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HEALTH LITERACY TRAINERS' TRAINING

Development and Integration of Health Literacy Education with Innovative Methods in Medical Curricula Across Europe

Guide

2022

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Guide

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İçindekiler

SOCIAL PSYCHOLOGY FACTORS FOR HEALTH LITERACY 5
Methodology 5
Structure 5
A. To suggest that health literacy concept is evolving 5
B. To understand decision making processes in decisions regarding health 5
C. To reinforce the role of psychoeducation and health 6
INFODEMICS 7
Learning Objectives: 7
Methods and Techniques: 7
Tools and Materials: 7
Infodemics 8
How does infodemia contribute to misinformation? 8
What is misinformation, and disinformation? 9
Misinformation in Science 9
What Has Been Done About Infodemics? Infodemic Management 10
Infodemics and Health Literacy 12
Conclusions 13
CREATING POSITIVE LEARNING ATMOSPHERE 16
Learning Objectives 16
Tools/ Instruments/ Materials 16
A Positive Learning Atmosphere 16
The Steps to Create a Positive Learning Atmosphere 17
1st Step: The Preparations Before the Training 17
2nd Step: The Preparations During The Training 18
Warming Up Exercises 18
The Expectations and The Worries of The Participants 19
3rd Step: After The Training 21
Summary Activity 22
INTERACTIVE EDUCATION METHODS AND TECHNIQUES 24
Learning Objectives: 24
Methods and Techniques: 24
Tools and Instruments: 24
The Importance Of Interactive Education 25
Questıon –Answer 25
Case Study 26
Brainstorming 26
Discussion 27

Role Play 28
Simulation 28
Demonstration 29
Clinical Skills Coaching 30
Appendices 31
Interactive Training Methods And Techniques Pre/Post Test Questions 42
HOW TO USE AND DEVELOP AUDIOVISUAL MATERIALS 43
Learning Objectives 43
Methods and Techniques 43
Tools and Instruments 43
Introduction 44
Modelling control list for easy- to- read written materials 45
Comprehension control list for individual/ patient 45
Summary 46
Information Note 47
Advantages And Disadvantages Of Audiovisual Materials 47
The Factors Affecting Audiovisual Material Choice 50
Points to Pay Attention While Choosing a Too 50
COMMUNICATION SKILLS 51
Learning goals 51
The participant: 51
Methods and Techniques 51
Tools and Materials 51
Introduction 52
Types of communication 52
Effective communication skills 52
The basic skills are 52
Effective feedback 53
Feedback rules: 53
Person-cantered care 53
Verbal and non-verbal communication 53
Aspects for a good conversation or dialogue 54
Asking questions: open - closed - facts 54
ASE model 55
ASE group exercise 55
Explanation based on the theory 55
Learn to distinguish between: 56
Exercise in converting advising to informing: 57
What to do if the person is not “open” to receive/hear the information? 57

EFFECTIVE PRESENTATION SKILLS 62
Learning Objectives 62
Methods and Techniques 62
Tools and Materials 62
Features of The Effective Trainer 63
Cope With Stress Of Presenting 63
Cope with Difficult Participants 64
Preparations Before Presentation 65
Sections of The Presentation 68
1- Introduction 68
2- Body 69
3- Summary 70

SOCIAL PSYCHOLOGY FACTORS FOR HEALTH LITERACY

Objectives

- The objectives of this lecture are to extend the concept of mental health
- The extend the understanding of health literacy to its psychological precursors, including decision making, risk evaluation, personal beliefs and other dispositional factors
- To reinforce the sense of social responsibility of different actors in reinforcing health literacy

Methodology

The methodology is the frontal lecture with the use of educational materials and stimulating the audience with several questions while showing data and research. The structure of the educational materials (125 pages) is based on minimal information per page in order to focus correctly the attention of the audience.

Structure

A. To suggest that health literacy concept is evolving

The structure of the course is based on the proposition of information about health literacy, mental health and its implication of decision making. Specifically, the lecture highlights the importance of health literacy definition and its characteristics to evolve with the society issues.
A very broad concept of health is considered by including biopsychosocial factors.
The first goal of the trainer, after having introduced himself is to explain through examples how many psychological factors can impact on decision making.
In the first part of the lecture, in fact, is possible to make examples connected to the evaluation of psychological and psychiatric disorders throughout history.

B. To understand decision making processes in decisions regarding health

In this part of the lecture, starting at page 9. The main focus is to show what actually can favor health literacy. Many definition focus on the information that people have about health as main determinant of what decision can do a person based on the information had. Information is, in fact, very important in determining the literacy. The problem is that information is not all, and sometimes not enough. Even if it should be the main aspect to be considered at the legal level, we should consider especially how people process information and prevent some biases that may occur in decision making processes, also regarding health.
In this part of the lecture, the effort of the speaker should be to introduce the limited rationality approach of Herbert Simon and cognitive biases occurring in decision making. Several example taken by research shows that the only provision of the information about healthy decision may be not always motivating in undertaking healthy decision. For example, even if campaign about healthy food is performed, childhood obesity is increasing; or also, menu engineering methods promoting healthy food observes that the word "healthy"

sometimes even discourage the selection

C. To reinforce the role of psychoeducation and health

Mental health factors passes through the role of psychologists and psychoeducation. There are anyhow several factors that put obstacles in their correct implementation for several reasons object of this part of the lecture, starting at page 56.
The main focus of these lecture should be underlining the following factors:
- To understand problems connected to stigma on mental health issues
- To favor the critical knowledge of when it’s important to ask for the support of the psychologist
- To promote the role of the psychologist at a systemic level

The objective is reached by showing several examples of research connecting with social perception of the psychologists. And the case study of psychological variables connected with the Covid crises in Italy.

During this lecture is reinforced the importance of psychological support in healthy decision-making processes and the importance to promote it at a systemic level in order to increase the awareness of the population about mental health issues. Protocols for the inclusion of psychologist at a systemic level are provided.

INFODEMICS

Aim:

Gain knowledge about infodemics.

Learning Objectives:

1. To be able to define infodemics
2. To be able to tell the difference among infodemics, misinformation and disinformation
3. To be able to explain how infodemia contributes to disinformation
4. To be able to understand how scientists contribute to infodemics
5. To be able to speak about ways to fight against infodemia
6. To be able to explain briefly the WHO framework to fight infodemics
7. To be able to understand the relationship among infodemics and health literacy

Recommended minimum time: 45 Minutes

Methods and Techniques:

Lecture

Questions – Answers

Tools and Materials:

White board

Papers and pens

Computer

Projector

Infodemics

The **COVID-19 pandemic** has been accompanied by an explosion of inaccurate information about the disease, making it difficult for the general public to make informed decisions. The exact scale of spread of the excessive amount of online COVID-19 misinformation is still unknown but is nevertheless a cause of high concern. **Misinformation** can be broadly defined as "cases in which people's beliefs about factual matters are not supported by clear evidence and expert opinion". It is false information being spread regardless of intent to mislead, while disinformation is false information being spread with bad intent, to deliberately deceive. The Director General of the World Health Organization (WHO) used the COVID-19 misinformation situation as an '**infodemic**' (i.e., misinformation epidemic or misinformation pandemic) swarming with conspiracy theories, propaganda, and unproven scientific claims regarding the diagnosis, treatment, and prevention of the disease. This infodemic has made reliable information harder to find and discern, and allowed rumours to spread more quickly, putting public health at risk by making it difficult to implement effective preventive measures.

The term infodemic was born originally in 2002 when Dr. Eysenbach coined it to present evidence that led him to suggest that "a new research discipline and methodology has emerged—the study of the determinants and distribution of health information and misinformation—which may be useful in guiding health professionals and patients to quality health information on the Internet. Information epidemiology, or infodemiology, identifies areas where there is a knowledge translation gap between best evidence (what some experts know) and practice (what most people do or believe), as well as markers for "high-quality" information". Later, he modified this definition to "the science of distribution and determinants of information in an electronic medium, specifically the Internet, with the ultimate aim to inform public health and public policy."

Both of Eysenbach's definitions suggest information could be studied like a disease. Eysenbach also coined the terms "infoveillance" (for the systematic surveillance of information applications in public health) and "infodemic", which he defined as "**an excessive amount of unfiltered information concerning a problem such that the solution is made more difficult**." The new term was largely unused and forgotten until we reached the era of COVID-19, when Dr. Tedros Adhanom Ghebreyesus, the World Health Organization (WHO)'s Director-General, grappling with an epidemic, and later a pandemic, declared, at the Munich Safety Conference on February 15, 2020 (10), "We're not just fighting an epidemic; we're fighting an infodemic."

As stated by WHO, the COVID-19 outbreak and the corresponding response have been accompanied by a massive infodemic, i.e. an **excessive amount of information - in some cases correct, in others not - making it difficult for people to find the information they need**. The term infodemia refers to a large increase in the volume of information related to a particular topic, which may become timely and in exponential format in a short period due to a particular incident as the current pandemic. In this situation, misinformation and rumors, along with manipulation of information with dubious intentions, appear on the scene in this situation. A related concept is 'datademic' to describe the overabundance of data. Today we know that infodemia intoxicates public health surveillance and decision-making.

How does infodemia contribute to misinformation?

The world's increased access to Internet-enabled cell phones and social networks has led to the exponential production of information and the possible ways to obtain it, creating an information epidemic or infodemia. In other words, we are faced with a situation in which the distribution of information is being produced and exchanged in all the corners of the world, which reaches billions of people. How much of that information is correct? Only some

of it.

At the information age, this phenomenon is amplified by social networks, spreading further and faster, like a virus. Research studies put the focus on the reproduction number (R0), that is the number of individuals who will start posting fake news (that is, secondary cases) following contact with someone who is already posting misinformation (the infectious individual). It is therefore helpful to think of misinformation as a viral pathogen that can infect its host, spreading rapidly from one individual to another within a given network, without the need for physical contact. One benefit of this epidemiological approach lies in the fact that early detection systems could be designed to identify, for example, superspreaders, which would allow for the timely deployment of interventions to curb the spread of viral misinformation.

Too much information makes it difficult for individuals, decision-makers and health care workers to find reliable sources and reliable guidance when they need it. Sources include mobile phone applications, scientific organizations, websites, blogs and influencers, among others. People may experience anxiety, depression, overwhelm, emotional exhaustion and feel unable to meet important needs. It can affect decision-making processes when immediate responses are expected, but not enough time is allotted to thoroughly analyze the data. There is no quality control on what is published and sometimes no quality control on the information that is used to take action and make decisions. Anyone can write or publish anything on the internet (podcasts, articles, etc.), particularly on social media channels (social media accounts of individuals and institutions).

What is misinformation, and disinformation?

Misinformation is the information that is false but is not created with the intention of causing harm. On the contrary, disinformation is false or incorrect information with the deliberate purpose of misleading.

In a pandemic, the misinformation can negatively affect human health. Many false or misleading stories are made up and spread without checking their veracity or quality. In the context of the current pandemic, it can greatly affect all aspects of life, particularly mental health, given that internet searches for up-to-date information on the mental health have skyrocketed in all generations. Much of this misinformation is based on conspiracy theories, and some of it introduces some of them into the prevailing discourse.

The false information has been circulating in about all aspects of the disease, such as the origin of the virus, the cause, the treatment, and the mechanism of spread. The misinformation can spread and be assimilated very quickly, leading to behavioral changes that can lead to people behavioral changes that can lead people to take greater risks. All of this makes the pandemic much more severe, harming more people and jeopardizing the reach and sustainability of the global health system.

Misinformation in Science

Sometimes, scientists are very much responsible for misinformation.

Scientists feel **increased pressure to hype their results** because productivity metrics have taken on a greater role in scientific advancement. A publication is no longer merely a way of reporting results; it is a coveted prize that can make or break an early career.

During the last years and specially important durigmn the pandemic, scientists are making extensive use of **preprint servers** for unfinished papers and preliminary work alike. This can be a valuable mode of communication among researchers, but because it takes place in the open, journalists pick up on the work and do not always approach the findings with sufficient caution. The peer-review of colleagues, necessary for revising science before is made public is lost. Two examples, such as that SARS-CoV2 responsible for the COVID-19

pandemic has a bioengineered origin or that SARS-CoV-2 is an escaped bioweapon had their origin on preprints. Both received considerable attention from media, even Trump tweeted a videoclip of a news host praising the work.

Sometimes, research is being released to the media prior to any publication even available for critique. Also, researchers and university press offices commonly **misstate or overstate the implications** of their work, and these are amplified by media.

Related to this problem is the fact that many established scientific results in the social and biomedical sciences cannot readily be replicated. This has been called **replication crisis**, and it may be related to the incentivation of scientific publishing to make up a curriculum vitae, necessary to get a position of grants to pursue an academic career.

Journals preferentially publish positive results with statistically significant outcomes. Scientists who obtain negative results or nonsignificance may choose to move on to another project rather than to invest in writing and publishing work thought to be of only modest interest. The result is **publication bias**, whereby the published literature provides a biased sample of the research actually conducted.

Information distortion: As information moves from primary literature to social media to popular press and back to social media, it is often distorted both intentionally and unintentionally.

