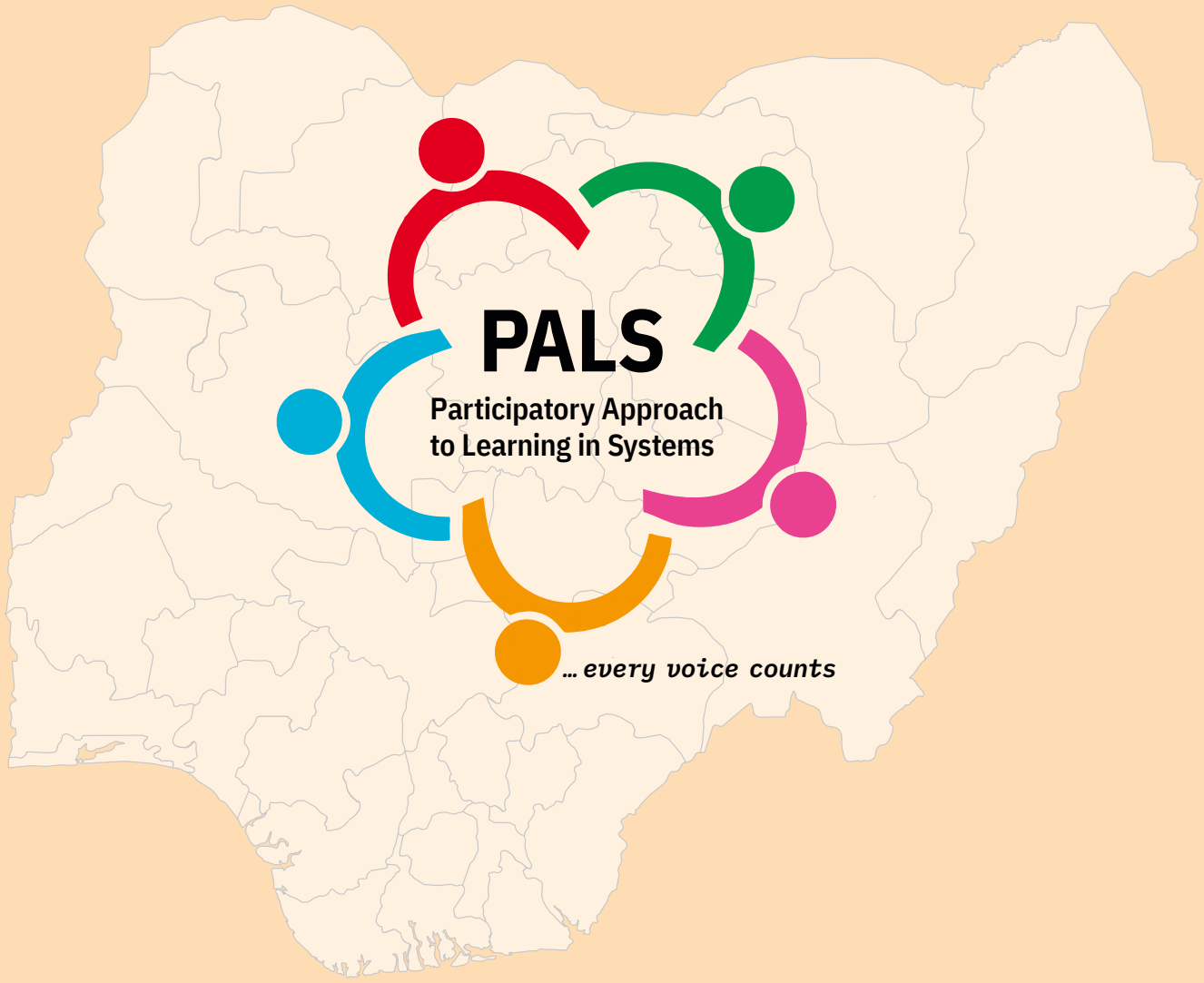
Change Agent Training Book

Participatory Approach to Learning in Systems (PALS)
For IPC Improvement in Nigerian Health Facilities

IPC for a Better Patient and Healthcare Worker Safety



NCDC
NIGERIA CENTRE FOR DISEASE CONTROL AND PREVENTION

ROBERT KOCH INSTITUT

Change Agent Training Book

Participatory Approach to Learning in Systems (PALS)

Imprint

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Participatory Approach to Learning in Systems (PALS)

For IPC Improvement in Nigerian Health Facilities

IPC for a Better Patient and Healthcare Worker Safety

“PALS: Catalyzing the Power of People for Sustainable IPC Improvement in Health Facilities”

(Slogan of the first PALS conference held in Abuja, December 2023)

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Abbreviations

CA	Change Agent
PALS	Participatory Approach to Learning in Systems
MD	Medical Director
CMD	Chief Medical Director
CMAC	Chair Medical Advisory Committee
CSSD	Central Sterile Services Department
PPE	Personal Protective Equipment
HM	Hospital Management
HMB	Hospital Management Board
IPC	Infection Prevention and Control
NCDC	Nigeria Centre for Disease Control and Prevention
RKI	Robert Koch Institute
MoH	Ministry of Health
HF	Health Facility
WS	Workshop
FPH	Field phase
TCI	Theme-Centered Interaction
PA	Participatory Approach
SV	Systemic View
4FS	Four Factor Structure

A PALSy Welcome

Welcome to the Change Agent program. As a healthcare worker and an Infection Control practitioner, you have yearned to do more and to be more effective in implementing IPC in your facility and reducing the threat of healthcare associated infections (HAIs). You have worked hard but have often felt some frustration when your efforts and the efforts of your colleagues did not lead to the changes you desire.

That is understandable. In the Change Agent program, you will learn through PALS valuable practical skills that will help you to make better contributions as a member of the IPC team in your facility. You will learn non-violent, respectful interpersonal communication that lets every voice count. You will learn the power of teamwork and how to achieve more as a team. And you will learn how to focus on finding local solutions that are tailored to the peculiar circumstances of your work environment. Above all, you will learn how to better leverage institutional structures including health facility management to strengthen and support the work you do.

The Nigerian health system is at a pivotal moment as we see the increase in the threat of antimicrobial resistance, most of which are healthcare associated as well as the emergence of new and re-emerging life-threatening infections. The nation looks up to you. You operate at the critical last mile of healthcare, the health facility.

So, I am happy to extend this PALSy welcome to you as you undergo the Change Agent training. Enjoy the PALS experience and let it become the new way you work. PALS after all, is a way of life.

Dr Jide Idris
Director General
Nigeria Centre for Disease Control and Prevention

Foreword

It is a privilege to write the foreword to this Change Agent Training Book. I feel a sense of deep fulfilment that the efforts of the last five years have resulted in this landmark publication.

Infection Prevention and Control (IPC) is an evidence-based practice which aims to prevent patients and health care personnel from acquiring preventable infections in healthcare. With the increasing threat of antimicrobial resistance most of which are healthcare asssociated and emergence of new and re-emerging life-threatening infections, effective infection control practices that prevent or reduce the prevalence of healthcare-associated infections have become even more critical. Yet, training that has focused only on the technical and fact-based understanding of IPC practice has not always yielded the desired results. Researchers have found that the current training circumstances are considered insufficient, given the low level of compliance. Hence, more effective education which recognizes the contextual features of the healthcare facility as a complex social system is essential to improve infection control practices.

The PALS Change Agent program is one way that we have tried to make IPC education "more effective". It builds on the key pillars of teamwork, equitable communication and leverages the experiences of local players and the local conditions in the health facility to address identified challenges. The approach adds a social and systemic organizational lens to the clinical or technical knowledge to make effective implementation possible.

In collaboration with the Robert Koch Institute in Germany, the Nigeria Centre for Disease Control and Prevention has implemented the Change Agent training program since 2019. Now, the Change Agent program has been incorporated into our National IPC Program as one more tool to implement IPC in the country.

I am excited to be part of this unfolding historical development. I am even more excited that we now publish the Change Agent Training Book. This is one in a series of training handbooks for various target groups. May this training book serve to strengthen IPC teams in health facilities across the country for more effective IPC practice.

Dr Tochi Okwor
National IPC Programme Coordinator and Chair, Antimicrobial Resistance Coordinating Committee
Nigeria Centre for Disease Control and Prevention

Acknowledgements

The PALS Change Agent Training Book reflects the intensive work of the last five years, in which many colleagues from different countries and states in Nigeria and in different roles actively participated. We are proud to stand on their shoulders:

We are grateful for the contributions of the public health experts and PALS visionaries of the MAURICE project (2017–2018) from Nigeria and Germany (Dr Yahya Disu, Dr Ita Okokon Ita, Dr Thairu Yunusa, Dr M. M Saleh, Dr Gaby Poggensee, Mr Abiodun Ogunniyi, Mr Steven Onimisi, Ms Chioma Dan-Nwafor, Dr Winifred Sandra Ukponu).

We acknowledge the first cohort of PALS trainers (2019–2022) from Ebonyi, Edo, Ondo, and FCT for their commitment, enthusiasm and willingness to join us in this exciting PALS journey and share their practical experiences of PALS with us: Professor Steve Abah, Professor Chiedozie Kingsley Ojide, Dr Abejegah Chuckwuyem, Dr Alfred Friday Una, Dr Airefetalor Amanda Ivie, Dr Juliet Sebastine, Dr Nelson Adedosu, Dr Maero Origho, Dr Mercy Aiguomodu, Dr Olubunmi Ojji, Dr Usman Abdurahman, Mr Benson Agwu, Mr Johnson Joseph Ojo, Mr Michael Aluu, Mr Simeon Chubiyor Usman, Mrs Blessing Onyia, Mrs Florence Isuh, and Mrs Olaseigbe Olasimbo Banke.

We are grateful for the collaboration with many Change Agents and their hospital managements across Nigeria. Only by working with practitioners we have been able to gain deep insights into the different realities of hospitals and health care practice. We have seen how PALS has led to small IPC changes in well-planned and continuous improvement processes as well as amazing, huge improvements in working conditions (water supply, electricity coverage) that have laid the foundation for quality healthcare and IPC routines in the first place.

Last but not the least, we are grateful for the institutional trust and support that the NiCaDe-IPC project team received from the leadership and from colleagues at NCDC and RKI.

