NEW INITIATIVES :**

Placement of spots in private satellite channels doordarshan , FM channels, etc.ϖ Innovative IEC(use of postal stationary ,use of NRHM health messages in official stationary ,NRHM massages in prescription slips used at PHC ,CHC in states, in melas calendar etc. ϖ Integration of IEC on AIDS ,RCH ,etc. ϖ Theme based campaign-immunization week in jan , feb , and march 2006 ,breast feeding ,institutional delivery , save girl child, iodized salt, JSY, profiling of ASHA role and responsibilities ,convergence of health worker-AWW,ASHA, ANM. ϖ Launch of NRHM newsletter special issues on maternal mortality and immunization published. ϖ Branding of NRHM through mutli-mediatools( logo, visual ,massage, audio video spots) ϖNew initiatives in IEC

**Definition:** ‘**’Information, Education and Communication’’**

 IEC is a process of working with individuals, communities and societies to develop communication strategies to promote positive behaviors which are appropriate to their settings.

‘’Behavior Change Communication” BCC is a process of working with individuals, communities and societies to develop communication strategies to promote positive behaviors which are appropriate to their settings AND provide a supportive environment which will enable people to initiate and sustain positive behaviors.

**What is the difference between BCC and IEC?**

Experience has shown that providing people with information and telling them how they should behave (“teaching” them) is not enough to bring about behavior change. While providing information to help people to make a personal decision is a necessary part of behavior change, BCC recognizes that behavior is not only a matter of having information and making a personal choice.

* Behavior Modification also requires a supportive environment.”Behavior change communication” is influenced by “development” and “health services provision” and that the individual is influenced by community and society. Community and society provide the supportiveenvironment necessary for behavior change.
* IEC is thus part of BCC while BCC is build up on IEC.

**Behavior change communication:**

* **BCC is can be presenting to many names.**
	+ IEC
	+ Health education
	+ Health promotion
	+ AIDS education
	+ Social Marketing

***Principle of IEC & BCC:***

* Information/education programs are generally more effective with visitors who are less experienced and who are less knowledgeable.
* Use of multiple media to deliver messages can be more effective than use of a single medium.
* Information/education programs may be most effective when applied to problem behaviour.
* Information/education programs designed to “connect” with or modify visitor attitudes, beliefs, or norms are likely to be most effective in the long-term.
* Messages should be targeted to specific audiences to the extent possible.
* Personal contact with visitors by rangers or other employees can be effective in communicating information/ education.
* Role modeling by volunteers can be an effective information/education strategy.
* Information on the impacts, costs, and consequences of problem behaviors can be an effective information/ education strategy.
* Non agency media, such as newspapers, magazines, and guidebooks can be effective Strongly worded messages and aggressive delivery of such messages can be an effective way of enhancing the “mindfulness” of visitors, and may be warranted when applied to issues such as visitor safety and protection of critical and/or sensitive resources.

**Behavior change- A need for prevention**

* Behavior determines whether a person is at risk or not.
* Those with risky behavior need to change their risky behavior to safe behaviors.
* Those with safe behaviors need to maintain existing behaviors.
* Targeted interventions aim behavior change of people with risky behaviors.

**Change in behavior is the ultimate goal of targeted interventions**

**Behavior change can take place at each level individual, community and societal level**

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**BCC- Salient features:**

* Behaviour change communication uses a science based approach to communication that involves behavioural sciences, social learning, persuasion theory to achieve realistic targets.
* Recognises that behaviour change is much a societal process as it is an individual decision making process. Focused on audience involvement and participation throughout the BCC process**.**
* Appreciation of the crucial role of environment to capture attention, interest and most importantly emotions to make learning and change a pleasurable experience.
* Focus on sustainability of communication messages and strategies.
* Behaviour change is a goal, but people move through several stages and steps before they change behaviour.

**Overview of BCC programs:**

Identifying precisely whose behavior is to be changed and which part of that behavior should be the focus of change is crucial before developing a BCC intervention or strategy.
 Different groups with varying risk and susceptibility criteria make up communities. There may be subgroups with unique traits even within the same large group. Different strategies will be needed for various target groups.
Motivators for behavior change; potential obstacles to behavior change; and the kinds of messaging that will resonate with each target group.
which communication channels would be most effective in reaching the target audience; which services and resources are available to the target audience;

* Therefore, when making decisions about which target groups and which factors to address, it is necessary to consider:
* which target groups are most vulnerable;
* which risk / vulnerability factors are most important;
* which factors may be related to the impact of conflict and displacement;
* what could be motivators for behaviour change;
* what could be barriers to behaviour change;
* what type of messages will be meaningful to each target group.
* which communication media would best reach the target group;
* which services/resources are accessible to the target group;

**Behavior modification is a continuous process.**

* Not everyone follows the same steps in the same order, at the same pace, or in the same amount of time. People at different stages need different messages and occasionally different strategies.
* As awareness and approval increase, BCC's focus needs to move to subsequent phases.
Recognizing action cues, optimizing service quality and accessibility, identifying and eliminating obstacles to change, and establishing chances for greater peer advocacy
* It has to be used in conjunction with other strategies such as STD treatment, condoms and creation of enabling environment
* BCC often complements and supports other prevention strategies and approaches

**Cycle consists of :**

**PLANNING**

**DESIGN**

**FEEDBACK**

**EVALUATION**

**PRODUCTION**

**DISTRIBUTE**

**PLANNING :**

* Identify problems and causes
* Identify problems that IEC/HE can tackle
* Decide strategies ,possible media and target audience
* Produce guidelines on use of material
* Produce draft distribution plan.