During the last years we have also witnessed the growth of **Fake News and Predatory Publishing**, which has produced massive shifts in communication technology and associated economic structures for monetizing information. The rise of electronic distribution established a market for **online open access**, in which the costs of publishing are borne by the authors instead of the readers. While the open access model has numerous advantages, it also results in a transfer of purchasing decisions from highly trained, highly motivated librarians deciding on journal subscriptions to untrained and heterogeneously motivated authors shopping for venues in which to publish single articles.

There are several ways to try to reduce misinformation in science. Productivity metrics are used for hiring, promotion and funding. Marilyn Strathern said that "when a measure becomes a target, it ceases to be a good measure." Because universities and scientists are measured on these metrics, they face strong pressure to publish at high rates, and journal prestige takes on an inordinate significance. Scientific papers are "salami-sliced" into minimal publishable units, and claims are oversold. Thus, changing the incentives around publication would help. We also need wider and better controls in open science. More ethics and professionalism is also mandatory and efforts should be made to include them in the formation of medical and science graduates, in general at all levels. Finally, we need to increase the public trust in Science. During the pandemic we have seen many times top scientists having divergent views (which may be right in academic places) but not publicly were a science-based conclusion should be the one supported by all.

An interesting initiative is that of Stanford School of Medicine, the Stanford Global Health Media Fellowship aims to train medical students and residents in public communication strategies.

What Has Been Done About Infodemics? Infodemic Management

Recently, a group of authors associated with the World Health Organization (WHO) have published a paper entitled "**Framework for Managing the COVID-19 Infodemic**: Methods and Results of an Online, Crowdsourced WHO Technical Consultation". In the paper, the authors collected and organized global ideas to fight the current coronavirus disease (COVID-19) infodemic declared by the WHO on February 15, 2020. Impressively, this consultation meeting was entirely conducted online, and, as noted by the authors, turned out to be one of the largest meetings ever convened by the WHO. The results were obtained in the

1st WHO Infodemiology Conference in June-July 2020 and resulted in a framework for managing the COVID-19 infodemic. A follow-up process was done from August to October 2020, to review current multidisciplinary evidence, interventions, and practices that can be applied to the COVID-19 infodemic response. This resulted in the creation of a public health research agenda for managing infodemics.

As part of the conference, a structured expert judgment synthesis method was used to formulate a public health research agenda. A total of 110 participants represented diverse scientific disciplines from over 35 countries and global public health implementing partners. The conference used a laddered discussion sprint methodology by rotating participant teams, and a managed follow-up process was used to assemble a research agenda based on the discussion and structured expert feedback. This resulted in a **five-workstream frame** of the research agenda for infodemic management and **166 suggested research questions**. The participants then ranked the questions for feasibility and expected public health impact. The expert consensus was summarized in a public health research agenda that included a list of priority research questions. The five workstreams are: (1) **measuring and continuously monitoring** the impact of infodemics during health emergencies; (2) **detecting** signals and understanding the spread and risk of infodemics; (3) **responding** and deploying interventions that mitigate and protect against infodemics and their harmful effects; (4) **evaluating** infodemic interventions and strengthening the resilience of individuals and communities to infodemics; and (5) **promoting** the development, adaptation, and application of interventions and toolkits for infodemic management. Each workstream identifies research questions and highlights 49 high priority research questions. This research agenda proposes a structured framework for targeted investment for the scientific community, policy makers, implementing organizations, and other stakeholders to consider. This framework may be the basis for preparing all kind of ways to improve the knowledge of our medical students.

Other authors such as Eysenbach himself, has presented his four pillars of infodemic management: (1) information monitoring (infoveillance); (2) building eHealth Literacy and science literacy capacity; (3) encouraging knowledge refinement and quality improvement processes such as fact checking and peer-review; and (4) accurate and timely knowledge translation, minimizing distorting factors such as political or commercial influences. In the author's words, it supplements the WHO framework by providing a first broad roadmap on how to fight an infodemic. The current infodemic is a crisis to distill the sheer quantity of information, which is occurring on four levels: (1) science, (2) policy and practice, (3) news media, and (4) social media. The wedding cake model (Figure 1) illustrates these four levels as layers. The size of the layers is proportional to the amount of information generated by these four groups of actors. The model also shows some information flows and knowledge translation activities that take place between these different levels. Science is the smallest layer of the wedding cake in terms of the amount of information, and it is depicted at the top of the information wedding cake, which represents rigorous and selective information production cycles. Clearly, misinformation can be found here as well,

The main problem is not so much the prevalence of misinformation in the science layer, but the challenge of translating this information into actionable recommendations and conveying conclusions for different audiences and stakeholders in other layers. Social media is depicted as the largest and last segment of the wedding cake, representing the vast amount of nearly unfiltered and uncontrolled information generated or amplified by the public. Information in social media is, of course, also generated by science organizations, policy makers, health care organizations, and journalists.

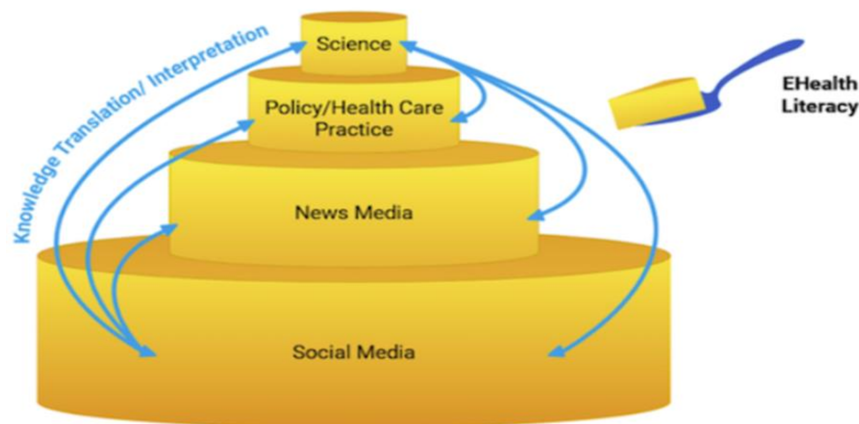

Figure 1. The wedding cake model

In relation to our Erasmus+ project I will comment briefly on the third layer, the one on building eHealth Literacy. These are the exact words: “the cake-serving utensil illustrates that in the age of the internet and openness, the end user is able to (but not always equipped) to consume information from any level, in any refinement stage, making **eHealth literacy an essential skill** in a networked world. eHealth literacy is defined as "the ability to seek, find, understand, and appraise health information from electronic sources and apply the knowledge gained to addressing or solving a health problem." ... Thus, the third pillar of infodemic management is to enhance the capacity of all stakeholders to build eHealth literacy, to select and assess health and science information found on the different layers of the information cake. This aspect is notably underdeveloped in the WHO paper’s taxonomy but can be seen as part of WHO’s “identify evidence” category.

Infodemics and Health Literacy

A comprehensive systematic review of studies published before March 2019 on the prevalence of health misinformation on social media reported widespread misinformation in six areas, namely (i) vaccines, (ii) drugs or smoking, (iii) non-communicable diseases, (iv) pandemics, (v) eating disorders, and (vi) medical treatments. Twitter was the leading source spreading health-related misinformation. For instance, the most commonly identified fake news about COVID-19 fell into three main types: (i) false claims, such as “coronavirus can be transmitted through houseflies or mosquito bites”, (ii) conspiracy theories, such as the ones about 5G (fifth generation technology standard for broadband cellular phone networks) and coronavirus, and (iii) pseudoscientific health therapies, such as “colloidal silver solution can help with coronavirus”.

Evidence from several studies showed that misleading information and conspiracy theories spread more rapidly when the flow of factual information is slow, and when people’s trust in the information sources and services available to them is also low, or when credible information is hard to come by. It has been argueed that “communications in a public health crisis are as crucial as medical intervention. In fact, communications policies ARE a medical intervention”. Effective health communication plays a critical role in speeding up the flow of factual information and building trust among people regarding health information sources and services.

Health literacy has received significant attention since the year 2000, when the WHO stated that a low level of public health literacy is a serious concern for public health, and

stressed the need to improve public health literacy to minimise inequities in health services. Health literacy covers “the ability to access, comprehend, evaluate and communicate information to promote, maintain and improve health in a variety of settings across the life course”. Health literacy has been defined by WHO as the individual features and societal resources required for the public and individuals to obtain, recognise, and evaluate information and services in order to make appropriate decisions about health. Health literacy allows and encourages the public to contribute to, and improve, their healthcare and well-being. People possessing good health literacy usually have more skills to manage their health in a better way compared to those with low health literacy skills. The WHO considers the level of people’s health literacy an indicator that can be used in assessing the health status of the population. Regarding COVID-19, it is known now that it has impacted people with inadequate health literacy more badly and more frequently as compared to people with proficient health literacy levels, due to the inability of the former to properly understand and follow health-related recommendations.

Health literacy has three main pillars, namely (i) the capacity to obtain health information (where to find help), (ii) the ability to (properly) understand the information gathered, and (iii) the ability to (properly) apply health information.

Low health literacy is very common among people across the world. According to a large-scale national survey, more than 1 in every 3 adults in America have low health literacy. Only 8.8% of people were health literate in China in 2012, leading the National Health Commission of China to issue a new strategic plan in the year 2014 to increase the health literacy of the population to 20% by 2020. In the UK, 4 in 10 adults struggle to understand health information that is meant for the public, and more than 6 in 10 adults struggle with health-related information that includes numbers and statistics. In Europe, a 12% of the citizens have an insufficient health literacy and almost 47% had limited (insufficient or problematic) health literacy. However, the distribution of levels differed substantially across countries (29–62%). Subgroups within the population, defined by financial deprivation, low social status, low education or old age, had higher proportions of people with limited health literacy, suggesting the presence of a social gradient. The evidence also shows that people with a low level of health literacy skills are more likely than those people with a greater level of health literacy skills to report poor health (thisd study was sone in 2015). More recently, in 2019, the WHO Action Network on Measuring Population and Organizational Health Literacy (M-POHL) has been conducting a cross-national survey in 17 countries to create comparative data on health literacy levels in order to build a strong foundation for future action. The results, which show that between 25% and 75% of adult populations in participating countries have limited health literacy, reveal a pressing challenge to public health.

The paper by Bin Naem & Boulos contains a large list of health literacy Guidelines, Checklists, Mythbusters and Fact-Checkers. Our Erasmus+ project will surely be one of these in the near future.

Conclusions

In the current COVID-19 pandemic, the United Nations has advocated that **facts and science** should be promoted and that these constitute the antidote to the current infodemic. Low digital health literacy affects large percentages of populations around the world and is a direct contributor to the spread of COVID-19-related online misinformation and to its devastating effects. The ease and ‘viral’ nature of social media sharing further complicate the situation. **A number of strategies, methods, and services exist** that can be used to detect and prevent the spread of COVID-19 misinformation, including machine learning-based approaches, health literacy guidelines, checklists, mythbusters, and fact-checkers. However,

given the complexity of the COVID-19 infodemic, it is very unlikely that any of these approaches or tools will be fully successful alone in combatting COVID-19 misinformation. Instead, **a mixed, synergistic approach, combining the best of these strategies, methods, and services** together, is essential as the most effective way forward to tackle online health misinformation, and mitigate its negative effects in COVID-19 and future pandemics. Furthermore, to achieve the best results possible, techniques, and tools should focus on **evaluating both the message** (information content) **and the messenger** (information author/publisher/source), and not just rely on assessing the latter as a quick and easy proxy for the trustworthiness and truthfulness of the former. **Surveying and improving population digital health literacy levels** is also key to future infodemic preparedness.

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Test questions (correct answer is in bold):

Infodemics is best defined as:

1. The epidemy of information.
2. The information about epidemics.
3. **An excessive amount of information.**
4. People that could not find the information they need.
5. Information that is false.

One of the following is not related to misinformation created by science:

1. Scientists using preprints widely.
2. Overstate the implications of the author's work.
3. Increased pressure to publish research results.
4. **Publishing research in peer-reviewed journals.**
5. Information is distorted as it moves to social media both intentionally and unintentionally.

CREATING POSITIVE LEARNING ATMOSPHERE

AIM:

To obtain awareness of creating positive learning atmosphere during educational process of an adult and the importance of group dynamics.

Learning Objectives

At the end of this training, the participant should be able to

1. Recognize positive learning atmosphere
2. Explain the preparations for a positive learning atmosphere before the training.
3. Explain what to do to create a positive learning atmosphere during the training.
4. Explain what to do to maintain positive learning atmosphere after the training.
5. Understand the importance to create positive learning atmosphere during adult training.

DURATION: 45 MINS

Tools/ Instruments/ Materials

- Board, paper, pencils
- Computer
- Projector

COURSE IMPRESSIVE ENTRANCE

Tell the aim and the learning objectives of the session.
Ask the group what they understand from positive learning atmosphere. Discuss why positive learning atmosphere could be important.