Introduction

The Challenge in IPC Practice

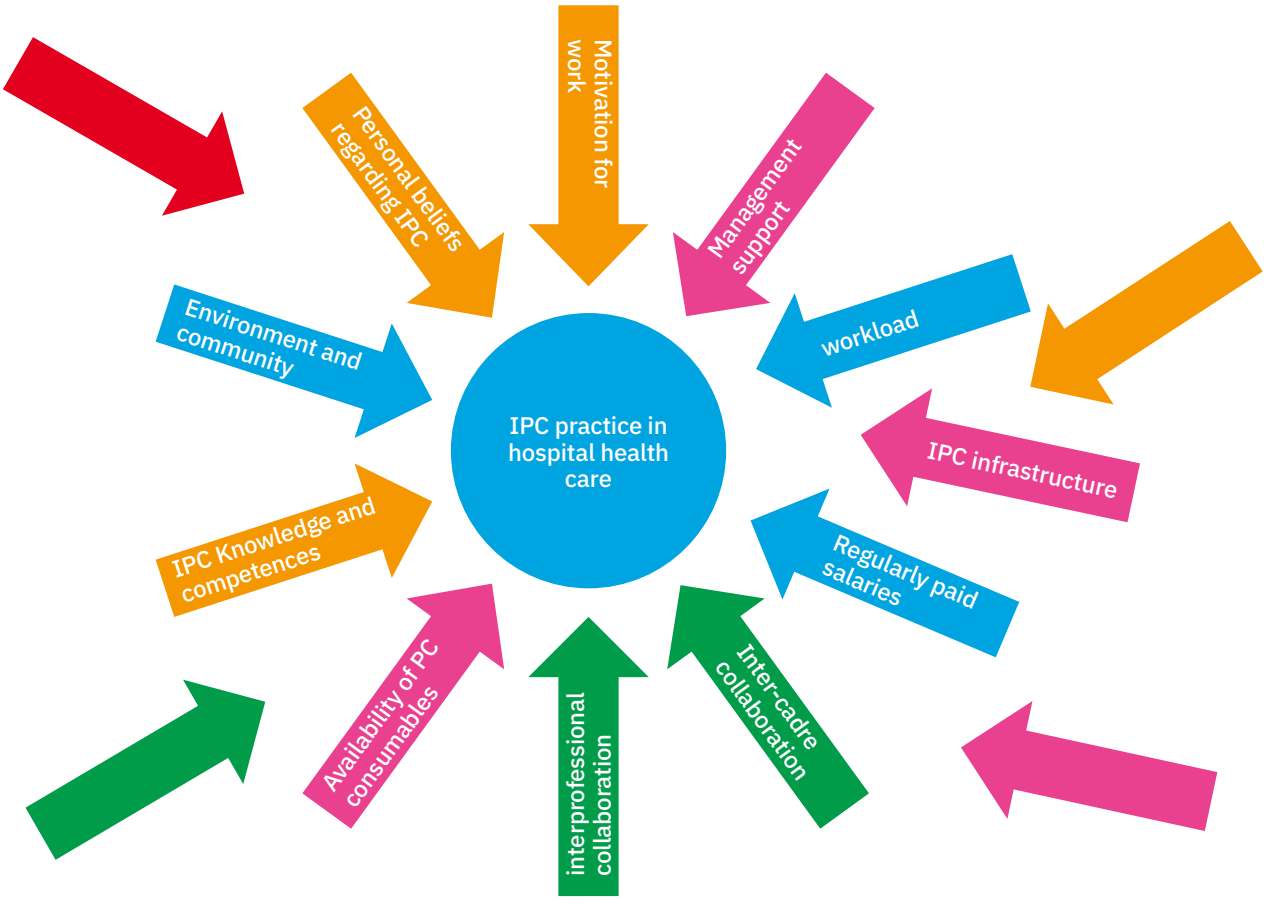
A newly employed clinical officer set an IV line to give medication. He left the needle on the patient's bed instead of dropping it inside the overfilled sharp box. The cleaner packed the linen to the laundry unhurt, however the laundry worker was pricked while sorting out the linen before washing.

IPC practice is a very complex activity that involves almost all health care routines in the hospital. It involves different professional groups and cadres. IPC is team work: for IPC to be effective all forces in the hospital like, cleaners, environmentalists and waste handlers, doctors, nurses, lab personnel and their medical directors need to understand and practice it. Even the patients themselves and their care givers are part of the chain of infection. Therefore, IPC needs functional infrastructure.

A lack of IPC knowledge, formal training of healthcare workers (HCW) and insufficient IPC infrastructure in health facilities are certainly the main reasons for the high rates of healthcare associated infections. But compliance with IPC standards becomes a major challenge during healthcare delivery especially when workload is overwhelming and wards are understaffed; therefore, even when IPC knowledge exists it is not always practiced and although IPC consumables may be available, they may not be properly utilized. Many factors influence professional IPC routines. The fight against the COVID-19 pandemic has shown once more the difficulty in implementing IPC practice effectively in health facilities: COVID-19 outbreaks affected patients, care givers and personnel in hospitals around the globe.

The question is, how can the IPC situation in the local reality of a health facility be improved? What can be done in the prevailing conditions? How can existing resources be mobilized and how can IPC practitioners interact effectively with their hospital management to improve the situation?

Figure 1: **Influencing Factors for Good IPC Practice in Health Care Service**



There are still some arrows without labelling in the graphic. Please think about additional influencing factors you would like to add? From your point of view: What are the most important hindering and supporting factors for good IPC practice in your hospital right now?

IPC strategies seem to work better when professional knowledge and competences, supportive working conditions (in terms of available IPC consumables and infrastructure, strong leadership, continuous supportive mentoring) and a productive culture of teamwork come together. Studies suggest that ownership and ongoing awareness are probably higher when the needs and perspectives, the ideas and the experiences of the actors themselves get visible and become a starting point for locally tailored change processes.

PALS shows innovative pathways to approach the problem …

We developed a training approach for an IPC programme that promotes the development of social competences and attitudes towards a vital IPC culture where every voice counts: the Participatory Approach to Learning in Systems, PALS.[1] PALS is integrated into the National IPC Strategy in Nigeria. The NCDC is promoting this approach.

1 The PALS concept was developed by the NCDC and the RKI during two project phases (NiCaDe-IPC project https://nicadeipcpals.ncdc.gov.ng/) based on a first pilot project called MAURICE in 2018 (Zocher et al., 2019). The interdisciplinary project team, compiled by public health experts and educators, implemented the IPC practice and training approach in secondary and tertiary health facilities in Nigeria. All training modules and materials have been evaluated, reviewed and adapted where necessary. PALS is an ongoing inquiry and learning process.

The PALS Multi-Module Training Programme for Change Agents and Hospital Management

Beside the Change Agents (CAs), the hospital managements (HM) of the participating hospitals are part of the multi-module Training Programme and are engaged with throughout the whole programme: we believe that changes for better IPC and improvement processes can only be reached by a strong collaboration of all members of the hospital. HM plays a key role in these processes. Change Agents and their Medical Directors or Chief Medical Directors are the driving force behind the development of an effective and appreciative IPC work culture in hospitals.

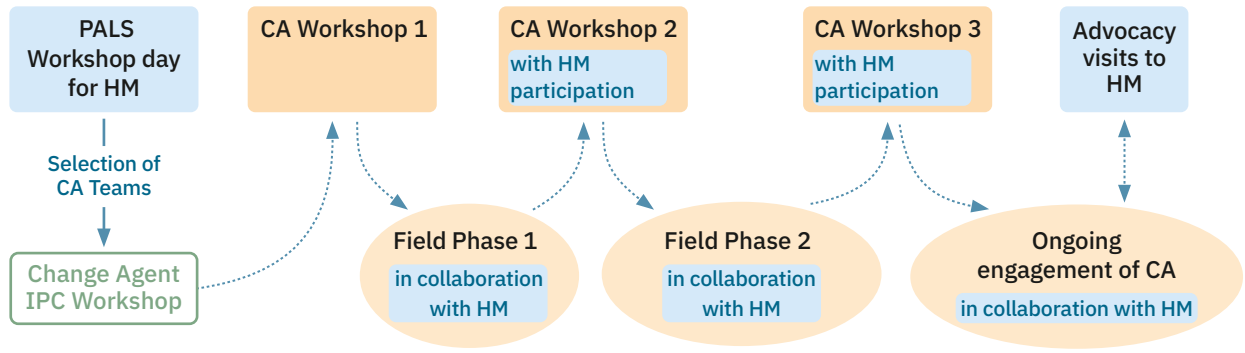
The HM select the Change Agents based on their competences, role and engagement in the hospital service. The CA teams are composed of four health care workers from the facility, representing different cadres of hospital personnel. If possible, members of the CA team should already be involved in the existing IPC structure on ground (IPC committee, IPC Team, IPC focal person, link-nurses).

> **"What is different with this project from other similar projects is taking ownership and also the use of the Participatory Approach and Systemic View for decision making. The Participatory Approach has changed my orientation in terms of managing human beings. It involves everybody and makes them feel important, when they do so, they feel they are the owners of the project."**
> *(Change Agent, Lagos 2018)*

The objective of the PALS Training Programme is to improve IPC understanding amongst the CAs and to foster their 'enabling skills': skills to organize and support the transfer of IPC knowledge into the very specific working routines in the local settings and to collaborate fruitfully together. Communication is at the core of these tools. The participating health care workers will be trained in these skills as IPC Change Agents.

Consequently, the training programme does not primarily focus on imparting IPC knowledge, but on the necessary social skills of healthcare staff in order to improve the IPC practice culture in hospitals. We assume that colleagues have basic IPC knowledge, that IPC knowledge has already been gained or can be provided if required.

Figure 2: **PALS Multi-Module Training Programme for Change Agents (CAs) and Hospital Management (HM)**



IPC experts who are trained as PALS trainers will train the participants in being Change Agents. They will mentor them during the training workshops as well as while translating the approach in their workplaces.

The training will be hold with groups of maximum 20-24 participants and will be carried out in two workshops of approximately 4 days each and a 4-6 weeks field phase in between. The mentoring phase (which is a second field phase) starts immediately after the workshop 2 and lasts about 6 months: weekly contact (phone calls, emails, messages) and at least one monthly onsite visit by a PALS Trainer will help CAs to use and apply PALS in the hospital routines and support the improvement of an IPC working culture on ground.

CAs document and monitor all steps of working towards IPC improvement in order to see how their IPC culture has grown and where they need to modify activities or fine-tune processes. CA teams are accompanied by one or more experienced PALS trainer who will celebrate you even for small successes, be on your side and give a helping hand whenever challenges occur.

A PALS Change Agent is a self-motivated health care worker, enabled with PALS understanding and practice skills. S/he is a facilitator of IPC change in her/his health facility. S/he participatorily leads and encourages others to generate locally tailored IPC improvement processes by

- listening actively to all colleagues and their perspectives on IPC issues and work conditions,
- understanding and appreciating different ideas,
- communicating in a non-violent way, carried on by the will of understanding and the spirit of inquiry,
- sharing ideas and decision making with other actors on how to move forward
- collaborating creatively together and try out new ways (thinking out of the box),
- implementing IPC improvement activities and constantly sharing information about these processes.

Change Agents act as role models of PALS and work together in a team. They are constantly in exchange with the IPC infrastructure on ground as well as with their hospital management. Change Agent teams will find it easy to understand IPC as a holistic challenge, approach potentials and human and financial resources; they reinforce all that already works well in the hospital!

We assume that you already embedded many of these features in your daily work routine and in your attitude which guides you through your work.
What do you think about your future role as CAs? Which challenges do you anticipate? What strengths do you already recognize in yourself and in your colleagues from the hospital in this regard?

What does the Change Agent Training Book Provide?

In this Training Book we describe the PALS in Practice approach in IPC, its mindset, models, tools and templates. It supports CAs both in actively engaging with and understanding the approach during the PALS training programme and in translating it into tailored IPC practice changes in their hospitals.

In addition to the descriptions of the concept in the paragraphs, coloured boxes accompany the use of the book:

We have summarised key statements on the concept in orange framed boxes to provide CAs with a quick thematic overview.

Orange boxes encourage CAs to think and reflect together with others in order to relate the concept to their hospital reality and to critically questioning it.

Quotes from previous participants in PALS programmes and short case studies from everyday hospital life are included in pink boxes for illustrative purposes.

The final chapter “How to Organize and Facilitate PALSy IPC Improvement” is dedicated exclusively to the implementation of PALS in IPC improvement and assigns PALS methods to different phases of activities in a change process.

The compilation of PALS perspectives and methods in this Training Book cannot replace the active and collective experience of the training programme and the incorporated field phases. Understanding PALS is an intensive process that has to be experienced and lived, an inquiry into new mindsets and patterns of behavior. This happens in teams and in the hospital, in the reality for which PALS was developed, accompanied and supported by competent PALS trainers.