**DESIGN**

* Engage designer
* Decide message /slogan
* Review drafts of massage /slogan
* Engage artist /illustrator
* Pretest materials
* Summarize &review results of pretest

**PRODUCTION**

* Finalize material
* Produce artwork
* Subcontract-orientation and printing
* Finalize distribution plan

**DISTRIBUTE**

 Distribute material and monitor effects

**FEEDBACK**

* Review and reports /summarize results
* Review results and summarization
* Distribute and discuss results and proposed actions.

**EVALUATION**

* Design evaluation tools
* Conduct evaluation and distribute results

**Theories About Behavior Change**

**Health Belief Model**

 Assumes that people change their behavior according to whether or not they believe themselves to be at risk

 **For example**

 In order to use condom an individual must believe that he or she is at risk of HIV , feel that HIV is serious and believe that HIV transmission can be prevented by using condom

* **Social learning theory**

 Assumes that behavior change is the result of interaction between personal factors(knowledge , skill, self efficacy, self control)and environmental influences (family, social support and expectation)using this model.

* **Cognitive behavior theory**

 Assumes that people need skills as well as information.IEC activities based on this theory emphasis educational interventions which include activities to personalize information ,training in decision making and assertiveness and practice in applying these skills

* **PEN-3 Model**

 It is based on the idea that health education is a dynamic process involving the individual ,family , and community and behavior are divided into positive or beneficial ,exotic and negative .Negative behavior are identified appropriate target for change.

**Stage of behavior change**

* **PRECONTEMPLATION:** changing a behavior has not been considered; person might not realize that change is possible or that it might be of interest to them.
* **CONTEMPLATION:** something happens to prompt the person to start thinking about change - perhaps hearing that someone has made changes - or something else has changed - resulting in the need for further change.
* **PREPARATION:** person prepares to undertake the desired change – requires gathering information, finding out how to achieve the change, ascertaining skills necessary, deciding when change should take place - may include talking with others to see how they feel about the likely change, considering impact change will have and who will be affected.
* **ACTION**: people make changes, acting on previous decisions, experience, information, new skills, and motivations for making the change.
* **MAINTENANCE:** practice required for the new behavior to be consistently maintained, incorporated into the repertoire of behaviors available to a person at any one time.

**3 Main methods of communication channels in BCC:**

1. Interpersonal channels, often one-to-one communication, such as counseling and telephone hotlines.
2. Mass media channels, which can reach large audiences. Examples:include radio and television, widely circulated newspapers and magazines, billboards and bus advertising, and the Internet

(3) Community channels, which include rallies, public meetings, and folk dramas and also local newspapers and local radio stations.

**Seven ‘C’s of communication:**

 

**Command Attention**

Only messages that are noticed and remembered can be effective. Messages need to attract attention and elicit comments. Peer educators talking about HIV/AIDS should be received by their peers as an important issue**.**  ****

**Cater to the Heart and head**

* Most people are moved at least as much by emotion as much as reason.
* A message that arouses emotion are effective because people learn better when their emotions are aroused.
* Emotions can be aroused by story telling, reflecting however briefly on the individual or group.
* Appeal to reason at the same time adds staying power to the message and consolidates the thought process.

**Clarify the message**

* Focus and freedom from clutter are important. A message should convey a single important point. Ancillary information and multiple themes distract and some may simply miss the point.

**Communicate a benefit**

People need a strong motive to change their behaviour. The best motivator is the expectation of a personal benefit. People rarely use a clean needle or a condom, unless they see practical benefit in it. “The factories make the condoms… the peers sell hope for life”.

**Create trust**

* A message that people will act on their own accord must come from sources they trust. If the promise of trust does not come from a credible source, they will not believe it. It is important for the source to be available to support any need arising as a result of the trial of the messages given by them.

 

**Call for action**

* After seeing or receiving a message, people should know exactly what they should do. Once convinced that the promised benefit is worth pursuing, people need to know how to act on this belief ; where to go, what to do, what to buyand how to use. Directives should be clearly stated. Without a specific cue for action, people may hear, understand and even approve of a message but still take no action

**Consistency counts**

* Repetition is essential. The same message repeated with variations, but with basic consistency, becomes familiar and acceptable.

**CONCLUSION**

* Information, education and communication is a process which make the public aware and enhance their knowledge regarding health issues as well as other information of health services and Govt. schemes which are accessible for them**.**
* Behavior change communication (BCC) is a process that motivates people to adopt healthy behaviors and lifestyles. Behaviour change communication uses a science based approach to communication that involves behavioural sciences, social learning, persuasion theory to achieve realistic targets.Recognises that behaviour change is much a societal process as it is an individual decision making process. Emphasises on audience involvement and participation throughout the BCC process**.**

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