A Positive Learning Atmosphere

A positive learning atmosphere is the atmosphere that is planned according to the main principles of adult training, also that facilitates learning and that is set in a mutual and right environment between the trainer and the trainee. If this environment is planned correctly, it makes learning easier. By the help of this created interactive structure, the trainees can reach their goals as much as the trainers. Positive learning atmosphere cannot be created spontaneously nor by chance. Itcan only be created by a very careful and detailed planning ahead of the training. It is very crucialto create a positive learning atmosphere during the training and also to maintain it afterwards.

That's why we need to talk about them under these 3 titles:

1st STEP: Before the training

2nd STEP: During the trainig

3rd STEP: After the training

The Steps to Create a Positive Learning Atmosphere

1st Step: The Preparations Before the Training

The training should be arranged according to the needs of the trainees. This means the training should be flexible and everybody could find an opportunity to get trained. This is why a good planning is important for the training to reach its goal. These are the things to do to create a positive learning atmosphere before the training:

- Obtaining general information about theparticipants
- Revising the materials for the training.
- Organizing the physical conditions of the place where the training will be held.
- Estimating the needs of the participants and making arrangements according to that.
- Preparing yourself for the training.

It is very important to collect general information about the participants about their number, socio-cultural features, the reason(s) and the goals why they choose to participate in this training, their previous experiences and trainings, the tasks they held during their previous works. (It isimportant to keep the participant numbers between 14 to 18 to create small groups that helps the interactive communication.)
Revising the material that is going to be used for the training, adapting the provided training package to local conditions, planning carefully to decide the timing of the training activities and the methods, their place and their development are vital. That is also important to have enough number of materials and to have precautions for the possible unlucky situations. (Printing the slides of the presentations etc)
It is also needed to check the size of the room, the rooms for the small group activities, the provision of enough tables, chairs, the sitting arrangement (U-shaped order, rectangular, circle) in order to arrange the physical conditions. We also need to prepare ourselves in case the projector or the computer goes down, in case of a possible power cut.
It is also advised to arrange name tags for the participants. Another important thing is to check the temperature of the room, the ventilation, the lighting, the material and visual/auditory toolrelevance.
Assuming the possible needs of the participants (food, accomodation, telephone, accident, illness and other emergency situations) and making arrangements according to that, is another crucial thing to mention in this chapter.
The trainer should prepare footnotes, key questions and proper examples for her/himself. The trainer is also supposed to revise her/his knowledge, the latest updates about this field, the lecture notes and the training plan in order to prepare her/himself for the training.
On the top of that, the trainer should prepare her/himself mentally. The trainers also have their worries just like the trainees. It is okay to have a little bit of stress and because it is a warning tobe careful about the planning the training, though it should be kept in a normal level.

2nd Step: The Preparations During The Training

A good planning before the training will provide a positive learning atmosphere. Yet, there are many points that should be kept in mind to make a better positive learning atmosphere during the training which actually begins from the moment the participants enter to the training room. Thosepoints are listed below:

- Giving general information about thetraining
- Meeting each other
- Expressing the expectations from thistraining
- Revising aims and the learning objectives of thetraining
- Explaining the activities that are going to be used during the training
- Answering questions of the participants
- Making rules of the group

The explanation of the reasons why the adults are here for this training and who organizes thistraining is important. Adults would like to know about the situation that they are in and what kind of an event they are here for. This is why, the aim of the training program should be told beforehand and making the participants meet each other, discussing the expectations and the targets of the training are significant points to remark. Another vital thing is to make the rules together with the group since it is an important factor that lets them be a part of this.

***Note to the trainer: Giving a description about vector-borne diseases couldbe a good opening phrase that can give us a good understanding to the participants why they are participating to this training.

Warming Up Exercises

These exercises support an efficient participation and the mutual communication, as well as it helps the worries of the participants go away. They could be done not only at the beginning of thetraining, but also the following days. For instance, every day a warming up exercise could be a good opening act. Participation of the trainer her/himself to this activity provides the unity feeling of the group and the easier communication. Making the participants meet each other could be an example of the first day warming up exercise. Other games can be played for the following days.
It is important for the trainees to get to know each other and to the trainer is important. It has a significance even if they already know each other. This meeting activity is supposed to be organized and planned well in order to avoid making it a "responsibility" or a boring thing, and tomake it an ice breaker, an enjoyable and pleasant time.

***Note to the trainer: Play a game that lasts for minimum 15 mins to give aproper example.

The Expectations and The Worries of The Participants

Learning the expectations of the trainees before the training is major activity during adult training.It is noteworthy to check learning objectives and aims.
It's important to revise the material before and to describe the program, to explain the activities that is going to be done during the training. That's how we can provide a bigger picture to the participants and also help them find some answers to the questions they have in mind and to find out if their expectations will meet. Meeting the expectations of the participants is an activity that affects the training as a whole. Failing this, only randers this training that something to kill time. When an adult participates in a training, that means that she/he was able to do it only by postponing their daily errands. That's why it is very important for them to have some gainings at the end. From this point of view, all of the positive learnings that are anticipated by the trainee and that are going to be given by the trainer.

***Note to the trainer: For instance, it is reminded that at the beginning of thetraining, this was done. Ask if they remember and/or relate to this chapter and what they think about (whether they find it efficient and/or relevant)

The warming up exercises can be adjusted with small-mini games to soothe the worries of the participants and to support them for the mutual interaction and to provide an efficient participation.
Besides, it is crucial to evaluate the the knowledge difference between the beginning and the end in order to see the efficacy of the training. To do this, a pre-training test could be used, that alsohelps to determine the level of the group. If the training does not give a certificate at the end, it is unnecessary to force the participants to write down their name on it, whereas a nickname should be written in order to compare the knowledge gain, if there is, before and after.

Another important aspect is to show the locations where they can use bathroom, where they can eat etc during the training and to answer the questions related to them beforehand.
Making rules all together is a need since it provides the active participation of the group and the prevention the likely conflicts in between the group. The rules made by the adults all together, has a real sanction on the people who made them since everybody took part of it. In this context, it should be provided that the participants make the rule themselves.

***Note to the trainer: Remind the group how the rules were set by them in the beginning of the training. For instance, the break times, the flexibility ofthe learning atmosphere etc.

Apart from all of these, the voice tone and the facial expressions of the trainer have a major significance. How it is expressed is as important as what is being said.
In verbal communication the voice tone, the frequency, the emphasis. Every subject

should be started with a powerful beginning to emphasize the important aspects. The presentation style and the tempo should be well adjusted. While passing from one subject to another, logical and soft ways should be preferred.
The instructions for the activities during the training should be clearly stated. The communications should be kept on a personal level and the participants should be called by their names.
It is also important to use and refer the examples that the participants previously used.
In verbal communication, specific phrases and words should not be repeated. It is important to use the phrases and words that the participants could accept.
Non-verbal communication is as important as the verbal one. The fig, eye contact, body language, walking around the room while presenting are the important factors to create a positive learning atmosphere and maintain it.
The first impression is crucial in non-verbal communication. The positive facial expression of the trainer, the enthusiasm and the eagerness of the trainer while presenting it, the energy of the trainer are important as well as facing the trainees while answering a question. The trainer should avoid repeating same movements and the desks, the chairs that will give an artificial boundary between the trainer and the trainee.
The humor that will be used during the training in the correct amount and correct place could help creating a positive learning atmosphere. Jokes, caricatures and funny stories could be used. But the humor absolutely should not be aggressive, and offensive language should not be allowed. (Race, religion, sexual orientation etc.) Because education can be something that even the adults might have a hard time to cope with. Sometimes the fears rooting from early school ages could be reborn.
There are five types of needs that defines the essentials of "Adult Educational Training". They are like the steps in a staircase following each other. To meet one need can help reaching the other one and it follows step by step in a hierarchy.

1. **The need to understand:** This is the first need that also makes up of the basis. It is important to understand what the trainers saying (the words she/he is using, the examples, the comparisons), and to understand the the bigger concept of the logic of the training program (the order of the sessions, the flow of the program, the relation between the topics, the goals of the training and the expected results). In general, the trainers realized very late that they are not well understood by most of the trainees.

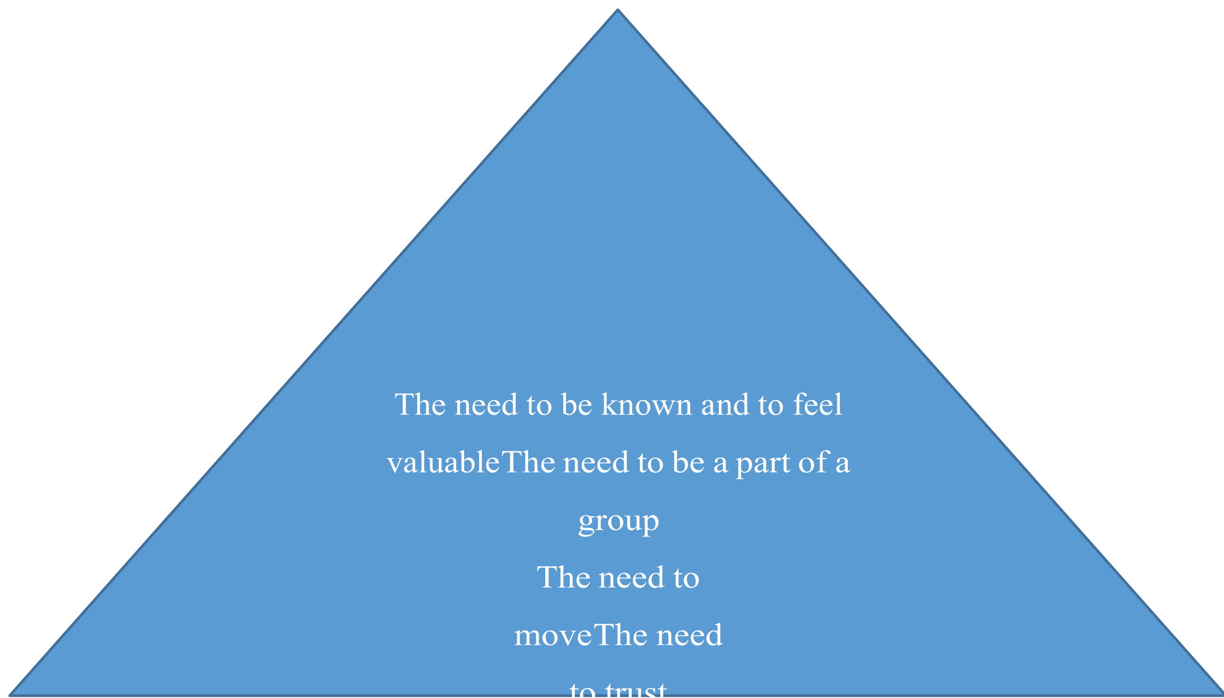
2. **The need to trust:** Training could trigger the feeling of insecurity and it scares the participants like the feeling that comes to us when we are being dragged to a place we have not been before.

3. **The need to move:** Most participants cannot stay still more than an hour. They can show this feeling by being aggressive to the trainer while asking questions, asking weird questions or making stereotype jokes that can distract the group.

4. **The need to be a part of a group:** A participant that is left out can show her/his feelings to the trainer in an aggressive way.

For instance, she/he can try to draw all attention to her/himself.

5. **The need to be known and to feel valuable:** Most of the problems that the trainer faces mostly derive from the in satisfaction of the participants. These hard problems are mainly from this particular human need.



Sometimes, it could be hard to meet the participants halfway. There could be some participants that could give a bad affection to the group. If this happens, the trainer should remain calm andapproach in a positive way towards her/him.

3rd Step: After The Training

The social activities outside the training room (conversations, lunch, trips etc) is effective to create and maintain a positive learning atmosphere. Visiting the participants, newly trainers, after the education to figure out what their problems are helps the sustainability of the positive learning atmosphere. Besides, informing them about all of the updates about the field and making sure thatthey have them are also important acts.

How can we sustain the positive learning atmosphere?

- ✓ Follow up visits should be made in order to give support to the participants in the place where they give the education for vector-borne diseases.
- ✓ Determining the obstacles and the problems related to work while helping them tofind a solution maintaining the positive learning atmosphere.
- ✓ It is vital to give supportive and encouraging feedbacks.

By the help of this follow up visits, the positive atmosphere that is created can be

sustained.
It should be noted that the participants can act just like before the training (it could be even up to 90% of them) unless we do perform the follow up visits.

These methods can be used for the follow up:

- Organizing meeting with the training group to discuss the common problems and share theexperiences.
- Sending articles about the topic of the training.
- Keeping in touch about their success and problems.
- Helping the participants form a network and support them.
- Providing enough material and resource.
- Arranging personal visits to talk about the problems.
- Giving refreshing trainings to revise and expand the knowledge.

***Note to the trainer: Ask the group if they ever had an experience on having a difficulty creatinga positive learning atmosphere before. Let them explain how they dealt with this, by the help of giving examples.

Summary Activity

Considering the characteristics to create a positive learning atmosphere, everybody should give examples for the obstacles and possible problems.

INTERACTIVE EDUCATION METHODS AND TECHNIQUES

Aim:
At the end of this session, the participants can use interactive education methods and techniques that will be used during of the health literacy program.