1. PALS: A Practice Approach for IPC Improvement in Hospitals

PALS is the combination of the Participatory Approach (PA) and a systemic, holistic view reflected by the four-factor structure (4FS, Theme Centred Interaction) which focus on the organisation, the relationship and collaboration. Both core elements are part of bigger concepts which are well proven. Both indicate a certain understanding of change processes, personal growth and emphasize a special way of how we talk to each other, understand each other and most productively collaborate.

IPC practice in hospitals will only change sustainably if evidence-based knowledge about IPC is reflected on local competences, working conditions and understanding of the context as well as skillful and appreciative cooperation of all colleagues involved - colleagues with different professional backgrounds and roles, from cleaning staff to hospital management.

What do you think about this description of the IPC practice as a social and context-related endeavour?

The practice of PALS in hospitals has shown that a third pillar is important and had to be integrated into the concept of PALS: team work. In order to effect even small changes in the reality of a hospital, which means to modify well established patterns of behaviour and mindsets, the team cohesion amongst Change Agents seems to be almost a precondition for success. Only when Change Agents work together can they create a certain PALS spirit and find the energy to act accordingly in collaboration with other colleagues and actors in the hospital.

The PALS Slogans

To provide a handier description of the PALS approach and to communicate what it means, PALS mentors and former participants created slogans. The slogans express that PALS is not only a technique but an approach, a way of thinking and working. One of the most famous might be “Every voice counts!” which is part of our PALS logo.

The slogans have become an important way of communication in all meetings and trainings. We always invent new slogans - this is an open collection and we are looking forward to add another one to this page!

Space for your PALS slogan coming up during the training programme ...

The slogans are based on the understanding of a PALSy change and IPC improvement process. You will experience many of them during this training by exercises, discussions or other interactive sessions.

Figure 3: **PALS Slogans**

1.1 The Participatory Approach

The Participatory Approach in IPC means that CAs start the IPC improvement based on the local perspectives of needs, the local resources and the interaction with colleagues in the local context of healthcare service. This happens embedded into the local IPC infrastructure on ground, e.g. the annual IPC activity plan (if available). The constant support of local institutional leadership is needed.

The basic principles of the Participatory Approach (PA) are:

- Respectful, accommodating and candid collaboration (expert meets expert)
- Respectful, non-threatening communication.
- The expertise is "local" (local knowledge, local context, local solutions) as a starting point of any process.
- Participation should happen on all steps of intervention: decision making, planning, implementing and monitoring and evaluation (Public Health Action Cycle).
- Resource and solution-oriented procedures (don't get stuck in a problem-trance).
- Changes and improvements have to suit the concrete work context: tailored solutions.
- No blaming working style, but a correction friendly working culture
- Appreciative working attitude.

The health care workers become the main actors in the IPC change and improvement process!
Institutional support and encouragement are needed for all activities.

You are the expert on the IPC situation in your health facility on the strengths and weaknesses in your hospital. During the Training Programme the PALS trainer will listen to you, try to understand your ideas, discuss with you and support you in what you think is the best way to start an IPC improvement process. You will do the same when you are back in the hospital: Listen to all colleagues of different professional groups and cadres involved to better understand their perspectives.

It is important that you feel the spirit of participatory collaboration and experience a PALSy way of communication: a way of working together which is stimulating and appreciative.

You as a team of CAs and your colleagues in the hospital are full of ideas and skills to address IPC challenges and find solutions - many of them you have already put into practice and you invent new ones every day by coping with your challenging and sometimes inadequate working conditions.

Constructive collaboration between all health workers and management is essential for sustainable improvement: together we will work on this and reflect on daily problems and professional attitudes.

Some suggestions for further discussion on the basic principles of the PA are compiled in the box below.

Colleagues report that the collaboration in hospitals is rarely characterized by features like the list above. How is the situation in your hospital? Where do you experience a participatory spirit in your work area or even outside, in your private world?
Or: PALS Change Agents reported that applying a PALSy communication opened up new ways of collaboration and understanding. Can you imagine what happens if someone starts showing appreciation for the work you are doing and even keeps calm if an error happened and instead of
blaming you, tries to understand what led to the mistake and how to resolve the matter?
Or: The cleaning staff are invited to an internal hospital meeting about IPC for the first time. A cleaner sits next to a doctor and a nurse. When the discussion turns to the availability of IPC materials and working conditions, he stands up and talks about the lack of materials and personal protective equipment available to him and his colleagues, as well as the difficulties of organising their cleaning rounds amongst themselves and coordinating them in the hospital schedule. He sounds unhappy and somehow frustrated as he speaks, and also a bit insecure. It is probably the first time he talks in front of clinicians. As the CA and facilitator of the meeting who invited the cleaning staff to this assembly, would you react to his comment and if yes, how?

1.1.1. Spectrum of Participation

The spectrum of participation shows different grades of participation of the target group.[2] The authors clarify that participation always involves the dynamics of who has the power to make decisions. Providing the target group with the opportunity to discuss their problems and formulate the most important challenges from their perspective is already an important step towards participation. However, as long as they have no voice in the decision-making process, such involvement is at the "preliminary stage of participation". The freedom and responsibility of decision-making is essential for the quality of participation in a process: only participation in decision-making processes creates ownership and responsibility and further empowers the actors.

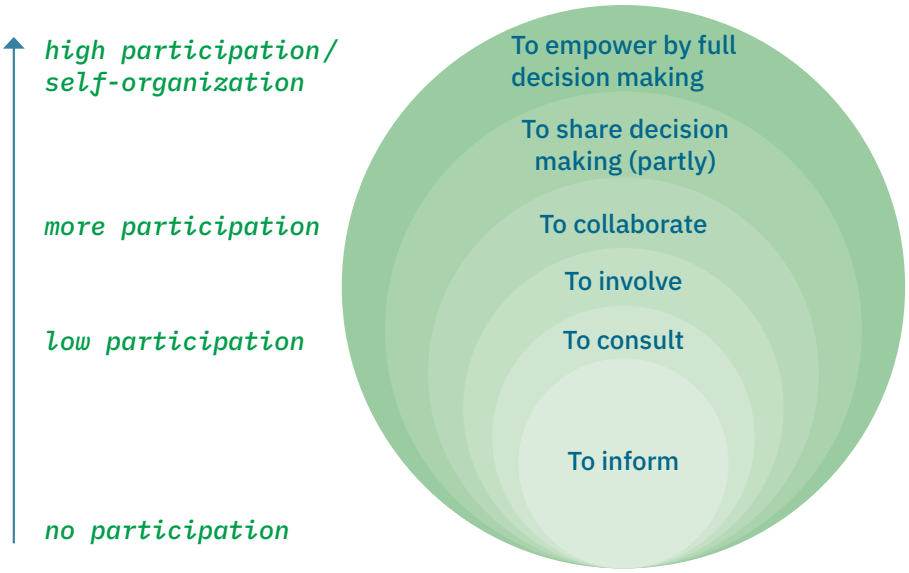
Unfortunately, in trainings as well as in the dally working situations, people very often only give instructions and information to others. They show how to do the right thing and blame it on the missing willingness of a person when s/he does not apply it in routine practice. This approach does not work at all and is far from a participatory working culture where ownership and commitment can grow.

What does that mean in practice?

It starts by e.g. inviting all affected, concerned, involved, impacted colleagues to a round table discussion, to listen actively to people’s perspectives and opinions, invite them to participate in a meeting, to do a blitz interview or ask them to take pictures on an IPC situation they want to discuss.

2 For further reading on the levels of participation, see “Participatory Quality Development. Concepts, Toolkit and Case Studies”. https://www.iqhiv.org/fileadmin/stuff/pdf/Tool-PQD-EN.pdf

Figure 4: **Spectrum of Participation**



Source: **adapted from International Association for Public Participation, 2007**

It is important to encourage colleagues to speak up without any fear – showing a picture they took might help in this regard. From your experience, which steps of the spectrum of participation are the most challenging? Which professional group in the hospital seems to be easier to motivate to act participatorily? Why?

Working together in a participatory way offers many advantages:

- More ideas and human resources are brought into the process and enrich the understanding of the identified IPC challenge.
- Shared decision making and shared responsibilities: workload can be distributed more equitably and actors develop the sense of ownership.
- A participatory planned process has more possibilities to be successful by finding tailored solutions.
- A participatory planned process is owned by all actors and creates a flow of motivation and mutual support; the sense of responsibility grows.
- All actors provide mutual support to ensure success in the implementation, and where there is a need to adjust the plan, everyone is involved and success is seen as the effort of the team, not of just a few.

Waste is not properly managed in your health facility and you can see over-filled sharp boxes, no color-coded bins, there is waste outside the hospital buildings, even in the rest rooms. There have been series of attempts by the IPC Team to improve the situation, but for several reasons had limited progress like lack of commitment, paucity of resources, attitudinal issues by healthcare workers, and poor management support. The CA team of the hospital was recently appointed to help address this challenge.
Who needs to sit together to discuss? Who decides on what the problem is? Reflect on these questions having the spectrum of participation in mind.

In PALS, the Participatory Approach is complemented and enhanced by a Systemic View and a relational understanding of the complexity of IPC and change processes.

1.2 The Systemic View

The System Theory describes an interdisciplinary concept of analysis of all kinds of systems regarding their structure, dynamics and function. It generally assumes that a system, an organization, unit or institution like a hospital basically consists of relationships and roles: it is a vital human system, interdependent, constantly in interaction and nothing beside the building itself is cast in stone. A system, like the hospital, can change by changing the way colleagues relate to each other and collaborate differently with their management. A system is like a slippery-slope or ripple-effect: The behaviour of the single individual, like a HCW might influence the behaviour of others and so on.

Furthermore, the behaviour of the single individual should always be seen and understood in its context. This means that behaviour is not static and acontextual. A nurse or a doctor, a cleaner, a patient or an MD does not “always” act in a certain way or “is” one way or the other by nature. How someone acts and reacts is influenced by a complex network of personal perspectives and, e.g. other people, situational factors, current mood, framework conditions or the culture of the organisation. The observer of a certain behaviour of somebody is also influenced by these aspects, which are then reflected in the interpretation and judgment of what has been observed and understood.

> With this holistic view of the hospital in mind: what role do patients and their caregivers play in relation to IPC practice and healthcare associated infections? How do the organisation of care and the conditions in the hospital influence their behaviour?

The Theme Centred Interaction (TCI), developed by Ruth Cohn in the early 60s represents this understanding. TCI transfers the systemic perspective into more concrete learning of teams and stimulation of change processes. Cohn generally promotes “living learning” in various contexts and makes teamwork more constructive and efficient[3].