Learning Objectives:

To achieve this aim, the participants;
1. Determine the interactive education methods suitable for the learning goal.
2. Use the following methods/techniques to ensure interaction in the lesson:
   a) Question answer
   b) Case study
   c) Brainstorming
   d) Discussion
   e) Role play
   f) Simulation
   g) Demonstration and Coaching
3. Use interactive education method materials effectively developed in the context of health literacy.

Methods and Techniques:

- Presentation
- Question-answer
- Small group discussion
- Role playing
- Demonstration

Duration: 180 min (90+90)

Tools and Instruments:

- Flipchart
- Board maker
- Barcovision and computer
- Role play scenarios (Annex-1)
- Teachback checklist (Annex-2)
- Communication skills checklist (Annex-3)
- Reflection and feedback guides (Annex-4)
- Simulation video example (Annex-5)
- Coaching video example (Appendix-6)
- Coaching skill assessment guide (Annex-7)

1st Session (Before noon) 90 min

Notes to trainer
Explain the importance of interactive training methods and techniques. Present the principles of question and answer and case study. Discuss the practical use of these technics with the participants. Share the principles of the brainstorming technique with the participants, impement a practical example. Present the principles of the discussion and give examples of different discussion techniques.

The Importance Of Interactive Education

Interactive educational activities are widely used in medical education. In these activities, learners study in interaction with each other to achieve clear goals. In order for these activities to be successful, the educational characteristics of the trainer are important. In addition, the method and technique used should be chosen in accordance with the learning objectives. Interactive education methods and techniques enable learners to be independent, active, self-directed learners instead of passive recipients of information and develop learners' skills to self-regulate and take responsibility for their learning. There are many interactive methods and techniques. In these two sessions, we will discuss the interactive education methods and techniques used in the health literacy program for medical students only.

Questıon –Answer

Questioning is a highly effective tool that can be used in clinical learning. A common mistake in asking questions is to present all necessary information to the learner about the learning objectives without discussion.
However, questions and discussion allow learners to think about new information and to learn permanently by associating it with the existing context and their own knowledge structure.
Questions can be asked to help students explain or integrate their knowledge and understanding. Since the learner has the opportunity to meet the patient in the clinic, superficial questions should be asked as well as making application, analysis and evaluation.
Along with asking questions, how students answer the questions is also important. The answers should help the learner rethink the topic and learn more deeply.
What should be considered?

- Before introducing new information, questions that will reveal the knowledge that the learners have should be asked.
- The question should be clear enough for each learner to gain a deep understanding of the information.
- After asking the question, time should be allowed to think.
- Students who give wrong answers or who have difficulty in answering should not be humiliating.
- Questions concerning the whole group should be asked to the whole group and everyone should think simultaneously to find the answer. If students are asked one-by-one questions, students should be randomly selected.
- Regularly check the learners by asking them to summarize what they have learned.

- The new material should be related to clinical cases that the learners may have seen on a regular basis.
- Discussions should be expanded with hypothetical questions (if they were …..).
- High-level questions that will enable analysis and evaluation should be asked.
- While answering, it should be avoided to answer many questions in a direct and detailed way.
- The question should be tried to be reflected to the person asking the question or other people in the group.
- The relationship between the patient phenomenon being examined or seen in the clinic and the problem should be established.
- Reflecting back, checking comprehension, repetition and silence strategies should be used appropriately when responding.

Case Study

It is learning through solving real-life problems in the learning environment.
Real patient presentations in a clinical setting can be discussed in accordance with the case study.

Points to consider

- The basic details of the case should be well defined.
- The case should be selected and presented in accordance with the level of the learners.
- Goals, relationships and values should be evaluated.
- Learners should be given preliminary information.
- Discussion questions should be determined.
- How to benefit from the results should be discussed.

How is it applied?

- Preparation of the case: The case and the points and questions to be discussed or answered about the case should be prepared.
- Presentation of the case: Simply arranged slides can be used in patient cases or the case can be distributed in written form.
- Discussing the data / information about the case: The data / information about the presented case / patient should be discussed by interrupting the presentation at certain intervals (or after reading a part of the case in the written text).
- Interaction should be provided by using the question-answer technique.
- Management of the small group process should be ensured to ensure participation.
- Discussion of options and decision making should be provided.
- Discuss results: Additional studies should be provided for unanswered questions if necessary.

Brainstorming

It is a technique that involves a group talking on a topic for 5-10 minutes, stimulating thinking and creativity. Brainstorming is an effective problem-solving technique and a teaching

technique used to generate ideas for solving a problem or expressing an opinion on a subject.

How is it applied?
- Explain what the problem is
- Specify the time limit
- Receiving everyone's opinion without limitations
- Encourage participation by giving positive feedback to participants
- Discussing the opinions expressed at the end of the period

Discussion

It is used to direct students/groups to think about a subject and to explain poorly understood points. It is based on listening to each other, criticizing, asking questions when necessary and examining opinions / thoughts.

Discussion techniques:
- Large group discussion
- Buzz group / Group 66
- Circle
- Debate
- Panel
- Opposite Panel
- Symposium
- Forum

How is it applied?
- The subject and objectives of the discussion are determined.
- Students' readiness for discussion should be appropriate.
- The duration of the discussion is determined.
- The method / technique to be used in the discussion is selected.
- The rules to be followed in the discussion are determined.
- How the outcome of the discussion are explained.
- An environment is created for discussion.
- All participants are encouraged to contribute during the discussion.
- At the end of the discussion, the main discussion topics are summarized and their relationship to the objectives is established.

2nd Session (After noon) 90 min

Trainer note

The principles of the roleplay method will be presented. A roleplay focusing teach-back method in health literacy is implemented with the following steps:

-Two volunteer participants are determined, one of whom will perform the patient role and the other will perform the doctor role.

-Scenarios regarding the roles (Annex-1) are shared with the volunteers. Additional information about the patient should only be shared with the participant who will play the

patient role. The participant, who will play the patient role, is asked to put himself in the patient's place and to react to the physician's tone, expression and body language as if he were a patient.
-Teachback checklist (Annex-2) is distributed to all participants. Information is given about the monitoring of the performance by using the checklist.
Questions for discussion after performance:
-What went well?
-What could have been done better?
-Is there anything missing?

Role Play

Role-playing (Gamification) is an educational technique in which participants play a situation related to the aims of education, in accordance with reality. The aim is to help students understand their own feelings and thoughts about certain situations. Participants can experiment with a real-life situation in an educational setting without facing real-life risks.

How is it applied?

- Preparation: Games and roles are prepared in accordance with the educational objectives, and the distribution of roles is decided.
- Preparing the scene: The time is planned, the place and the decor are prepared.
- Creating the environment: It is determined what the audience will observe.
- Selecting the students and preparing for the roles: Written or verbal information is given to the participants in the game. Time is given for their preparation and the duration of the game is indicated.
- Playing the roles: It is ensured that the game is exhibited by paying attention to the time without interfering with the game.
- Discussing the event: First of all, the participants in the game are asked how they felt. The important points of the game are discussed with both the players and the audience by asking questions.

What has been learned and how to apply it to real life is summarized.

Trainer note

The principles of the simulation method used in health education are presented. The communication skills assessment guide (Annex-3) and feedback and reflection guides (Appendix-4) are shared with the participants. A video sample (Appendix-5) prepared in a simulation environment containing a patient-physician interview is watched. The simulation debriefing session is performed after the video.

Simulation

It is a method in which an event or situation is handled by analogy with the real conditions and educational studies are made on it. It is very effective in preparing learners for their future roles. While applying knowledge and skills, high-level skills such as analysis and evaluation can be gained. With the simulation method, it is possible to learn complex clinical skills including technical (story taking, physical examination, communication skills with the patient, procedural skills and information management) and non-technical skills (situational awareness, task management, team communication, decision making).

Simulation applications can be classified as follows:
Low Reality Simulation:

- Task trainers (models and models produced in the form of the organ or body area where the skill will be applied)
- Fresh frozen cadaver trainings
- Medium Reality Simulation:
- Gamification

Medium reality simulators

- Virtual patient / hospital applications
- Haptic simulators

High Reality Simulation

- Standard patients
- High-fidelity simulators

How is it applied?

- Preparing scenarios
- Preparing people to take part
- Prepare the environment
- Preparing the trainers
- Preparing the participants
- Performing the simulation
- Arrange a post-simulation analysis session

Trainer note
Demonstration and coaching principles will be presented. A coaching video sample (Annex-6) and a coaching skill evaluation guide (Appendix-7) will be shared.

Demonstration

It is an educational technique used to learn a skill related to manual dexterity or psychomotor domain by showing and doing it.

How is it applied?
WHOLE-PIECE-WHOLE

- First, the whole process is shown to the group from start to finish.
- Then the process is divided into small parts and these parts are practiced one by one.
- Finally, the whole application is shown as a whole again and the group is practiced.

What the trainer should pay attention to in the application:

- State the purpose clearly before starting the process.
- Must be able to perform the operation skillfully and without errors.
- Should be able to draw attention to the work he is doing, not to himself.
- It should show the steps in which it divides the presentation in the appropriate order.
- Allocate sufficient time for each step.
- He/she should tell what he/she is doing.

- It should ensure active participation; questions should be directed.
- It should ensure that the steps are followed with the learning guide.

Clinical Skills Coaching

It is an educational technique used to learn manual skills or a skill related to the psychomotor field in an education.

The coaching (COACH) steps are as follows:

C Clear Performance Model
O Openness to Learning
A Performance Evaluation (Assess Performance)
C Communication
H Help and Follow-up

How is it applied?

- The skill to be studied is defined.
- A positive communication and learning environment is created.
- It is shown to those who learn the method in the correct form (demonstration).
- The learner is monitored while practicing the skill with the model or simulated patient. Reflecting is provided and constructive feedback is given. It is ensured that they practice the skill until they do it at a sufficient level.
- If the performance is at an acceptable level, the learner is provided with the opportunity to practice the skill with the real patient. By gradually reducing follow-up and intervention with each new application are allowed to demonstrate the skill at the mastery level. The learner is supported by reflection and constructive feedback.
- Assistance and monitoring is provided. For some skills that are not practiced frequently, it is monitored whether the learner needs to go back to step 3

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Appendices

1. Role play scenarios
2. Teachback checklist
3. Communication skill checklist
4. Reflection and feedback guides
5. Simulation video example
6. Coaching video example
7. Coaching skill assessment guide

Annex-1 Role play scenario

CASE INFORMATION
Facilitators: Bürge Atılgan, Sevgi Turan
Name of case: Diabet (Teachback)
Name of educational activity: Assessment of health literacy of the individual with the practice of communication skills (Session 5)
Type and level of learner: Phase 3 Medical students
Setting: Family medicine outpatient clinic

Trainer Instruction

A roleplay focusing teach-back method in health literacy is implemented with the following steps:
-Two volunteer participants are determined, one of whom will perform the patient role and the other will perform the doctor role.
-Scenarios regarding the roles (Annex-1) are shared with the volunteers. Additional information about the patient should only be shared with the participant who will play the patient role. The participant, who will play the patient role, is asked to put himself in the patient's place and to react to the physician's tone, expression and body language as if he were a patient.
-Teachback checklist (Annex-2) is distributed to all participants. Information is given about the monitoring of the performance by using the checklist.
Questions for discussion after performance:
-What went well?
-What could have been done better?
-Is there anything missing?

Demonstration and Expectations about Teach back

The physician is asked to first demonstrate the use of the glucometer to the patient and then teach-back to make sure the patient understands.

Did student use initial sentences for teach back, such as Ms. Şirin , I'm going to show you how to use your new blood glucometer. Glucose is another name for sugar. This instrument will measure the glucose level in your blood…..I want to make sure that I explain these steps to you in a good way, as it can be difficult to start something new sometimes… Can you show me now how to use your blood glucometer?

Did the physician use simple non-medical language?

If the patient did not explain what he/she understood correctly, did the physician explain until the patient understood clearly?

Did the patient feel like he/she was tested?

Physician Role

Show how to use the device you have prescribed to measure blood sugar following with the instructions below to 51 years old secondary school graduate Ms. Şirin who you diagnosed with diabetes. Make sure that the patient can do it right.

Blood glucose measurement instruction

1. Review the user manual of the device
2. Prepare glucometer, test strip/test stick, lancet pen, lancet and clean napkin.
3. Check that the expiration date of the test strips has not passed.
4. Wash and dry your hands (use warm water to help blood flow).
5. Turn on the device using the “on/off” key and insert the test strip into the device.(Most devices are automatically turned on and ready for use when the test stick is inserted. Some devices require blood to be dripped onto the test strip first and then inserted into the device. These features should be reviewed in the user manual. Share and show the information written in the user manual with the patient.)
6. Attach the lancet to the lancet pen and adjust the depth according to the skin thickness.
7. Collect the blood towards the tip of the finger to be pricked with the fingers of the other hand. (“Do not always use the same finger, Using the side of the fingertip may be less painful as there are fewer nerve endings …”).
8. Clean finger with a napkin.
9. Perform pricking by pressing the key of the lancet pen.
10. Wipe off the first drop of blood with a clean napkin after the prick .(“Cotton leaves residues due to its texture, and these residues may absorb blood and cause an incorrect measurement result. Therefore, do the cleaning with a napkin instead of cotton.…”)
11. Touch the subsequent blood drop to the end of the test strip and let the blood be absorbed. (“The test will start automatically when the test stick has absorbed enough blood.”)
12. The measurement value will appear on the screen in a few seconds.(If there are any deficiencies in the procedures, the device does not conclude the test and gives a warning. In such a case, it is necessary to repeat the test.)
13. Write test results with date and clock in your diabetes diary. (previously informed.) Please bring your diary with you a week from today.
14. The test strip and the lancet inside the lancet pen are disposable. Pack test strip, lancet in a way that these things do not harm other people and throw them in the trash.
15. Keep the test strips box closed and away from devices that create magnetic fields such as microwave ovens, televisions, radios, cell phones.

Patient Role

You are Ms. Şirin who is 51 years old and a diabetic patient. Your family physician diagnosed diabetes and prescribed glucometer to you. You bought the prescribed device from the pharmacy and came back to the family physician.

Task: The physician will show you how to use your new blood glucometer and then ask you to show it.

Additional information about patient (Only to the student in the patient role)

- Ms. Şirin expresses that it is complicated and she mixes the steps. That's why she was worried and panicked.
- Put yourself in the patient's place, react to the voice tone, expression and body language of the physician as if you were sick and graduated from secondary school.

Annex-2 Teachback checklist

Key: Yes = majority of time, Partial= about half of time, No = Almost never, N/A: Not Applicable

Teachback steps	**Yes**	**Partial**	**No**	**N/A**
Used positive body language, eye contact and voice tone.				
Checked the patient’s understanding of the information given (care plan, treatment plan, healthy lifestyle recommendations, etc.).				
Used simple language which did not contain any medical terminology.				
İnterview and speed of information transfer was appropriate for patient.				
Stated that the responsibility for disclosure is his/her own. *(I want to make sure I can explain everything clearly)*				
Asked the patient to explain the information given in his/her own words as he/she understood.				
Encouraged the patient's understanding without creating a feeling of being tested, clarifying it with open-ended questions. *(Let's remember How many times a day do you use* fluoxetine*?... Great..)*				
Took precautions by anticipating obstacles that could lead to any misunderstanding (e.g. speaking a little loudly to older person, writing notes, allowing person to take notes, etc.)				
If the patient was unable to correctly implement teach-back, he explained it again and rechecked the patient's grasp.				
Applied part whole method in the transfer of complicated information.				

Annex-3 Communication skill checklist

Communication Skill Assessment Tool

Date: ______________
Student Name:

Year: 1 2 3

-

Key: Yes = majority of time, Partial= about half of time, No = Almost never, N/A: Not Applicable

A) Beginning the interview	Yes	Partial	No	N/A	Comments
1. Greeted the applicant					
2. Introduced self					
3. Asked the patient to sit down and providing privacy					
4. Obtained the patient's name					
5. Called patient by the name during interview					
6. Asked the applicant an open question					
7. Listened to the patient without interrupting him/her					
Personal Manner	**Yes**	**Partial**	**No**	**N/A**	**Comments**
8. Made eye contact					
9. Used appropriate body language, tone of voice, facial expression					
10. Avoided using cell phones or other distractions					
11. Considering non-verbal cues (applicant's facial expressions, tone of voice, posture, etc.)					
Gathering Information	**Yes**	**Partial**	**No**	**N/A**	**Comments**
12. Displayed awareness of information from medical record (if not at the first meeting)					
13. Asked open ended questions to let the patient describe the problem					
14. Assured confidentially and privacy during interview					
15. Avoided medical jargon					
16. Asked questions one at a time					
17. Avoided rushing the patient					

18. Took notes					
19. Focused, as to not asking a question that was already answered					
20. Summarized the history in the end, and ask if the patient has anything to add or correct					
Understanding the patient's perspective	**Yes**	**Partial**	**No**	**N/A**	**Comments**
21. Encourage the patient to tell his/her story in a more complete fashion					
22. Determine what effect the problem has on their day-to-day life and relationships					
23. Respond supportively to the patient's expression of feelings and thoughts					
Explanation and planning	**Yes**	**Partial**	**No**	**N/A**	**Comments**
24. Provide explanations that the patient can remember and understand					
25. Check patient's understanding of information given					
26. Discuss the importance of the patient's involvement in the plans					
27. Encourage patient to be involved in implementing plans, and negotiate an acceptable plan					
28. Elicit the patient's reactions and concerns about plans and treatments					
29. Obtain informed consent					
Ending the interview	**Yes**	**Partial**	**No**	**N/A**	**Comments**
30. Summarize and confirm the established plan of care					
31. Explain possible outcomes, what to do if plan is not working, when and how to seek help					
32. Check final agreement (ask if any corrections, questions or other items to discuss)					
33. Contract with the patient about next steps for both patient and physician					
34. End the interview and politely, let him/her go out					

TOTAL

Annex-4 Reflection and feedback guides

REFLECTION GUIDE

1. Description of the situation: What did I do? What did I think?
The situation is considered in detail. What exactly happened? Who were they and what did they do? What have I done? What was my role? What was I thinking while doing this? What happened after all?

2. Identifying emotions: How did I feel? What were my feelings?
What crossed my mind while experiencing these and how did I feel? What emotions did I feel: resentment, anger, fear, etc. Have there been other occasions in my life where I felt the same emotions? Can I encounter such situations in the future?

3. Why did this happen? Why did I feel like this?
The situation is clarified by considering in detail and analyzing the emotions. Howt was the situation for me and others? Why did this happen? Why did things turn out like this? Why did I feel like this? What has been caused?
What factors were caused by me, other people, and the environment?

4. What are the results of the condition for me and others?
How did this development of the situation influenced the process and the outcome? How have I and others been affected by the situation and what conclusion have we reached?

5. What did I do well?
The situation is reviewed. What did I do that was effective? Why do I think it is effective?

6. Could I have done differently?
Factors affecting the condition are considered. What can I do better? (Considering not enough attention and care, not done, forgotten, etc.) Could I have managed the matters differently? What can I do or specifically do when I encounter a similar situation in the future? Why do I do this? Wwhat are the possible consequences?

GIVING FEEDBACK GUIDE

1.Focus feedback on behavior rather than the personality

We should focus on what a person does. It is required that we should use words describing behavior rather than person. For example we might say a person who is interviewing very fast with a patient "talked very fast in this encounter," rather than that he/she "is a person who talks incoherent". When we talk in terms of "personality traits" it implies inherited, constant qualities difficult, if not impossible, to change. Focusing on behavior implies that it is something related to a specific situation that might be changed. It is less threatening to a person to hear comments about his behavior than his "traits".

2. Focus feedback on observation rather than inferences

Observations refer to what we can see or hear in the behavior of another person, while inferences refer to interpretations and conclusions which we make from what we see or hear. In a sense, inferences or conclusions about a person contaminate our observations. When

inferences or conclusions are shared and it may be valuable to have this data, it is important that they be so identified.

3. Focus feedback on description rather than judgment

The effort to describe represents a process for reporting what occurred, while judgment refers to an evaluation in terms of good or bad, right or wrong, nice or not nice. The judgments' arise out of a personal frame of reference or values, whereas description represents neutral reporting.

4. Focus feedback on descriptions of behavior in terms of "more or less" rather than in terms of "good or bad"

The "more or less" terminology implies a continuum on which any behavior may fall, stressing quantity, which is objective and meaningful rather than quality, which is subjective and judgmental. Thus, eye contact of a person may fall on a continuum from less to more, rather than "good" or "bad".

5. Focus feedback on behavior related to a specific situation

Feedback should refer to behavior placing in the "here and now" rather than to behavior in the past. What you and I do is always tied in some way to time and place. Feedback is generally more meaningful if given as soon as appropriate after the observation or reactions occur, thus keeping it concrete and relatively free of distortions that come with the lapse of time.

6. Focus feedback on the sharing of ideas and information rather than on giving advice

By sharing ideas and information we leave the person free to decide for himself, in the light of his own goals in a particular situation at a particular time, how to use the ideas and the information. When we give advice we tell him what to do with the information, and in that sense we take away his freedom to determine for himself what is for him the most appropriate course of action. Thus, we should share ideas and information rather than on giving advice and give them freedom in order to decide themselves.

7. Focus feedback on exploration of alternatives rather than answers or solutions

The more we can focus on a variety of procedures and means for the attainment of a particular goal, the less likely we are to accept our particular problem. We should explore alternatives that person have rather than go around with a collation of answers and solutions for which there are no problems

8. Focus feedback on the needs of the recipient

The feedback provided should serve the needs of the recipient rather than the needs of the giver. Help and feedback need to be given and heard as an offer, not an imposition.

9. Focus feedback on the amount of information that the person receiving it can use

Feedback should include the amount of information that the person receiving it can use, rather

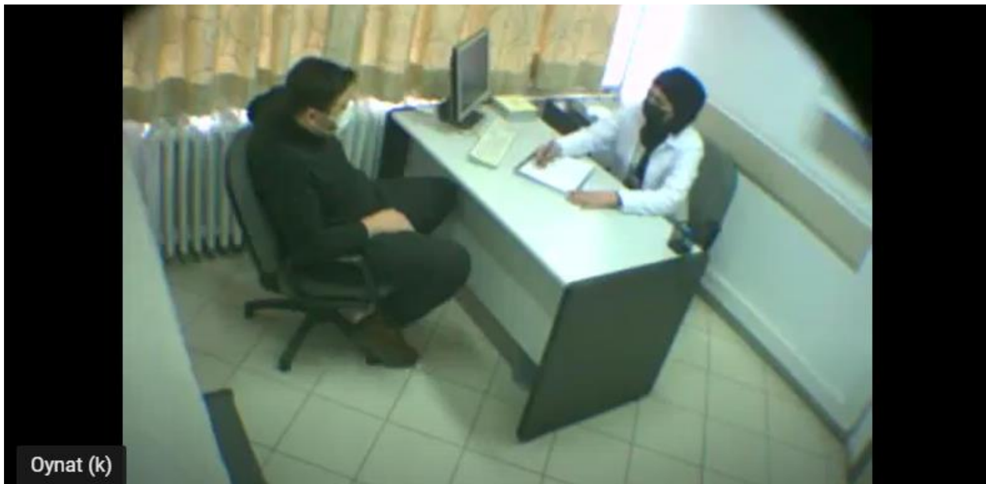
than on the amount that you have which you might like to give. To overload a person with feedback is to reduce the possibility that he may use what he receives effectively.

10. Focus feedback on time and place so that personal data can be shared at appropriate times

Because the reception and use of personal feedback involves many possible emotional reactions, it is important to be sensitive to when it is appropriate to provide feedback. Excellent feedback presented at an inappropriate time may do more harm than good. 11. Focus feedback on what is said rather than why it is said The aspects of feedback which relate to the what, how, when, where, of what is said are observable characteristics. The why of what is said takes us from the observable to the inferred, and brings up questions of "motive" or "intent". Thus we should focus on what is said rather than why it is said.

Annex-5 Simulation video example

https://drive.google.com/file/d/1injORH2iZNH9RqbuscM9ouK_d2A9_osT/view?usp=sharing



Annex-6 Coaching video example

https://drive.google.com/file/d/1UdQ0KWRsjdyT-_Lku2w93i_aTgfojcbw/view?usp=sharing

Annex-7 Coaching skill assessment guide

COACHING SKILLS ASSESSMENT GUIDE

(To be completed by the trainer)

1. **Need to be developed:** The step is not applied at all, applied incorrectly, or not applied sequentially
2. **Sufficient:** Performing the step correctly and in sequence, but having deficiencies and/or needing help or reminders from the trainer
3. **Satisfactory:** Performing the step correctly and in sequence without pauses or assistance

Participant's Name and Surname ……………………..

STEPS	OBSERVATIONS				
	1	2	3	4	5
BEFORE PRACTICE SESSION					
1. Greeting the participants					
2. Explaining the the spesific goals for the practice session					
3. Asking participant to review her/his performance in previous practice session					
4. Reviewing the steps in the learning guide					
5. Answering the participant's questions about the practice session					
DURING PRACTICE SESSION					
6. Observing the participant as s/he practices the procedures					
7. Using learning guide while observing the participant					
8. Taking notes about the participant performance during the observation.					
9. Encouraging the participant to ask questions					
10. Asking the participant some questions when necessary					
11. Providing positive reinforcement and suggestions for improvement as the participant practices the procedures					
AFTER PRACTICE SESSION					
12. Encouragingthe participant to share her/hisfeelings about the positive aspects of the experience.					
13. Encouraging the participant to evaluate his/her own performance and make an action plan for improvement					
14. Reviewing the all steps in the learning guide					
15. Giving feedback and suggestions to the participant for improvement					
16. Providing opportunity for repetition of practice if necessary					

Interactive Training Methods And Techniques Pre/Post Test Questions

1. A trainer asked his students "what could be the factors affecting health literacy" and wrote the ideas from the students on the board for 10 minutes. Then he encouraged the students to discuss and create ideas.
Which of the following method or technique used in the case above?
A) Simulation
B) Question and answer
C) Demonstration and Coaching
D) Discussion
E) Brainstorming

2. Which of the following methods and techniques is most effective in learning a practical skill related to the psychomotor domain?
A) Case study
B) Question and answer
C) Demonstration
D) Discussion
E) Role playing

I. Models produced in the form of an organ or body region for practical skills
II. Fresh frozen cadaver trainings
III. Gamification
IV. Standard patients
V. Haptic simulators

3. Which of the above statements is an example of high-fidelity simulation method?

A) I and II B) I and III **C) IV only**
D) I, III and IV E) II, III and IV

I. We should watch part of performance.
II. We should give feedback to the students on their behavior not on individual characteristics.
III. Firstly, we should give feedback, and then ask him to reflect.
IV. We should focus "why" he said and did, not "what" is said or done.
V. We should prefer many/few instead of nice/bad in describing the behavior.