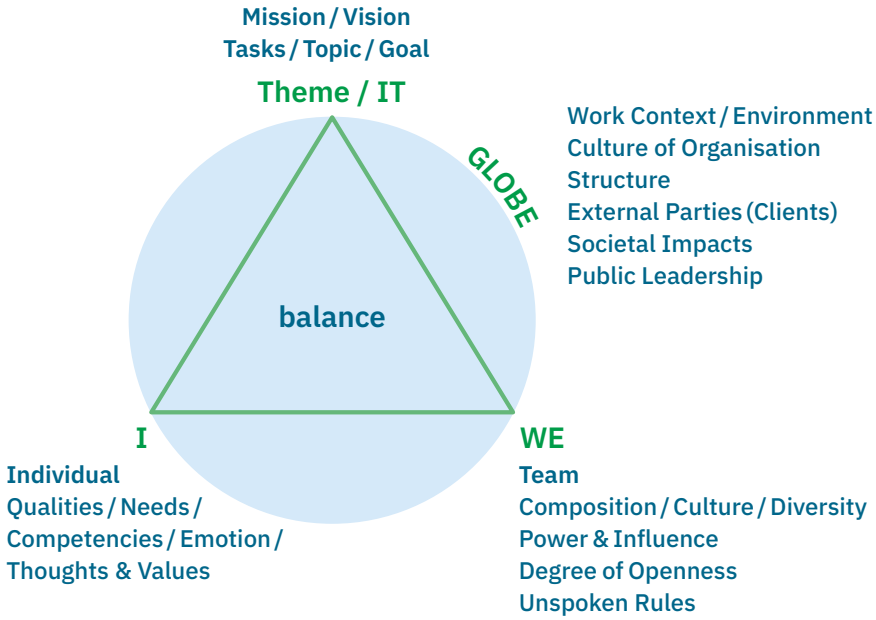
Cohn assumes that a group usually comes together - especially in a working context - in order to accomplish a task, for example, to improve IPC in a hospital. This task (THEME or IT) should be the focus of attention of the group. Each member of the working group (I or ME) has to relate to the topic and bring in his/her individual competences, questions, feelings etc. Of similar importance is the relationship and collaboration among the group members (WE) and the work conditions (GLOBE) under which the work takes place. The objective of teamwork is a good quality of process and result, personal growths of all participating members and if possible, an improvement of the surrounding conditions of work.

3 For a deeper insight, see chapter "The Globe" in the “Handbook of Theme-Centered Interaction”. https://www.vr-elibrary.de/doi/pdf/10.13109/9783666451904.125

Central to this concept is the Four Factor Structure (4FS), which defines the outlined complexity above in four influencing factors for successful collaboration in a team. The four factors are:

1. **Theme / It:** The characteristics or elements of the task or theme in question.
2. **I:** Individual factors including knowledge, skill, attitude, belief, perception, values etc.
3. **We:** The relational aspect between the group members including shared goals, complementary roles, effective communication, supportive relationships etc.
4. **Globe:** The environment and contexts that influence individual performance, relational aspects and the topic/task itself. The Globe is made by concrete circumstances (such as infrastructure of a health facility, climate in the area, or the political system in place) but also by more energetical/non material conditions (such as culture, the vogue or "Zeitgeist" – "spirit of the age").

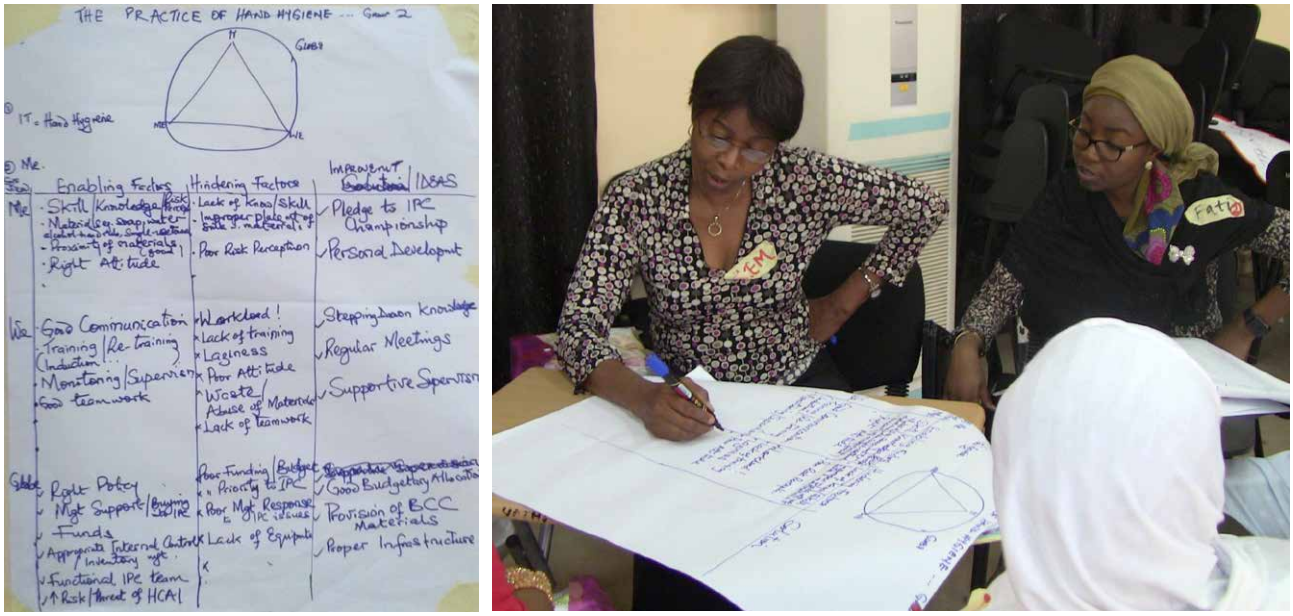
Figure 5: **Four Factor Structure (4FS)**



Change Agents use the 4FS in many ways, e.g. to analyse the problem of hand hygiene in their hospital by discussing hindering and enabling factors for the THEME, the I/ME, the WE, and the GLOBE. The next steps to improve this matter can be developed based on this analysis without losing the holistic view.

> Think of a teamwork or collegial collaboration which works or worked very well in your hospital. What made it work so well? How do/did you feel working in this group? What is/was the topic and how is/was the quality of the results in this working group? Under which GLOBE conditions does/did the group work take place?

During a learning or change process, all the four factors constantly interact and have to be monitored to be in a balance in order to serve the task and create personal growth for the actors. The model can be used in different ways: to plan an intervention, to analyse a problem, to understand the needs of a group or a task.



Change Agents using the Four Factor Structure to analyse the practice of hand hygiene in their health facility.

The balance of the four factors for learning and team work described by R. Cohn can provide important insights for planning, implementing and analysing challenges, training situations or change processes. All factors have to be reflected before starting a process and also during it. If problems occur, motivation goes down, colleagues get off, it might be helpful to check the four factors:

- Do we all have the same understanding of the task? Are we still focussed on it?
- Is the team in contact? Does the team collaborate well? Are there any tensions between team members?
- Are the resources and competencies of the individual members stimulated and included in the process? Does everyone bring in his/her competences?
- How are our working conditions? Are they supportive? What do we need to work best and fulfil our task? What do we need in order to feel good while doing our job?

1.3 The Translation of PALS Into Practice

Understanding the Participatory Approach and the Systemic View leads to a modified perspective of situation of collaboration in general or more specifically, on IPC related processes in the hospital.

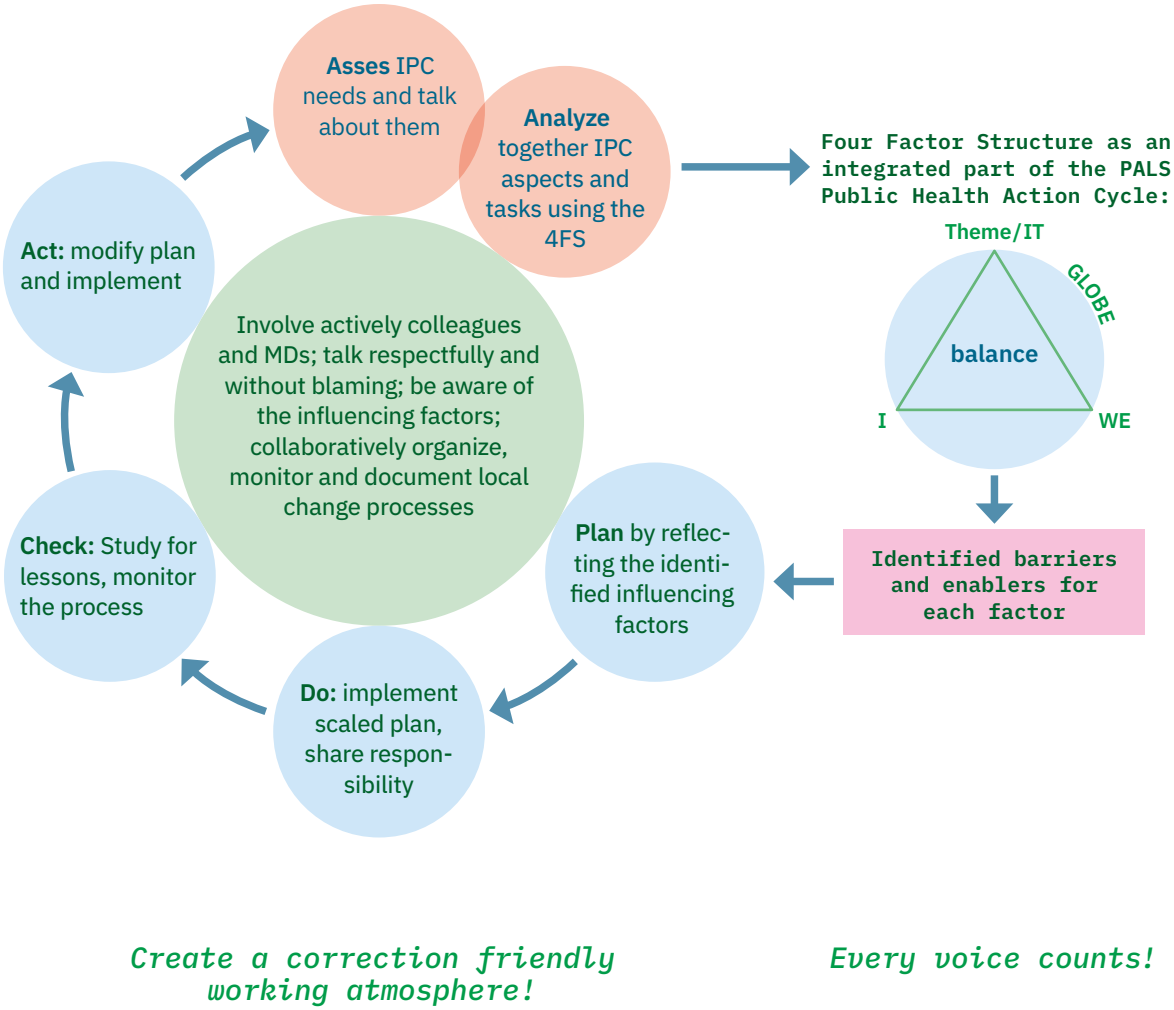
1.3.1 The PALS Public Health Action Cycle

In the field of Public Health and Health Promotion the Public Health Action Cycle is well noted. It describes a process of action by four activities: planning based on a needs assessment, doing or implementing, to check and reflect in order to act again.

The project team developed the PALS Public Health Action Cycle (PALS-PHAC) that shows how the Participatory Approach and the Systemic View are translated into

action. This cycle of PALSy engagement might lead and support the implementation of concrete IPC change processes in hospitals. The graphic shows a PHAC that is modified and further developed with PALSy aspects (see also chapter 3.1.3).

Figure 6: **The PALS Public Health Action Cycle**



1.3.2 The PALS Stories from Ebonyi and Ondo – an Approach to Improve IPC Practice

The following short stories from colleagues describe how they used PALS to improve IPC processes and standards in their hospitals. The first example talks about an intervention in the Central Sterile Services Department (CSSD) in a tertiary hospital in Ebonyi. The second also deals with an activity in the CSSD also in a tertiary hospital in Ondo and was done differently. Both interventions focus on the same area of IPC need but were adapted to the local conditions and the resources and established relationships in place.