4.Which of the statements above regarding debriefing principles is correct?

A) I and II **B) II and V** C) III only
D) I, III and IV E) II, III and V

HOW TO USE AND DEVELOP AUDIOVISUAL MATERIALS

AIM:

To teach and skill the health care professionals, who are supposed to serve, about developing different audiovisual educational materials and general principles of using these materials effectively.

Learning Objectives

At the end of this session, participants should be able to:

- Explain the importance of using audiovisual material related to vector-borne diseases
- Tell the audiovisual materials
- Tell the rules of using audiovisual materials
- State the advantages of audiovisual materials
- State the disadvantages of audiovisual materials
- Tell the points to pay attention while preparing

audiovisual materials

Methods and Techniques

- Catechism
- Small group work (Material use with the sample materials given and developing appropriate materials with the given scenarios)

DURATION:45x2

Tools and Instruments

- Following materials supposed to be provided at least: White and colourful A4 sized papers,white and colourful cardboards,
- Following materials supposed to be provided preferably: scissiors, glue, tape, post-it
- Round table for working groups
- Scenarios for the material development activity
- Vector-Borne Diseases Brochures of some hospitals affiliated to Ministry of Health
- Vector-Borne Diseases Brochures given by some municipalities

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Notes to trainer; First of all

What they remember about audiovisual material preperation and effective application, from distant training programme is questioned and reminded. The aim and learning objectives of the session is presented. The points to be paid attention in the introduction is given at the end of this part as a foot note. It is not supposed to make a newly presentation but to review the answers given by participants to what they remember from distant training. If it is considered necessary the time for reminder can be expended for 10-15 minutes regarding the

guidance of control lists, before the group work.

Introduction

In the training;

The more sensory organs engaged in the learning process; the more effective, meaningful, permenant and faster both the education and the learning are. Engaging multiple senses necessitates taking advantage of material use.

Role of Health Professional;

Health care professional plays a critical role in providing individuals/society to be informed reliablely, truely and helping them to make conscious decisions on their own health.

As health care professionals**, to learn conditions of our target group we should be looking for details about our target audience, their informational needs** and their comprehension capability of the information we want them to apply.

Notes to trainer;

Following a brief introduction and reminder

Participants are grouped into 4 groups using colourful cards and placed to theworktables.

Group-Material 1

Group-Material 2

Group- Material 3

Group- Material 4

At the session, groups are told to work at tables to develop a material according to informations stated above, by giving them time and about using this material efficiently. “Modelling control list for easy-to-read written materials” and “Comprehension control list for individual/patient” are handedout to all groups.

Modelling control list for easy- to- read written materials

General Content	Text
• Limit the content with one or two basic goals. Do not give too many information or do not try to contain everything. • Limit the content with the topics which individuals should really know. Avoid giving unnecessary information. • Only use the words which individuals who have not had medical education can understand too. • Make sure that the content is appropriate for the target group's age and culture.	• Write intended to individuals who had primary education (6th grade and under). • Use one or two syllable- words. • Use short paragraphs. • Do not use passive sentences, instead use active sentences. • Avoid using charts and graphs, if it is really necessary use the simplest one, add the description to the charts, the graphs and the text.
Font and Type Size	**Page Order**
• Prefer larger type size, at least 12 font size. • Do not use more than two or three different fonts and font sizes. Consistency in appearance is important. Use both upper and lower case in the text. IT IS INCONVENIENT TO READ A WHOLE TEXT WITH UPPER CASES.	• Do not fill the whole page with text or pictures.There should be enough empty space on the page. • Use titles and subtitles to separate the text blocks. Bullet pointed lists are preferred more than paragraph blocks. • The more understandable the figures are, themore beneficial they are. • The visual materials should be appropriate for the age, society and culture. • Avoid using complicated anatomical figures.

Comprehension control list for individual/ patient

Answers to the questions listed below must be found in the individual/patient- health careprofessional meeting.

- What is my main problem?
- What should I do (about my problem)?
- Why is it important for me to do this?
- What is the scope of vector-borne diseases?
- What number should I call and where should I go for vector-borne diseases?
- Other explanations
- What should I do?
- How should I do?
- When should I do?
- Following steps
- When am I going to come again?
- When and to whom am I going to talk to for my needs?

MATERIAL-1

While Mrs. Ayşe took a bath of her 5-year-old daughter, she noticed that her daughter has intense dandruff on the scalp. Seeing that the trouble did not pass after washing, Mrs. Ayşe took her daughter to the doctor two days later. He is said to have lice in his hair after he was examined. Prepare a material for prevention and treatment against lice accordingly

MATERIAL- 2

Preparing visual materials for protect agricultural workers who works outdoors from tick bites.

Note to Trainer:

30 minutes for the prepetation of the groups, 5 minutes for the presentation

Giving feed back after presentation and evaluation based on control list shouldbe couraged.

Trainer supports and directs the participants while the groups are working.

Required environment for the material development and using themeffectively should be provided.

After each group's presentation positive and tobedeveloped feedbacks are given by the participantsfirstly.

Then feedbacks are summarized relating them with the topic.

Summary

Ask participants what points they paid attention while preparing the audio visual materials individually or as group. Summarize the session by quoting the group work presentations. Participants' questions are answered, getting the feed backs and assessing the session.

Information Note

The Most Frequently Used Audiovisual Educational Materials by Health Care Professionals

- Black board, paperboard
- Slide(powerpoint)
- Data display unit(barcovision)
- Video
- Printed educational tools “books, brochures, posters, illustrated guidelines”
- Demonstration tools “anatomical models, billboards”

Advantages And Disadvantages Of Audiovisual Materials

Advantages	Disadvantages
• Provides standardization, • Intriguing, improving attention, • Provides change in attitude towardseducation, • Helps saving time, • Makes complicated states simpler, • Improves the quality of education, • Makes abstract facts more concrete, • Motivates, • Makes the learning process moreassorted	• Can decrease participants thoughtprocess • Can limit the language use • It can be expensive and difficult tocarry the tool, • The time for preparation can be insufficient to use the tool efficiently, • Distractions can be more common in some tools (especially audial materials) • There can be issues about size, colour,and structure. • Can be broken down quickly and difficult to save.

PROS AND CONS OF USING BLACKBOARD

Pros	Cons
• It is common • Electricity independent • Useful, cheap, • Both trainer and trainees can use it, • Appropriate for brain storming, problem solving, listing and other activities.	• You cannot write so many things • It takes time to write it, • It is not easy to write and talk to the participants at the same time. • Writings can be messy, • The information given is not recorded, what you write to the board are gone by cleaning them.

PROS AND CONS OF COMPUTER/PROJECTOR

Pros	Cons
• It provides colourful, live and acousticvision • You can prepare as much as slides youwant, • It does not take money to prepare apresentation, • The presentation can be enriched byusing the internet possibilities, • Altered information can be correctedimmediately, • The presentation can be copied andprinted.	• Electrical equipment is expensive, • It is electricity-dependent, • It does not give good results in brightplaces, • There can be troubles related tocomputer, • There can be resolution problems between computer andprojector.

Points to Pay Attention While Preparing PowerPoint Slides:

- There should be a topic, and trainer's information on the first slide,
- There should be presentation plan on the second slide,
- Font types should be one of the followings, Arial, Times New Roman, Tahoma, Trebuchet MS, Verdana, Comic Sans. In all slides there should be the same font type.
- Font size for the topic should be 36-44 and 20-32 font for the text,
- Lower case letters should be preferred. If it is not necessary do not use uppercase letters,
- There should be 1 cm empty space on each side of the page.
- The number of lines should be lesser than 9.
- There should be only one context on each slide.
- All slides should have a topic. If the same context is continued on the following slides, the pages should be numbered, and it should be written after the same topic.
- Slides should be numbered.
- If the background is bright prefer dark colours for the typing.
- Long sentences should be avoided. Sentences should be simple and clear,
- Short reminding sentences should be preferred (There should not be paragraphs.)
- Graphs and symbols should be used to clarify,
- There should not be misspellings,
- There should not be more than four colours on a slide,
- You should not prefer Italic font style writings unless it is necessary,
- Ornaments and animations should not be used that can interrupt the participants,
- There should not be unnecessary information or table/schema/maps,
- You should use images which are related to topic,
- You should not write the information that you are not planning to mention.
- You should not use audios and music unless they are goal-oriented

PROS AND CONS OF VIDEO USE

Pros	Cons
• A real situation can be displayed indetail, • The video can be paused, rewinded,played in slow motion, • It is cheap to copy.	• Difficult to prepare, • Most of videos being used and undersale are not up-to-date, • The same video recording can give falseimpressions on each culture.

A Guide for Using Videos

Before the video use for the purpose education, make sure you share the following properties.

Is the duration of video pointed out?	Yes/No
Is the purpose of watching the video and the context explained?	Yes/No
Is it possible to translate or provide subtitles if the video's original language is foreign?	Yes/No
Are there daily life scenes?	Yes/No
Is the video up-to-date?	Yes/No
Are there any points to be paused and rewinded during the video?	Yes/No
Is it determined what questions to be discussed during the pauses or rewindings?	Yes/No
Is there a message of video?	Yes/No
If there is a message, is it clear to understand?	Yes/No
Is it possible to use it for each age group and culture?	Yes/No

PROS AND CONS OF ANATOMICAL MODEL USE

Pros	Cons
• It is prepared, • It is easy to carry, • It is long lasting, • It provides participants to learn themby seeing and applying, • It makes the demonstration and cultivation easier for the trainer.	• They are not prevalent, • They are expensive.

While developing health messages

Target group should be determined. “We should know details about the age, gender, beliefs, attitude, culture, literacy, socio economical status of target group.”

Key messages should be determined.

The way ofconducting the message should be determined. These can be one of the followings: “face to face, video, mail, brochure, web page”.

The Factors Affecting Audiovisual Material Choice

- Learning objective
- Method of education, attitude and skills of trainer
- Characteristics of participants
- Educational atmosphere
- Properties of tools
- Cost
- Availability
- Time for preparation
- Reachability

The factors similar to the ones listed above can affect the trainers material/tool choice.

Points to Pay Attention While Choosing a Too

- Preferred tools should be coherent to the purpose and the context.
- Should be utilized coherently,
- Should be helping learning process,
- Should not be used just for fun, spending time, personal pleasure or to keep the participants busy.
- The trainer should strongly believe the benefits of using tools while presenting the educational materials and should have the capability and the knowledge to utilize them

COMMUNICATION SKILLS

Aim:

In this training you will learn how to provide information in an effective way. You will learn making use of appropriate communication skills so that the person understands, interprets and remembers information.

Learning goals

The participant:

1. Describes what is meant by person-cantered communication, indicates, holds and brings the structure to a conversation.
2. Indicates the difference between an everyday conversation and a professional conversation.
3. Applies verbal and non-verbal communication in a conversation.
4. Names the influence of verbal and non-verbal communication and its effect in a conversation.
5. Names skills in structuring a conversation, relationship building, and information gathering.
6. Identifies the skills needed to enter into a relationship with the person based on equality: be beside the person, respecting his/her autonomy and approaching him/her as an expert.
7. Conducts a conversation with a person according to his/her plan, applies communication principles and reflects according to professional values and norms.
8. Explains and applies the distinction between counselling and informing.
9. Establishes a relationship between the informational interview and the behaviour change process sequence.
10. Recognizes the signals/cues that show the caregiver is open to receive information and can apply interventions that contribute to this.
11. Provides information that is understandable and engaging.
12. Makes a distinction between a monologue and interactive explanations/dialogue.
13. Gives information in an interactive and understandable way to a person.
14. Identifies his/her own strengths and learning points (weaknesses) and knows (where to find) the guidelines for giving information to a person.
15. Recognizes resistance and lists the interventions he/she can apply if the person is not open to receive the information.
16. Formulates questions that provide insight into the person`s willingness for behaviour change. In doing so, he/she distinguishes between the factors of attitude, social influence, and self-efficacy.

Recommended minimum time: 45 Minutes

Methods and Techniques

Lecture
Interactive discussions
Feedback
Q & A

Tools and Materials

Laptop/desktop, (white) board, projector, digital screen, (video) recorder. paper & pen for taking notes.

Introduction

This communicative skills training may involve new things for the trainees: the subject of communicative skills, making and substantiating a plan of action, drafting learning questions, working with simulation patients, making a conversation analysis, reflecting on development, and giving (peer) feedback.
During practicing, ask what the trainees are doing, how they are doing it, why it is important to do, what effect they expect this to have, and possibly where they can find useful information (the source).

Types of communication

1. Verbal
2. Non-verbal
3. Visual
4. Written

Effective communication skills

1. Active listening
2. Communication method: the right way to communicate
3. Positive attitude
4. Confident communication
5. Providing and accepting feedback
6. Adjusting your speaking voice: be clear and audible
7. Empathy: understand other people's emotions and choose an appropriate response
8. Communicate respectfully
9. Non-verbal communication (cues and signals)
10. Responsiveness and acknowledgment

The basic skills are

1. Asking open questions
2. Identifying key words
3. Summarizing and paraphrasing
4. Giving emotional reflections, recognizing non-verbal signals
5. Making (eye) contact and giving recognition

Effective feedback

Feedback is 1) observation-based; 2) information-specific; 3) issue-focused. According to Hattie & Timperley (2007) effective feedback involves answering the following three questions:

1. Feed-up: where am I going? What is the end goal, what are the assessment criteria?
2. Feedback: how did I perform(ed)? How did the trainee perform the task? What progress has been made with respect to the assessment criteria (to be defined)?
3. Feed-forward: what is the next step? What approach is needed to reach the goal?

Feedback rules:

1. Content
2. Manner
3. Timing
4. Frequency

Person-cantered care

What do you understand by it and pay attention to possibilities, tailored to the person and his/her values, lifestyles, needs and preferences. Treat people as individuals, respect their rights as a person, respect their values and norms, and mutual trust and understanding.

Definition: "...an approach to care that arises in the formation and promotion of healthy relationships between all caregivers, care recipients, and other important people in their lives. It is based on the values: respect for people; individual right to self-determination; mutual respect and understanding. It is promoted in workplace cultures focused on empowerment and the continuous support of practice development" McCormack and McCance (2017)

Verbal and non-verbal communication

- Describe how you are sitting/standing there right now.
- What do you think you project with that posture?
- What would you like to project?
- What do you think is the first impression people get of you when, for example, you first walk into a room (in a hospital)?
- What do you think the trainer thought when he/she saw you sitting in the room just now?
- Have you ever thought about that question?

- What is the meaning of non-verbal communication for you?
- What do you pay attention to in (non-verbal) communication with people?
- Name something you like and something you find unpleasant in non-verbal communication of people? (Give examples)
- What are you satisfied about in terms of the appearance you think you have? And what would you like to work on?
- If you look at your posture, what should you pay attention to to make sure people don't see any things you are not satisfied with?
- How do you feel about your voice? (And why?)

Aspects for a good conversation or dialogue

- Listen, Summarize, ask Questions.
- NO Judgments & Opinions
- Always Ask, Never Assume
- Think in terms of Qualities
- DO NOT Fill in for Someone Else

Asking questions: open - closed - facts

It is important to recognize types of questions and its effects

1. The inventory of previous knowledge and experiences in the field of asking questions and its possible effects.

2. Intro trainer: each of you has experiences with illness, health, limitations, contacts with care providers. These can be your own experiences or the experiences of people you know personally. Choose an experience you want to tell.

3. Trainer invites trainee to tell about (a part of) his/her experience (short, 2-3 minutes). Other trainee asks a question. Any question is welcome and good! We learn from them.

Brief response: type of question? Effects of the question? Other question someone wants to ask.... Open up closed questions?

4. Working in turns (4 to 5 situations if possible) and practice in trios and make sure to practice: encouraging behaviour, active listening, summarizing and asking questions (open and closed questions). Observing other trainee and give feedback.

ASE model

With the Intention to change behaviour, the ASE determinants are decisive for the willingness to actually do something.

A = Attitude and refers to views and considerations of:

1. The current situation and experiences what is valuable in it and you (or the caregiver) would like to keep it that way

2. Possible improvements and solutions. Views may refer to:

- What do you (or the caregiver) see as the cause of the symptoms?
- What is of great value to you (or the person in need of care) and would you (or the person in need of care) like to keep in your (his/her) life?
- What can solutions/changes bring (results?) and the question: can I carry this out? (Personal effectiveness)

3. Considerations involve weighing the pros and cons of possible solutions. Personal needs, preferences and personal interests play a major role. They determine the weight of the pros and cons. Values and interests play a major role here, which is expressed in feeling attached to something and emotions such as loss in decisions. What does the person have to give up as well?

S= social norms (or influence). What does the person experience as support and pressure with different solutions?

E= self-efficacy. What does the person himself believe he will succeed in doing? Past experiences play an important role here.

ASE group exercise

What would you like to do differently or how do you take care of your health? What intentions do you have and what experiences and habits?

Task: discuss in subgroups everyone's own experiences and resolutions. Make sure that everyone's own experiences are discussed: listen and ask questions! What can you recognize in each person's story separately?

- **Attitude**: views and considerations?
- **Social norm**: experienced support and pressure from others?
- **Self-efficacy:** degree of confidence that you will or will not succeed.

Plenary: what do you learn from this for this training?

Explanation based on the theory

With good intentions that are not carried out, the ASE factors often play a role (disadvantages, pressure from the environment, believing that it will not succeed in putting the intention into practice). In the case of advice received (or information is given), factors relating to the steps “being open to” and “understanding” more often play a role in non-implementation. Personal factors such as “way of doing” things (coping) also play a role.

The total exercise should not take much longer than 20 minutes. Keep the speed up. Do not talk too long on some parts. This will not help. It is mainly about becoming aware of a wide variety of factors on the process of behavioural change.

What helps? Try this one: person experiences a dilemma. For example: “*do I stop taking the medication or not?”* What conversation skills are needed to discuss this with him?

- Thinking out loud
- Discussing pros and cons
- Listening
- Determining what the user's preferences are
- Asking questions
- Reflecting on feelings

In pairs: discuss the dilemma. Try to support each other.

Evaluation: How does this sharing of one's own situation benefit one's communication skills? What helped and what didn't? How do you deal with someone who has a very different approach and perhaps an inappropriate approach (according to you)? What do you do with the insights that the ASE model provided?

Learn to distinguish between:

1. Technical information: What can reduce constipation is the following....(factors). How much you drink affects the bowels and it works like this......Fiber (?) in the diet makes that in the bowels....Fiber is in....there is a correlation between exercise and constipation because exercise activates the bowels, etc.

2. Experiential information: you feel tension in your abdomen and have bloating.... pain during walking...

3. Procedure information (about the steps to follow in treatment or a concrete examination...) in case of …, an attempt can first be made to achieve improvement with adjustment of food and drink. If it is severe and very burdensome or serious. This gives much faster relief. This is done by the family doctor or in the hospital....

Exercise in converting advising to informing:

- You should not drive through a red light.
- I advise you to lock the door when you leave.
- It is important to eat and drink enough before you start the ½ marathon.
- Before you turn off your computer, you should close all programs.
- It is better not to smoke.
- It is better not to feed the deer.
- You have to do your homework / do the preparation assignments.
- You have to be sober for the operation.
- It is better to keep moving slowly than to spare the affected joints completely.
- Try to lose weight if you are overweight.
- If you are easily tired, make use of your good days and spare yourself on the days when you suffer a lot.
- Brown bread is better than white bread.
- You really need to drink more.
- Try to go for a walk outside every day.
- It is better to go swimming when you have a lot of pain when exercising.

What to do if the person is not "open" to receive/hear the information?

- Give feeling-reflections instead of extra information.
- Ask if the person recognizes the symptoms (e.g. experiential information).
- What effects does the illness have on the person (what things does the person is not able doing anymore?)
- Ask how the person is currently coping with the symptoms.
- What does the caregiver already know about the subject?
- What are you afraid of?
- What do you think now after hearing all this information?
- Allow the person to choose which "chapter" of the information they want to know.
- Name non-verbal behaviours of the person seeking care ("you look sad/surprised/angry")
- Be honest if you don't know something. Say you will find out and come back to it in the next conversation, say this again at the conclusion.

- Think out loud
- Say what you are doing in the conversation ("I am going to wrap up/summarize now")

Attachment 1.

Evaluation criteria list:

Item/criteria	Sufficient / non-sufficient	Notes
1. You engage (properly) with the person and reach a common goal in accordance with shared decision-making aspects.		
2. You show connection with individual's needs, emotions, views and his/her prior knowledge.		
3. You stimulate interaction.		
4. You can provide the information in an effective manner.		
5. You check (even in between) whether the person understands and can process the information.		

Attachment 2.

Conversation Analysis

The purpose of making a conversation analysis is that you learn from your (practice) conversation. Things went well and when you look back you will undoubtedly also see things that you would do differently next time. That is not a problem, you will learn from it.

How do you make an analysis?

For a conversation analysis you first type out the conversation verbatim. You also describe what you or the (simulation) patient have shown nonverbally. Then you reflect on what you did/answered. The idea is that you become aware of the skills that you apply, how you do it and how it might be done differently and what that would additionally bring (added value).

The elaboration and analysis of your conversation contains three columns:

1. The 1st column is a record of the conversation - verbatim. Also, accurately depict exactly what happens in the interaction between yourself and the simulation patient, for example non-verbally. In the layout, make a clear distinction between the reactions. Use for example different fonts or colours.

2. The 2nd column is the analysis. For each of your actions, you indicate the conversation techniques (skills) involved. Also show the phasing of your conversation. Indicate which part or which phase this part of the conversation falls under; for example opening or core, evaluation phase.

3. The 3rd column is meant for your critical reaction, your critical reflection. Integrate in this column also the feedback you have received from the simulation patient, your fellow students and the teacher and what you think of it. Explain or comment on your skills and your methodical approach. If you are not satisfied, describe why and make a suggestion as to what you could have said better (e.g., make a closed question an open one). Be critical, only then will you learn from your conversation!

Conversation (verbatim)	Analysis	Critical reflection
…………….	?!?	+++

Attachment 3.

Multiple choice questions:

1) An effective feedback incorporates several components, one of those components is:
a. information-focused
b. observation-based
c. subjective
d. keywords-based
e. positive

Right answer is B

2) The ASE model has a focus in changing persons' behaviour. The letter S stands for:
a. social integration
b. social efficacy
c. social norm
d. social experience
e. societal perspective

Right answer is C

3) Aspects for a good conversation or dialogue are:

a. Assume and give your opinion

b. Listen and fill in missing information

c. Think in terms of assumptions

d. Summarise and ask questions

e. Always give feedback

Right answer is D

EFFECTIVE PRESENTATION SKILLS

AIM

Gain knowledge and attitude about effective presentation by using educational methods andtechniques.

Learning Objectives

- To be able to tell the characteristics of effective trainer
- To be able to tell the methods of coping with stress of presenting
- To be able to say ways to cope with difficult participants
- To be able to explain the preparations before the presentation
- To be able to create draft presentation plan
- To be able to explain the importance of effective input
- To be able to tell the considerations in presentation
- To be able to tell the rules of making abstract

presentation

RECOMMENDED MINIMUM TIME: 45MINUTES

Methods and Techniques

- Lecture
- Questions
- Answers

Tools and Materials

- White board
- Papers and pens
- Computer
- Projector

Effective Introduction

The main aim and learning objectives of the session are read. The trainer asksthe participants whether they have been trained in any subject and asks them to share their experiences with the group. Then, by explaining the aims and objectives of the session, the trainer begins to explain the subject.

NOTE TOTRAINER:

At the beginning of the session, you should inform the participants aboutmaking a presentation at the end of the session with using effective presentation techniques

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Features of The Effective Trainer

Trainers who effectively communicate their knowledge and experience in trainings and who provide new knowledge, skills and attitudes in the accordance with their educational purposes aredefined as effective trainers.

Features of the effective trainers:

1. Being positive and optimistic
2. Using his/her sound effectively
3. Having a reading and research habit
4. Being interested in teaching skills and should have competence in teaching
5. Being modest and open to criticism
6. Being relevant, sensitive and patient
7. Being able to establish empathy
8. Being open to different opinions, should be objective
9. Being honest and sincere
10. Having ability to manage time
11. Having a sense of responsibility
12. Being at peace with himself and with his environment
13. Being able to cope with presentation stress
14. Being a facilitator and guide to learning
15. Being a role model
16. Paying attention to body language, clothing and behavior
17. Being proficient in the skill taught
18. Being knowledgeable and experienced in the presentation
19. Being able to provide effective communication with participants
20. Being able to direct the Group
21. Being able to deal with difficult participants
22. Being able to apply educational methods and techniques
23. Using audio-visual educational tools effectively
24. Being able to demonstrate an approach according to people in different sensing styles

Cope With Stress Of Presenting

The fear of presentation, which is defined as the anxiety and tension of the speaker for speaking or presenting, can usually occur because the speaker has not had such experience before, his shyness, his unwillingness to communicate, his sensitivity to the audience, and etc. with reasons may arise. The presence of fear of presentation is normal. Everyone may be concerned up to a level to talk to a community. In the Guinness Book of Records, it is stated that the number one fear of people is to speak in front of a group of people. In this shows how fear of presentation is widespread. However, this fear should not prevent the speaker from making a successful presentation.