The Ebonyi Story

WALK THROUGH SURVEY AND PROPOSED INTERVENTION TO BRIDGE IDENTIFIED GAPS AT CSSD OF AEFUTHA

> **"Initially the approach was confusing to me but when we used it in my facility, I understood the importance of the tools, the models and the approach towards achieving the results."** *(Change Agent, Abuja 2023)*

A walk-through assessment at the CSSD of Alex Ekwueme Federal University Teaching Hospital Abakaliki (AEFUTHA) revealed a haphazard movement of staff, materials, medical equipment and instruments. Following a participatory interaction of the IPC Team and staff of the CSSD, a number of gaps in the operation were discovered and the need to make changes. Some of these were: there was no unidirectional movement from the receiving point of contaminated instruments to the exit point of sterilized one; contaminated instruments from the service point were kept on the same table where sterilized ones were packaged. Both used and contaminated instruments were washed inside the CSSD. Even on the shelves, the separation of sterile and contaminated instruments was not properly done. Movement of staff was also crisscrossing in the CSSD. These practices increased the risk of contamination of sterilized instruments with the consequences of increased incidence of Health Care Associated Infections in the health facility.

Having identified these gaps, the IPC team engaged the CSSD personnel in a discussion that was approached as a boss-subordinate encounter. The team attributed the non-adherence to IPC best practices by the CSSD staff to their incompetence and leadership failure. Every member of the department had a share of blame for their ineptitude and lack of knowledge and skill. The IPC team suggested practical solutions on how to reorganize the CSSD to the staff. There was no documentation of the gaps nor the identified solution. The viewpoints of the staff were not sought both in the identification of the gaps and in proffering solutions therein. In fact, the personnel of the CSSD did not participate actively in either. It was only the Matron in Charge that took the team round the unit and responded to a few questions and clarification sought by the team. The team promised to come back on a later date that was not scheduled. On the day of the unscheduled second visit, the team discovered that nothing had changed. Instead, there was obvious nonchalant attitude of the personnel towards the visiting team as the Matron in Charge excused herself and left for a meeting. Other members of staff declined talking as they were not permitted by the Matron to do so.

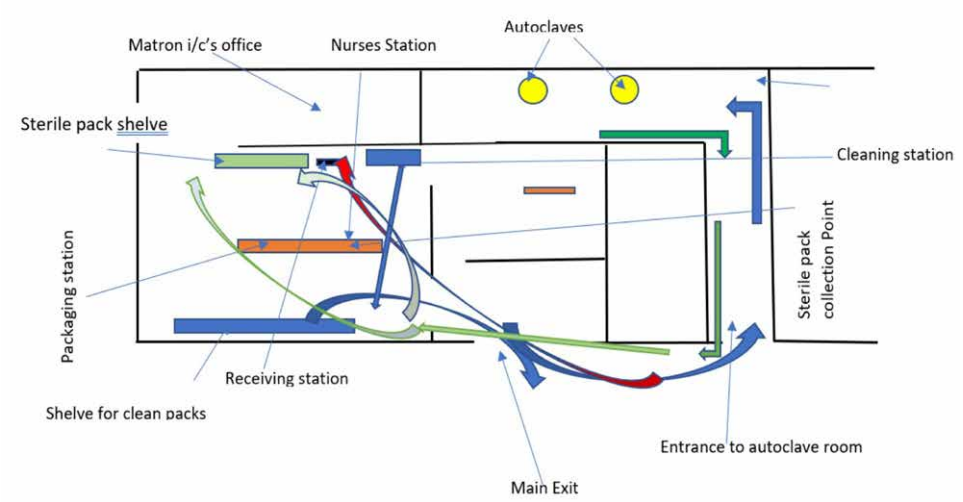
Following this failure in communication and intervention, the IPC Team decided to use a different approach. Date for a reassessment of the CSSD was rescheduled with an input from the Matron in Charge. Before the visit, the IPC Team resolved to adopt the PALS approach during the reassessment and solution identification.

In preparation for the visit, the IPC team informed the CSSD staff about the plan for a visit and the purpose thereof. By means of effective communication of the IPC Team with CSSD personnel along with supportive supervision, these gaps were identified and reaffirmed. During the visit, the IPC team moderated a discussion on IPC best practices in the CSSD. This was useful in the identification of the gaps mentioned earlier.

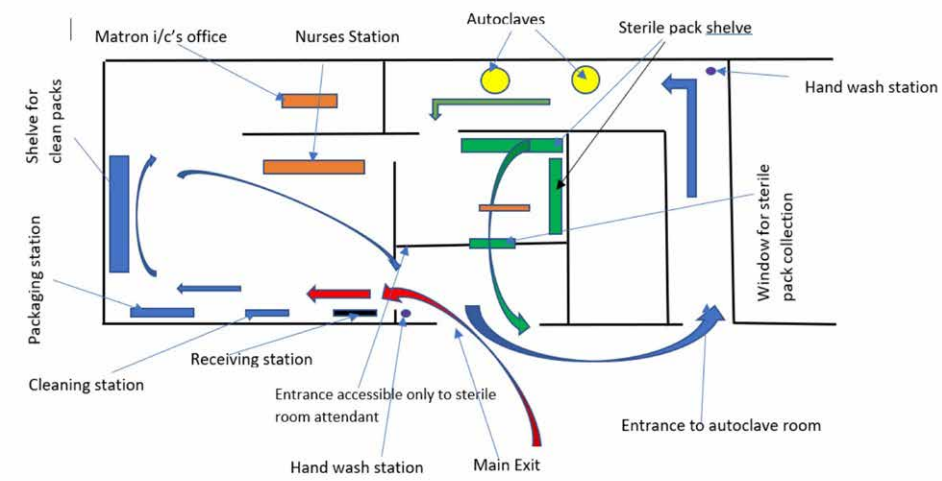
The IPC team used the four factor model to guide the personnel of the CSSD to identify their roles and responsibilities in closing the identified gaps, both as individuals and as a group. The CSSD staff also identified the place of facility top management in optimizing service delivery and IPC practices in the CSSD, including the Chief Medical Director.

Together with the CSSD personnel, the IPC Team drafted a proposal for change which was presented to the hospital management. The proposal clearly stated the identified goals and the problem statement. The proposal outlined practical solutions aimed at reorganizing/streamlining the workflow in the CSSD in order to prevent cross contamination of sterile instruments by contaminated ones or staff of CSSD contaminating sterilized instruments. These were implemented, and the problem was solved.

The following diagrams show the workflow before the assessment and the proposed workflow which was eventually implemented.



Workflow at the AEFUTHA 2 CSSD before the intervention



Workflow at the AEFUTHA 2 CSSD after the intervention

The Ondo Story

ONDO STATE TEAM VISIT TO CSSD FMC, OWO, ONDO STATE

We will like to share the summary of our experience at the CSSD Department before and after our encounter with PALS training.

The CSSD at Federal Medical Center (FMC) Owo is the main theatre CSSD of the hospital where the nurses played a dual role as theatre nurses and CSSD staff.

Immediately after our IPC training in Lagos in June 2019, we scheduled a visit to CSSD for our first assignment. We went in to see how things were done as the only CSSD in the hospital. We tried to ask while some things were not functioning or done incorrectly in the CSSD which affected the quality of service. We made different suggestions including the possibility of using nearby CSSD because there was only one functioning autoclave there. But little did we know that the CSSD staff saw us as IPC police who only came to point out their deficiencies. This became clear to us in our next visit in December 2019.

Our next visit was after our first PALS training. We then realized what went wrong in our first approach to the CSSD staff. We decided to revisit them. Our approach this time was different. We dropped our titles as IPC police they knew us to be. We used some PALS tools like needs assessment, non-violent communication and photo voice. We approached them as colleagues, we said, "we are here to see how the CSSD Department can move forward" and one of them responded "now you are talking". We had a successful discussion with them and requested that they give us one person to be recommended as a member of IPC committee in the facility and also as part of change agents for training. We gave them some PPE.

PALS training and tools helped us to make work improve at CSSD Department, FMC, Owo.

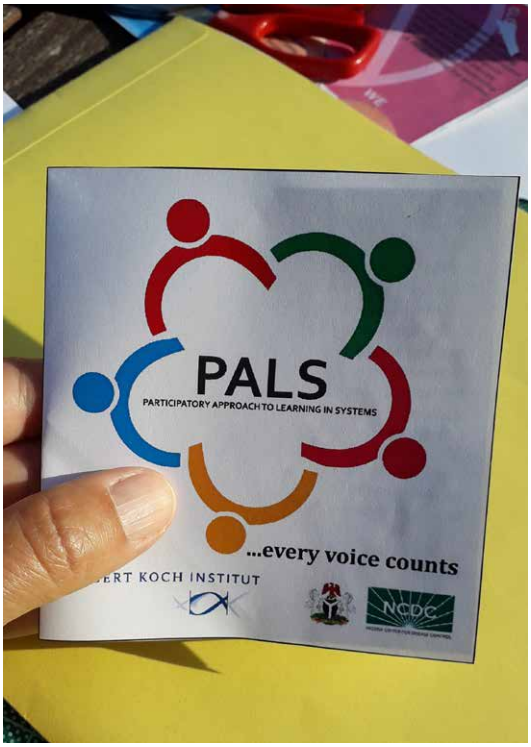
Entrance to the CSSD

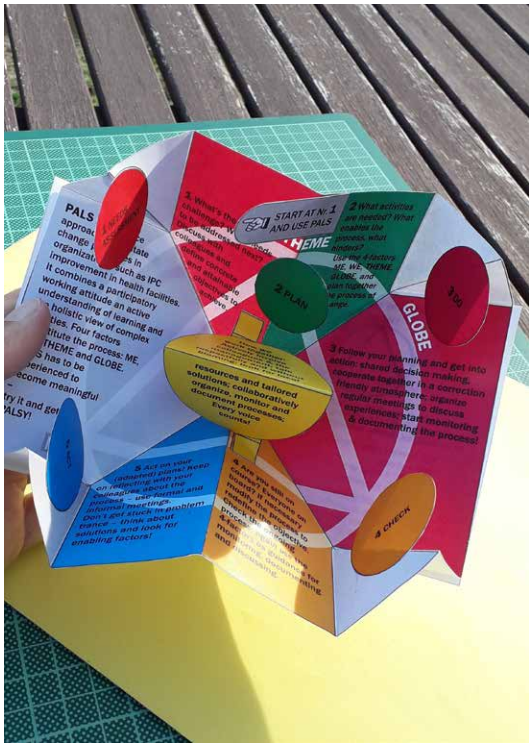
IPC PALS Team with staff of the CSSD. Everyone is happy.

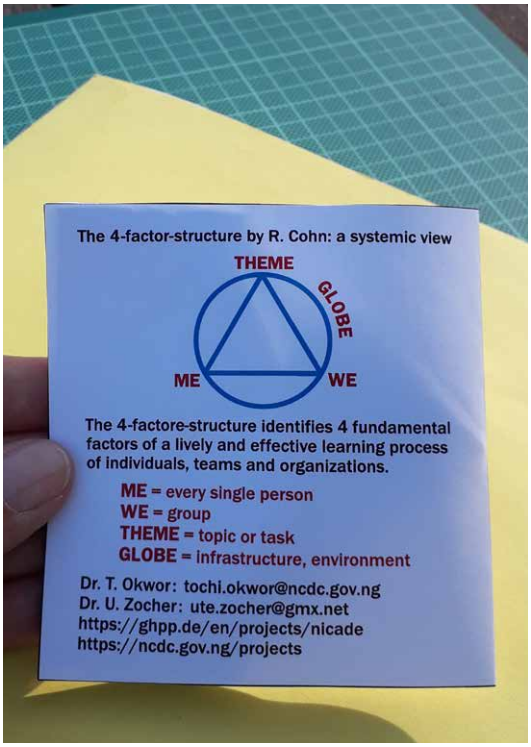
Reflect on the reports from FMC Owo, Ondo State and AEFUTHA Ebony. How did their approach to CSSD change after they started PALS training? What do you think has made the difference? To what extent do you think the results reflect a sustained improvement in IPC practice?