Ways to cope of the fear of presentation:

1- **Preparation and Proofing:** The preparation of the presentation by conducting detailed research on the subject and gaining familiarity with the subject within a certain period of time increase the confidence of the speaker. All the details about the presentation and the number of rehearsals remain better in the minds, so it feels comfortable knowing that there is little chance of making mistakes. Moreover, being prepared for possible questions and situations plays an important role in eliminating the stress of presentation.

2- Transforming Excitement into Advantage: Excitement creates adrenaline effect and keeps the speaker strong throughout the presentation and improves performance. Speakers who do not exhibit any excitement or control their emotions under constant control, are characterized by participants as being distant, cold and therefore less interested in presentation.

3- Making Physical and Mental Preparations: Making mental animations that you are making a very good presentation in a calm environment before presentation allows you to prepare for mental presentation. Imagine the place of presentation, sounds, emotion with a detailed and vivid animation as possible and reinforce the animation by repeating it. To be prepared physically a day before a good sleep, to avoid strenuous activities before the presentation, not to be hungry or not to eat too much, it is recommended to stay away from carbonated beverages. Care must also be taken when selecting clothes. On the one hand, the selected outfit should have a respectable effect on the participants, while on the other hand it should allow the trainer to be comfortable while presenting. Tight belt, tie, uncomfortable shoes etc. it will increase the stress by distracting the trainer.

4- Visiting Presentation Place Before Presentation: If possible, reviewing the materials to be used in the place of presentation and checking the session plan and devices will reduce the presentation stress. To meet and chat with the participants a few hours before the presentation will help the trainer.

5- Doing Breathing Exercises: Taking proper and deep breathing is the most important step in the way of relaxation. Proper breathing expands the vessels and allows the blood, and therefore oxygen, to reach the most extreme points of the body. Thus, the substances that appear with anxiety (adrenaline, noradrenalin, etc.) are reduced. This makes the person calm and balanced.

TO TAKE A PROPER AND DEEP BREATH:

- Place your right palm just below your belly and your left hand on your chest.
- Thoroughly drain your lungs before breathing.
- Slowly fill your whole lung by counting "one, two". Wait for a short period of time and empty your lungs twice as much as you receive. With your right hand, you should feel yourchest bones open to the side.
- Exercise at least 4-5 normal breaths before repeating the exercise. This exercise should not be repeated in a row without interruption and should be deeply breathed maximum between 40 and 60 breaths per day.

Note to Trainer

After proper breathing technique is told to the group, the application is made.An appropriate music is set in advance for the application. (S)He teaches the group how to do it with the instructional music and performs breathing exercises and repeats it several times. 5-10 minutes is enough for this application.

Cope with Difficult Participants

Difficult participant is the fearful dream of most trainers, it is necessary to accept and be prepared those one or two difficult participants will be present in almost every education.

Common difficult participant types:

- Discussants

- Pedantic
- Speaking among themselves
- Constantly complaining
- Non-speaking / Non-Participant

It is possible to replicate the profiles covered by difficult participants; however, the way in coping is similar. First, the trainer should try to win the hard participant. They should therefore not personalize the situation and avoid discussion as much as possible. (S)He should pay attention to all participants to stand on equal distance and to give equal rights. (S)He should be open to different ideas and correct the wrong messages with an appropriate language. The trainer should not refrain from answering the questions, but if the questions or contributions are out of the context and are not in the best interest of the participants, (s)he should close the topic for reciprocal interruption. (S)He should not be discussed with participants who negatively affect the environment and flow of the class and, should ask for the reason for the behavior when speaking ended. Ignoring the person or throwing the ball to other participants is the last way to go.

Preparations Before Presentation

- Setting goals and objectives
- Analysis of the audience
- Preparation of draft plan
- Determination of methods and techniques, select of welding materials
- Flow planning: introduction, body, summary
- Practice and evaluation of performance

1 - Setting goals and objectives:

The aim of the training is to describe what participants will know or do at the end of the training.

In learning objectives, the participant's knowledge, skills and attitudes are defined in order to achieve the goal (for detailed information on the relationship between knowledge, skills, attitude areas and learning, see Basic Concepts of Education and Learning in Adults.) Two separate verbs should not be used in a learning objective sentence. Verb must comprise sufficiency meaning.(Eg: should be able to explain the pre-presentation preparations.)

Goals and objectives should be clear and measurable. At the beginning of the presentation, the participants should be informed about the goals and objectives and at the end of the presentation, what information, skills and attitudes will be gained.

2 - Analysis of the audience

See. “Positive Education Environment”

3 - Preparation of draft plan

While preparing the presentation, how to fill out the Draft Presentation Plan Form should be discussed.

Note to trainer

The trainer distributes the Draft Presentation Plan Form and it should beemphasized what needs to be taken into consideration when planning a training plan.

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4 - *Determination of methods and techniques, select of welding materials*

When determining techniques and methods in education:

- The goals and objectives of the training should be taken into account
- Review the advantages and disadvantages of training methods
- Activity scale guide should be taken
- Additional training material should be prepared
- Determine if special class arrangement is required

Table 1. Educational Methods and Techniques Activity Scale

Goals >	Knowledge	Behavior Change	Problem Solving Skills	Communication Skills	Psychomotor Skills
Methods Techniques					
Lecture	8	4	5	3	1
Group Discussion	9	10	7	8	3
Slideshow/ Video / Movie	7	4	5	2	5
Dramatization	5	9	9	9	4
Case Study	6	8	10	4	5
Coaching and Practice	6	7	9	8	10

5 - *Flow planning: introduction, body, summary*

While the configuring the prepared presentation materials the last stage is sequencing of the subjects. A presentation flow should be created considering the sections of the presentation (introduction, body, summary). In addition, the trainer should prepare the main messages, keywords, and questions of each department in a visible manner on the training notes.

6 - *Practice and evaluation of performance*

The trainer can make the presentation practice loudly by himself or (s)he can evaluate his presentation by recording his presentation. A better way to practice is to do a rehearsal with atrusted colleague and ask him to make an honest assessment. In addition, the trainer should make the presentation and prepare the hall.

Benefits of presentation practice:

- Increases self-confidence of the trainer, reduces presentation stress.
- Allows the trainer to see the gaps and materials in the preparation and to make somecorrections.
- It gives the chance to use the material more easily.
- Allows anticipating potential problems and making preparations accordingly.

- Enables visual tools to be used more regularly and in a manner to support its presentation.

Sections of The Presentation

A good presentation consists of 3 parts:

1 -*Introduction:* Explain what to tell (it represents 15% of the entire presentation time).

An effective entry is made that attracts the attention of the participants. After aim and objectives are read and continue with a smooth transition.

2 -*Body:* Tell (it represents 75% of the entire presentation time)

While lecture the presentation audio-visual tools and interactive training methods are used.

3- *Conclusion And Summary:* Tell what you said (it represents 10% of the entire presentation time)

The outlines are briefly repeated.

1- Introduction

The first few minutes of the presentation are very important. Participants will follow you through the impression that you have created in this time. The subject should not be started immediately. Participants may be wondering about something else at the time, wondering how the meeting would take place. Entering the topic immediately and maintaining the conversation will cause the unprepared attention to miss the beginning of the subject until you concentrate on you. Wait a while for the gaze to turn over before you start talking. In the meantime, a positive facial expression and body language to give you the message that you are happy to be there, or even verbal expression will make you get a good start.

Prior to start to the main topic, an effective entry application (examples are given below) is necessary to collect interest and warm up the group to the subject. After entering to the topic effectively, the entry must continue with a smooth transition, associated with the subject of the presentation. After effective introduction, the purpose is important to ensure that the targets are passed smoothly.

You should not start to the presentation with negative impressions and criticisms. Apologizing for the presentation or admitting that you are unprepared and excited, are not appropriate. Trainer should start by greeting the group and definitely introducing him/herself.

FEATURES OF EFFECTIVE INTRODUCTION:

- Attracting the whole group's attention
- Preparing participants for future reference
- Ensuring that participants understand the expectations of the instructor
- Creating a positive educational environment

EFFECTIVE INTRODUCTION TECHNIQUES:

- A number of questions can be asked about the subject
- The topic can be linked to previously processed topics
- Personal experiences can be shared
- Subject can be linked to real-life experiences
- Short film about the subject can be shown
- Moments, anecdotes, stories, etc. explicable
- Start with dramatization

2- Body

It is the widest part of the presentation. It is very important to maintain the same attention in the body part as well as to attract attention with an effective introduction. In order to keep the interest alive, the questioning technique (Question-Answer Technique, see "Teaching Methods and Techniques") should be used. However, the trainer should plan in advance what to ask at what stage of the presentation. Also, the trainer should be ready to participants' questions.

Participants can ask questions for various purposes, such as getting information, being noticed, being appreciated, commenting, deflecting the subject, and refuting what you say.

With participants' questions:

- You can receive feedback; strengthen your relationships with the participant.
- You can learn the name of the participant asking the question and you can use the effect of addressing the name.
- You will have the opportunity to repeat even if you have been talked something.
- You can show dominance in the subject.

ADVICE TO THE TRAINER:

- Should be prepared for questions
- Should not appear reluctant to answer questions
- Should not discussion with a participant
- If the answer to the question is not known, it should be said that the question is not known; the question should be directed to the group. If no one knows the answer and question is in the interest of the group, it should be promised to investigate. (The trainer should be sensitive to keeping his/her promise)
- Eye contact should not be interrupted by the person asking the question.
- The question should not be answered before the question is fully understood.
- A short and concise speech should be spoken.
- If the question is out of the topic, it should be answered if it is in the best interest of the group, if not, it can be stated that the problem is not related to the subject.

At the body part the trainer should focus on providing a better understanding of the subject and creating the desired effect in the audience. For this purpose, it should benefit from some methods to strengthen the content.

Supporting Methods in Strengthen Content:

1- Explanations of Definitions: The trainer should clarify the definition of the concepts that the participants think they do not particularly know or qualify as foreign. This is especially important for the participants to understand the next stage in informative presentations.

2- Using Statistics and Graphing: Showing the results of the measurements made by certain individuals or institutions on the subject the attention of the participants and provides a better understanding of the subject. The graph provides explanations that cannot be expressed by words. It can be very useful in a presentation that is informative and convincing.

3- Exemplify: Providing the best understanding of a subject is provided by giving examples on the subject. Giving examples during the presentation, giving clues about the

subject, more detailed considerations on the subject, provides discussion of the subject.

4- Anecdotal Narration: It is fun, interesting, and creates an intimate, sincere approach when the trainer shares an anecdote about him/her. If anecdotes belonging to others are shared, it should be sure of the accuracy.

5- Demonstration of documents: The presentation of documents which are evidence proves that the trainer is respected, at the same time, the participants get information about the past importance and details of the subject mentioned at the time.

6- Using Metaphors: Metaphor allows explanation by making use of the similarity between the two concepts. For example, presentation is like cooking. Because both of them require preparationbeforehand. It is not recommended to use metaphors very often since they can be confusing.

7- Using Positive Humor: Attention should be paid not to use humor over the physicalcharacteristics, beliefs and values of the participants.

8- Using Various Audiovisual Materials: See "Preparation and Use of Audio-Visual

Materials"CONSIDERATIONS WHEN PRESENTING:

1. Communicate with participants on a personal level.
2. Make eye contact with the participants.
3. Speak with a voice to be heard by all participants and walk equally in the classroom to all participants.
4. Use descriptions, examples, explanations, comparisons, evidence, statistical information and visual materials.
5. Be enthusiastic and enthusiastic during the presentation.
6. Use positive humor.
7. Positive feedback should be given
8. Avoid using a foreign language if there is no technical term related to the subject
9. The trainer should be a good model with the preparation of the subject, the presentationof the subject, his / her information, his / her communication with the participants and his / her appearance.
10. If necessary for the learning and reinforcement of complex subjects in the presentation, it should be shortly repeated but should be avoided frequently and unnecessarily.
11. In terms of the efficiency of training, many messages should not be given in the presentation and the participants should be given less message instead of being knowledge bombarded.
12. The use of time as planned is essential for the respect of the participants. When there is a problem with the use of time, the planning of time use should be done together with theparticipants.

3- Summary

The presentation should be completed with a summary section to ensure that the level of recall is high during the presentation. Summarizing should be short; the main points should be gatheredand the active participation of all participants should be ensured.

Summarizing Techniques:

- A login can be established by repeating the wit, citation, or information used in a differentway, or by telling the attendant
- The future can be pointed out
- In the trainings related to attitude and behavior change, the audience can share theirdecisions about the given education in the future.
- Can be linked to the flow of the next presentation
- Participants may be asked to ask questions.
- Participants can be asked about the main points of the subject
- Main points can be summarized in the game

Summarizing Application

At the end of the presentation, the trainer summarizes the main outline of the presentation. The trainer shares "Presentation Skill Assessment and Evaluation Guide" which is attached at the end of this chapter. Encourages participants to make presentations at the end of the course, taking into account the criteria set out in the guidelines.

The trainer should remind that group presentations should be accordance with the "Draft Presentation Plan Form" which is shared during the presentation

Development and Integration of Health Literacy Education with Innovative Methods in Medical Curricula Across Europe