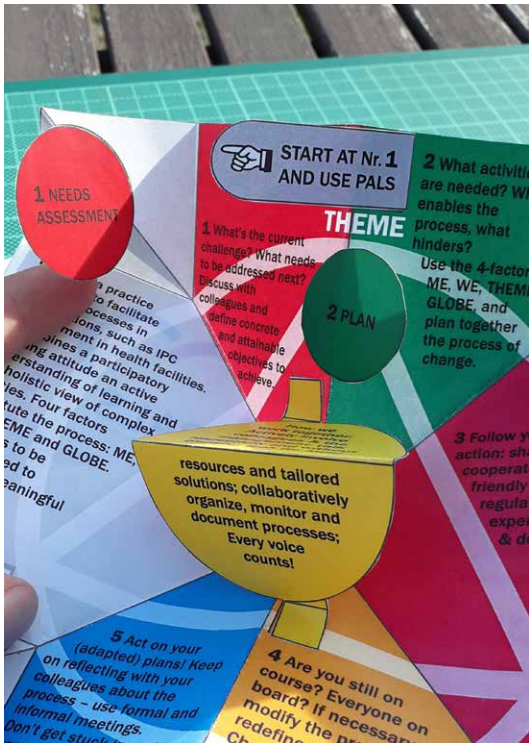
1.3.3 The PALS Pop-Up Flyer

The PALS pop-up flyer shows another representation of the PALS approach and is inspired by the PALS Public Health Action Cycle. The flyer can support Change Agents to talk about PALS and inform people and colleagues about the approach and support the process of PALSy IPC activities. You will find the templates to assemble it in the annex.









1.4 Teamwork – the Third Pillar of PALS

The Participatory Approach enables and encourages collaboration and cooperation in working groups. The 4FS organizes this cooperation regarding the complexity of influencing factors.

Research shows that collaborative problem-solving leads to better outcomes. People are more likely to take calculated risks that lead to innovation if they have the support of a team behind them. Working in a team encourages personal growth, increases job satisfaction, and reduces stress The Participatory Approach enables and encourages collaboration and cooperation in working groups. The 4FS organizes this cooperation regarding the complexity of influencing factors.

One of the four factors focuses on teamwork: how people work together, how they relate to each other and to the task at hand (WE). In line with a growing number of researchers[4], we have observed that good teamwork is central for good results of work and well-being of the team members. CA teams that take the time to work together respectfully and bring their different competences and perspectives to bear on the matter were mostly successful in their activities and brought about remarkable IPC changes. They were able to support and motivate each other and skilfully used their different roles to move things forward in the hospital. In the cases where team spirit was lacking, we saw that the daily work routine, work overload and the system's persistence to avoid change were likely to burn out the enthusiasm and motivation of Change Agents.

Team spirit and engagement cannot be talked down or preached – there is no button to press “start”! How can we promote and grow the team spirit?

A good team player exhibit characteristics and skills like the following:

- shows a positive mental attitude,
- offers help to team mates,
- constantly communicates and updates team members on the ongoing processes,
- practice active listening,
- is flexible and respectful regarding the ideas and opinions of others
- celebrates the successes of teammates,
- shows commitment and accountability.

What about you? Are you an experienced team player at work or in other contexts of your life? Reflect on your strengths in teamwork. Do you like working with others or do you prefer to elaborate tasks individually? What do you experience as challenging when groups are given a task to fulfil together?

4 You can find more information in this article on “The importance of teamwork”: https://www.atlassian.com/blog/teamwork/the-importance-of-teamwork

The team spirit is usually not the starting point of a process, but a product of shared attitude towards cooperation and stimulating experiences. The preconditions for creating team spirit and motivation are trust, openness and willingness to work together. The ability to listen to each other, to analyse a situation together and plan together create a feeling of "we".

We assume that all members of a group have ideas and competences to contribute to a process and find solutions to a problem. Each person is willing to participate in teamwork, if

- her/his contribution is recognised and appreciated,
- he/she can actively participate in the decision-making processes,
- the decisions are negotiated and not arranged in a top-down manner,
- the whole work process and information are accessible to all,
- the responsibilities are shared and
- successes or small milestones are cherished and celebrated together.

The African language and culture are full of proverbs regarding team work. Do you know and remember any?

The four factors can be used to organise a CA team meeting:

Theme: Do we all know the topic of the meeting? Do we all agree on it? Do we need to modify it in order to productively start? Any other ideas on what needs to be discussed?
Globe: What are the conditions of our meeting: do we all have time to meet – how much? Are we sitting in an appropriate space? Does everybody have a place to sit? Are we under pressure?
We: Do we need to give information to someone in the team first? Are we ok to start? And during the meeting: Are we still on track? Do we all participate in the discussion? Is there tension among team members or are there conflicts coming up?
I/Me: How does the individual team member feel? What's his or her expertise related to the topic?

All the communication tools and concepts listed below (chapter 2 on communication) can emphasize the growth of efficient and stimulating teamwork and need to be practiced almost all day to become a natural attitude.

One of the principles of R. Cohn's approach is: Disturbances have precedence!

All too often, glitches, frustrations, disagreements, etc. in work processes are simply swept under the carpet instead of being resolved. As a result, the team is not 100% operational. Individual team members might be held back by these annoyances, are not sufficiently connected and accordingly not all resources can flow into the process. People are not satisfied with what they are doing.

Hence, if you don't feel comfortable in your team, if you think that something in your teamwork is preventing you from fully contributing or blocking the next steps, please take the courage to voice it out loud during your next meeting.

2. PALS Communication and the Informing Concepts Behind

Communication skills and attitudes are a clue to grow mutual understanding and improve on collaboration.

Change Agents train people and facilitate lessons about IPC and the Participatory Approach. In order to bring the spirit across, and encourage people to get active and own the process CAs have to work in a participatory way, with a participatory attitude and pay attention to the aspect of relationship themselves. CAs model the concept they teach. Communication skills play a key role in this: the way you talk and listen to another person will be crucial to their understanding, their motivation and engagement in the process.

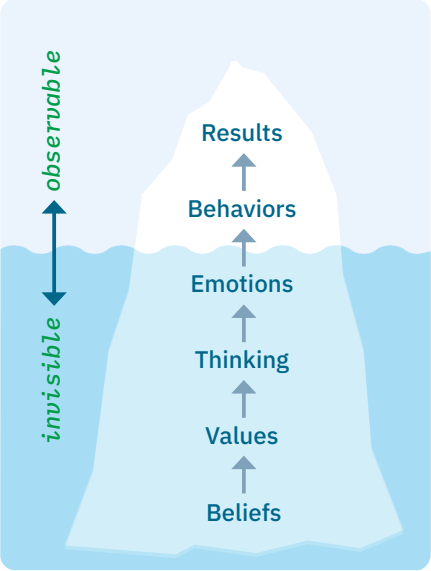
Mrs Bello, a 32-year-old woman who had a surgical procedure due to breast cancer is on daily wound dressing, parenteral antibiotics and adjuvant chemotherapy. She hardly has visitors and she doesn't talk to people, she is aggressive and irritable, this attitude earns her the name- madam pepper during handing or taking over of shifts. Thus, nurses avoid her and carry out their procedures without communicating or using few words with her because of her attitude.
What do you think about Mrs Bello? What might be the reasons for her behaviour? How do nurses and doctors normally respond to a patient behaving like Mrs Bello and why?
How do you feel, if a patient is showing this behaviour?

The methods of communication only work on the basis of a corresponding set of values: curiosity to understand better, appreciation of others, open mindedness, a competence and solution- oriented perspective, appreciation of differences. Trust and confidence are basic values for initiating and accompanying participatory improvement processes.

2.1 The Iceberg Model

For better understanding of what happens in daily interaction and how to improve mutual understanding and productive collaboration, the Behaviour Iceberg represents a useful model:

Figure 7: **The Behavior Iceberg**



The iceberg model shows that the visible behavior of a person is carried by a variety of elements that are deeply rooted within the person: feelings, ideas about one self, values, thought patterns, beliefs. These are driving forces that are hidden and not visible, even mostly unconsciously buried for the actor himself. The visible part makes up about 20 % of the person, the invisible part makes up 80 %.

Emotional needs, and the strong wish to fulfill them, shape our patterns of behavior and motivate our personal and professional growing. Acting and behaving are always connected to these underlying layers of ourselves which represent an expression of our complex identity.

Communication is mostly driven by these invisible forces. With trained communication skills we can address the invisible parts, get more insight on why and how a person acts and consequently enable real understanding, mediate conflicts and overcome challenges.

Probably we've all experienced a situation where we were very irritated by someone's behaviour, disappointed in them or condemned their actions and became upset. It was only later that we found out about the background to the behaviour, about the "good reasons behind" that put the situation in a completely different light.
Do you remember such an experience: What happened? How did you feel at first and how did you feel after you understood more about the reasons behind the behaviour? Please also pay attention to the feelings you experience today when you think back to this episode.
Can you relate this experience to the iceberg model? What does it mean to you?

Below you find some statements on communication which can be used on the basis of a participatory attitude and the understanding of the iceberg model in mind. They can be helpful to discover the invisible part below the water surface in order to improve understanding and collaboration.

1. **There is always a good reason behind a behaviour or a way of communication.** Try to figure out why the person acts like s/he does, without judging him/her. What is the motivation? You do not have to agree with the response but let the communication process continue. The important thing is understanding “why”, to get an idea of the mindset of the actor.
2. **You can only understand a behaviour if you know the context in which it happened and the motivation.** It is very similar to the statement above. It invites you to ask many questions to gather concrete information about the contextual conditions, where behaviour takes place. Many resources and changing points will become visible through a more detailed and complex discussion (ME, WE, IT, GLOBE). The mechanism and routines get clearer to everybody.

3. **You already know what you are thinking. But you don't know what the other person knows and thinks and how s/he interprets common situations!** Get curious about the way others construct reality, try to listen and refrain from early, premature interpretation and judgment!

2.2. The Non-Violent Communication

The Non-Violent Communication by M. Rosenberg is developed for a more peaceful and constructive way of a daily communication and to mitigate conflicts effectively. The overall goal is to satisfy our own needs on the one side, and, on the other side, to give others the same opportunity. The need for recognition, love, autonomy, control, security, safety and so on, are generally the same for all human beings. People act in order to serve these needs.

Rosenberg asks us to express ourselves clearly without blaming and criticizing others, and to receive messages empathically without hearing blame and criticism. Self-empathy, receiving empathetically and honest expression are the three core pillars of NvC.

Marshall Rosenberg describes four steps of Non-Violent Communication:

Observe: The first step is simply to describe what we hear, see, remember, imagine without any evaluation or interpretation - just what we noticed.

Then, step two, we add what this makes us **feel** like: no arguing, no justification - only the description of feelings related to the observation.

The third step means to explain what causes our feelings. Here we are talking about our **needs**. It gives us the opportunity to clarify what the issue is about: why do I get irritated or sad? What is my unfulfilled need behind?

Request: And as step four, we might gently ask the other person, if s/he would be willing to take a concrete action in order to address my needs and create a mutually beneficial situation.

The four steps of communication slow down the interaction. It may seem ridiculous and unnatural initially, but it helps to disconnect observation from feelings and interpretation. Often, we deliver our conviction and judgment immediately and automatically and our counterpart reacts with agreement, rejection or justification, with his feelings and interpretations. This pattern easily misdirects the matter or escalates a

conflictual situation and rarely helps to tackle the matter or the problem. In any case, it does not promote a trustful relationship between the actors or the appreciative communication culture in the organisation. Non-Violent Communication counteracts these problems. Just try it!

2.3. Three Basic Competences for Effective and Participatory Communication: Active Listening, Paraphrasing and Productive Questions

Active listening:

Listening is one of the most important skills in communication. We need to learn and acquire the skills to really listen to what the other person is saying. Try to pay full attention to his/her words. Pay attention to the body language which accompanies the words. Very often we already start interpreting the message or acting emotionally meanwhile the partner is still formulating his information. We often assume that we know how the other person will end and have already prepared our answer or comment before the other finishes speaking.

Instead of thinking and interpreting, look at your partner, fully concentrate on what s/he says. Don't pay attention to your smartphone or engage in other activities in the environment. If something is disturbing your attention, please ask your partner to pause the conversation until the disturbance is over, or find another place to continue.

Paraphrasing:

Paraphrasing helps you to understand exactly what your partner wants to express. You try to mirror, to repeat what you heard with your own words: "Did I get you right that...", "Let me try to rephrase to check if I got you right..." It slows down the speed of the conversation and guarantees that you and your partner are on the same page.

Productive questions:

Understanding the message could lead you to productive questions. The answers will further illuminate the context and you can gather more relevant and concrete information. Productive questions are real questions and not "didactical/rhetorical questions" where the answer is already known or a hidden message is passed on.

2.4. PALSy Communication

Think about your own way of communicating. When and under what circumstances do you find it easy to speak in a PALSy way? What sometimes hinders you from doing so? Find examples from your work place!
Non-Violent Communication is not a question of the 'right' technique. Rather, we assume that there are certain basic beliefs, attitudes and dispositions behind it that make this communication credible and authentic. And only then can it be effective.
What do you think is the most important personal conviction or attitude that is needed in order to be or become a PALSy communicator?

Table 1: **Two Glasses of Communication**

Normal way of IPC-communication is very often … 	**PALS communication** 
IPC police-attitude	Equality attitude: expert meets expert
Always addressing faults	Applauds good work; positive feedback for good intentions behind wrong IPC behavior and shifting attention to the unintended negative IPC consequences
Telling what's right and wrong; no interest in hearing "excuses"	Active listening and paraphrasing; asking concrete questions to understand better
Perception of "IPC has to improve now and it's your fault when not"	Perception of a process without judging: only description
Judgmental	Respectful, appreciative
Blaming and accusing	Try to understand the behavior observed (the good reasons behind it; inquiry into way of behavior)
Condemning	Showing authentic interest and attention for a process of improvement
Creating and manifesting hierarchy	Invitation to join the club: we can improve IPC together, Systemic View; protection of the health care worker and his or her family and of the patients
Receiver of this type of communication very often feels: • attacked and the need to defend him- or herself, • not acknowledged and perceived in all the efforts he/she already does, • injustice, not supported. Receiver of this type of communication very often reacts with: • ignoring or attacking you, • starting to hide other IPC information or lack of knowledge, • avoiding you or refusing to talk to you, • building resistance.	Receiver of this type of communication very often feels: • relaxed and start to think and to listen and to talk, • recognized / perceived and valued, • motivated. Receiver of this type of communication very often reacts with: • starting to talk about his / her view and perspective, • showing his/her personal and professional resources and the, resources in their work environment • starting to cooperate and to be more interested, • building commitment.

PALS communication is effective when:

- people start to appreciate each other and to listen to each other,
- people can bring in their thinking and contribute with their good ideas,
- people can confidently talk about their lack of knowledge,
- people start to look for improvement of situations and are eager to participate,
- flow of communication remains constant and feedback loops are organized,
- infrastructure supports this way of communication and exchange of perspectives (e.g. by regular team meetings, round tables with representatives of different professions, reduced workload for added IPC duties).

Take your time!
Changing ways of communication is an ongoing process – like always, doing the first step and realize how you normally communicate, might be the most important one.
How we listen, what we hear, how we talk is embedded in relationships, concepts, values and our personal story.
The training will offer exercises and lots of possibilities to try out and learn from each other.

3. How to Organize and Facilitate PALSy IPC Improvement

A PALSy IPC improvement process is based on the Participatory Approach and a Systemic View; actors apply communication skills accordingly and act in a team. They are convinced that a respectful and appreciative way of collaborating is the best way to go forward. PALS actors are great team players: the CA team is a reservoir of energy and PALS spirit, ideas and various competences which are merged for productive planning and doing.

Such processes are based on local needs and working conditions and integrate the already existing IPC structure as well as the leadership into the process. A PALS IPC improvement process is characterized by the use of certain tools and approaches during all steps of implementation. Particularly, sufficient attention is paid to the part of monitoring the dynamic of the process as well as the results and the evaluation and documentation of data.

In this chapter, we have summarised other PALS tools under different headings: We thought that they could be particularly useful in these specific contexts. But of course, they all have a variety of uses and can be adapted as appropriate and to best suit local conditions and processes.

3.1 Fostering and Monitoring the Quality of the Work Process

The following tools can be helpful for understanding and fostering the work process in general and for guiding Change Agents in identifying and organising their next steps.

3.1.1 The Starfish Tool

The Starfish Tool is borrowed from the world of agile project management. Especially in dynamic and complex processes, such as IPC improvement processes in a hospital, it can help actors to better understand what they have already achieved, which activities were appropriate and effective, and how they should best utilise their precious energy in stepping forward (see tool box).

The tool is called starfish and focuses on five simple questions on the already implemented activities and the results. The experiences and the analyses of the data gathered during this process informs the review.

But before a team uses this tool it should elaborate an overarching question that guides the review, like:

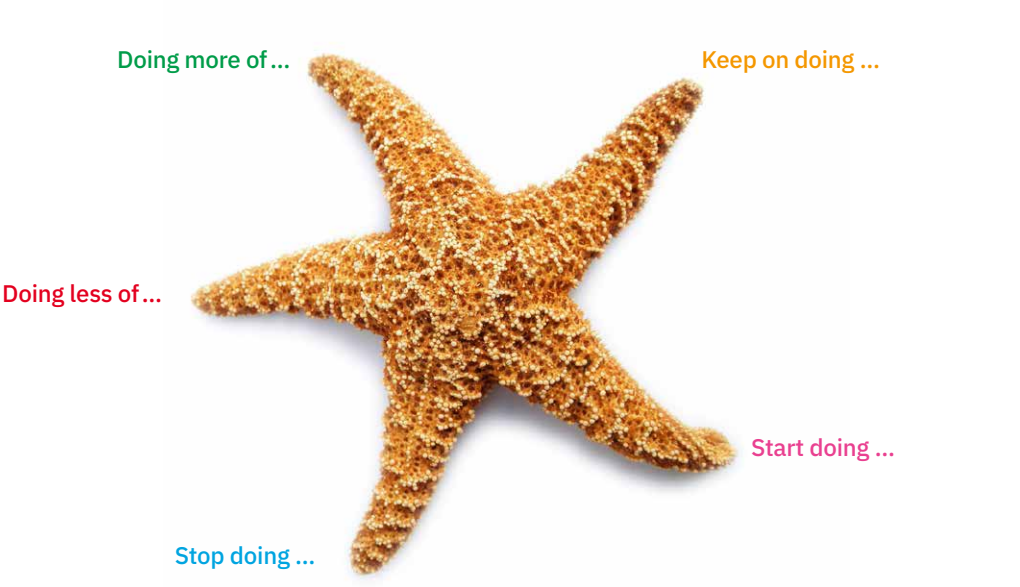
- How can we further support the already reached objectives?
- What could we do better to improve on the hand hygiene practice of group X?
- So far so good – what is our next step?

In order to find the answer to questions like these the starfish focuses on different perspectives of action:

In order to find the answer to questions like these the starfish focuses on different perspectives:

- What should we do **more**?
- What should we do **less**?
- What should we **keep on doing**?
- What should we **stop doing**?
- What should we **start doing**?

Figure 8: **Starfish Tool**



© pixabay: *cristty*

3.1.2 The Feedback Hand

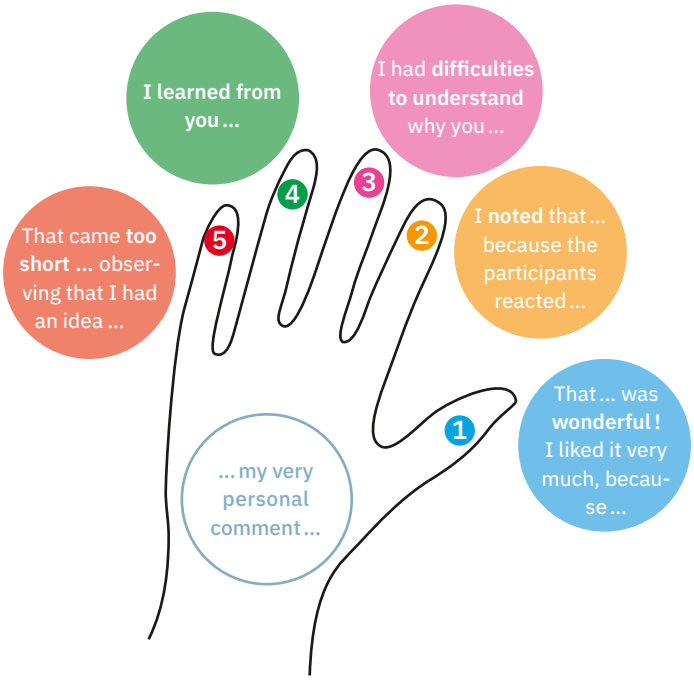
The CA team needs to know about the strengths and weaknesses of the individual team members and take care of their communication and collaboration style throughout all activities and phases. Others look up to them as models; it is only when CAs work together that they create the PALS spirit which might motivate them and enhance their competences. The feedback hand is a useful tool which helps to create a vital feedback culture in the team. (See also chapter 1.4. on teamwork.)

The application of the feedback hand should relate to a specific situation or challenge, to a colleague's work or performance, to a specific task or to the way he/she interacts in the team. The tool gives individual members the opportunity to reflect on their viewpoints and expectations by giving feedback to someone else. The person receiving the feedback learns more about an external view of his/her performance and behaviour, which may differ from his/her own perception and intentions.

The feedback is always based on the PALS communication spirit and consequently emphasizes an appreciative exchange of perspectives and fosters productive and respectful interaction.

Just give it a try!
Don't be shy, it's interesting to reflect your own perspective on the other team members and to hear from others how they experience you. The person giving feedback talks about their perceptions and expectations and thus always reveals something about themselves; the person receiving the feedback therefore learns something about themselves as well as about the person giving the feedback.

Figure 9: **Feedback Hand**



1. The thumb points to what you like about the activity, the specific situation or the person.
2. The fore finger points to what you have noted.
3. The middle finger points to what you found difficult to understand.
4. The ring finger points to what you have learned from one another. "I learned from you, together we can achieve more, two good heads are better than one."
5. The little finger points to what came too short.

... and if you like you can express a very personal comment in your palm.

3.1.3 The PALS IPC Public Health Action Cycle

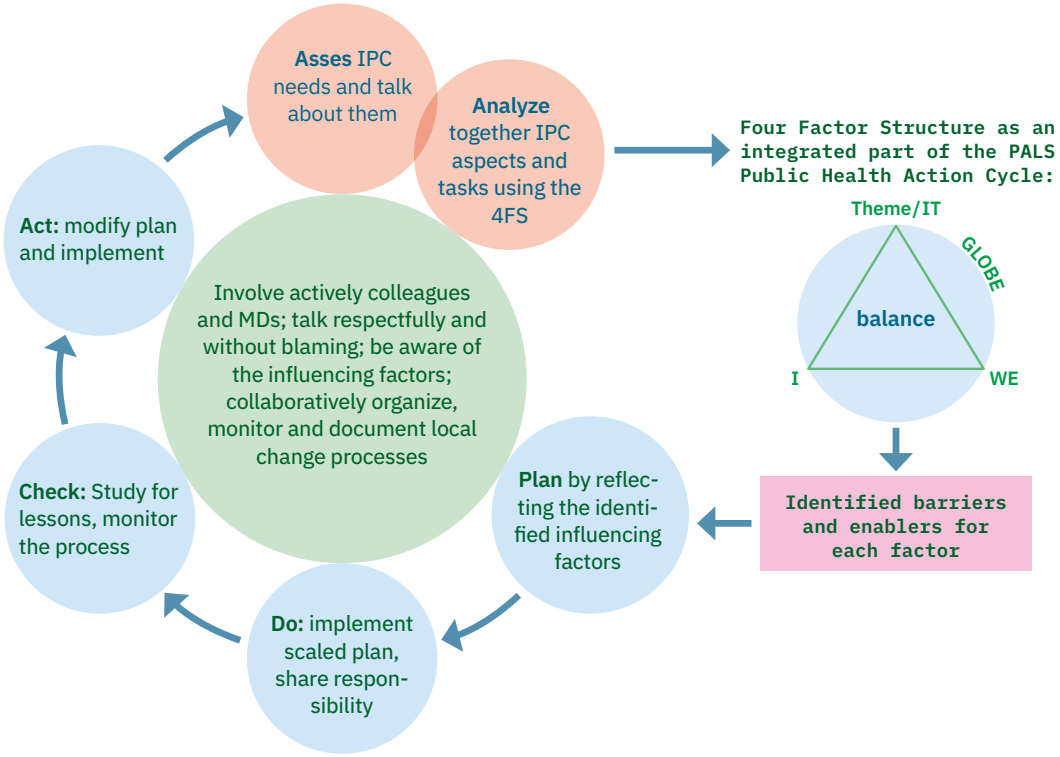
The Public Health Action Cycle (PHAC) is applicable at all levels of planned and non-spontaneous action – as a single activity in a health promotion project or for the implementation of improvement processes at micro, meso and macro levels. We further developed it to a PALS Public Health Action Cycle for IPC change processes which reflects and interweaves the PALS philosophy in all four dimensions of activities.

The PALSy Action Cycle for IPC integrates all necessary steps to a cycling process of IPC improvement. The model is based on the Systemic View and circles around a participatory way of communication and collaboration.

All PALS tools and methods can be integrated into this process.

Figure 10: **Public Health Action Cycle**

Figure 11: **The PALS Public Health Action Cycle**



Create a correction friendly working atmosphere!

Every voice counts!

3.1.4 Monitoring and Evaluation, Documenting and Reporting on IPC Improvements

Several IPC assessment tools already exist and can be used to monitor and document changes in IPC practice or infrastructure.[5] Unfortunately, these tools are not sufficiently differentiated to measure small changes or might not fit into the local situation at all. That makes it necessary to adapt them to the context and the specific objectives set.

PALS processes might show little IPC effects in the beginning, but support other moments of change which will lead to concrete IPC improvements in the long run, like: colleagues start talking more often about IPC issues, different professional cadres start to interact and collaborate, systemic thinking becomes the norm, the IPC committee meets more regularly, the MD takes more active interest in IPC and the meetings of the IPC committee. Although these processes are very meaningful and preparatory in terms of sustainable IPC changes and ongoing improvement processes, they are often not covered by the standard IPC assessment tools. CA teams should pay attention to these circumstances and develop monitoring tools that reflect this kind of change processes too.

We are still working on simple but efficient ways of documenting and monitoring these important changes. Let's inquire together!

Small changes can only be seen "from the inside", by the acting people involved. PALS trainers and Change Agents have to develop together the monitoring tools which reflect exactly what is meaningful to know and to show in the current IPC improvement processes in the hospital.

> Please make sure that you think about the way you will monitor and evaluate the PALSy IPC process from the very beginning. Keep in mind that not only the results are interesting but also the process of getting there. This doesn't have to be a linear process without any detours, roundabouts or dead ends. Learn a lot from your mistakes or unrealistic assumptions.
> The tools of measurement have to be tailored to the objective of your specific plan and based on the current situation on ground. They don't have to be "one size fits all": In PALS we prefer the local fit, for the specific matter in place, based on the current status quo, which includes all voices of the actors on ground.

During the 6 months mentoring phase the monitoring and evaluation (M&E) of the IPC change experiences will be part of the endeavor and a good starting point to become creative and develop what is needed. More information on that will be shared during WS 1 and WS 2.

5 Such as the WHO IPC assessment framework: https://www.who.int/publications/i/item/WHO-HIS-SDS-2018.9

A CA team of our last training cohort worked successfully on the improvement of the service of clean linen and improved the working condition of the laundry staff significantly. They adapted a well-known monitoring tool, a check-list for Laundry Unit and documented remarkable changes and improvements during the 6 months mentoring phase and further on. The M&E helped them to plan and redefine next steps as well as to communicate with their HM, the PALS trainer and other interested audiences. The data worked for the team and reflects their focus of the improvement process. It informed their next working steps and could be shared and explained to others.

Other colleagues took pictures of the matter in focus before and after the intervention and documented the change process. An exhibition in the hospipal might speak on the efforts done and stimulatre further discussion on IPC.

UATH PALS

ASSESSMENT TOOL (CHECKLIST) FOR LAUNDRY UNIT

S/N	STRUCTURE	NONE(0)	INADEQUATE(5)	ADEQUATE(10)	REMARK
1.	TRAINING FOR STAFF			10	Basic Ipc Training given
2.	COLOUR-CODED LAUNDRY CART WITH COVERS			10	Green(clean), Red(dirty)
3.	AVAILABILITY OF LAUNDRY BAGS	0			Not available
4.	WASHING MACHINES			10	3 machines functioning
5.	SPINNING MACHINES			10	1 machine functioning
6.	DRYING MACHINES			10	1 machine functioning
7.	HOT IRONING MACHINES	0			Not Serviceable
8.	BUILDING LAYOUT/STRUCTURAL QUALITY			10	Renovated
9.	HAND HYGIENE INFRASTRUCTURE	0			No handwash point
10.	PPE (UTILITY GLOVES,APRON,GOGGLES)		5		Not adequate
11.	WASH CONSUMABLES (SOAPS, DETERGENTS, DISINFECTANTS)			10	Available regularly
12.	VACCINATED STAFFS(HEPATTTIS)			10	All Staff vaccinated
13.	POLICY ON VACCINATION FOR STAFF	0			No written Policy
14.	CONSUMABLE INVENTORY MANAGEMENT			10	fairly Good
15.	WAIST-HIGH SORTING AREA	0			Floor level
	PROCESS				
16.	WORKPLACE SEPARATION (CLEAN/DIRTY AREAS)			10	Separated
17.	DEDICATED EQUIPMENTS FOR CLEAN/DIRTY AREAS			10	Green and Red
18.	QUALITY OF LINEN SORTING PROCESS			10	Fairly Good
19.	HOT WATER (70c-80c) SOAKING OF LINEN			10	Wall mounted heater
20.	USE OF DISINFECTANTS TO WASH LINEN			10	Available and Used
21.	CONSISTENT AND CORRECT USE OF PPE		5		Not Consistent/not correctly
22.	USE OF DEDICATED SCRUB (NOT HOUSE WEAR)			10	3 Scrubs each Provided
23.	HAND HYGEINE PRACTICE BEFORE/AFTER HANDLING LINEN		5		Poor Compliance
24.	IRONING PROCESS AFTER DRYING	0			No Ironing of linen
25.	USE OF DEDICATED CARTS FOR CLEAN/DIRTY LINEN			10	Colour-Coded Carts used
26.	SPECIAL PROCESSING OF INFECTIOUS LINENS		5		Not adequate
27.	DIRTY/SOILED LINENS COLLECTED IN BAGS BEFORE TRANSPORT	0			Not collected in bags
28.	CLEANING/DISINFECTION OF LINEN CARTS		5		Not done regularly
29.	CLEANING/DISINFECTION OF RE-USEABLE PPE		5		Not done regularly
30.	POLICY FOR STAFF WITH RESPIRATORY DISEASE	0			No Written Policy
	TOTAL	—	40	160	200

ADDITIONAL REMARK: Advocacy efforts is still Ongoing.

NAME/SIGN: Musa Yahaya Abdu DATE/TIME 30/11/2022.

0 – 100 (Inadequate)
101 – 200 (Basic)
201 – 250 (Adequate)
251 – 300 (Advanced)

Monitoring tools adapted and applied by Change Agents (2022)

3.2 More Tools for PALSy IPC Change Processes

More practice proven tools are compiled in this chapter; tools which helped CAs and PALS Trainers to start a PALSy IPC improvement process in their hospital and involve colleagues from the very beginning. Many of these tools are experienced during the CA training.

The project team, trainers and CAs constantly develop new tools or adapt already existing instruments to specific work conditions or to solve upcoming problems. All PALS actors are invited to share their experiences by using these tools and get creative in designing new ones.

3.2.1 Planning and Doing a PALSy Needs Assessment

Photo voice

Photo Voice[6] is an important method and is often used for participatory needs assessment in community development processes. It encourages people to document and reflect on their reality. We can adapt it to document and reflect on work realities in the process of IPC quality development. Colleagues are encouraged to take pictures of IPC work conditions to bring up important facts and challenges or examples of good practice of IPC.

The idea of photo voice is characterized by the fact that the TARGET GROUP itself takes pictures of situations and conditions they would like to talk about and change. It is the "learner" or "participant", the "target group" who decides on the subject of the picture and takes it! Their perspective will be at the centre of discussion; the purpose of photo voice is to offer a possibility to real participation and create engagement and commitment.

Photo Voice can stimulate the participation and easily open up a discussion. What is important is that the author of the photo:

1. Explains what is visible in the photo, describing the situation documented;
2. Explains why it seems meaningful and important to him or her;
3. Contextualizes the photo in larger themes. For example, a photo of a rotten soap dispenser on the ward doesn't only talk about itself but also about the engagement which has been taking place a couple of months before, fixing the soap dispensers without talking and creating awareness for the hand hygiene issue. Now the soap dispensers are mostly rotten or empty and …
4. Finally, the audience can add what they can see in the photo, what is of interest to them or ask questions.

Attention!
If CAs, trainers or members of the IPC committee walk around and take pictures of IPC problems, like overfilled sharp-boxes or used IPC gloves on bedsides to show these images during a training to HCWs and to stimulate a discussion on the challenges of IPC, this is a different objective; it becomes a didactic tool to focus on a problem which has been defined by the teacher or trainer.
Why is this not any more a participatory action?

Photo voice can be a starting point to shed light on a situation from different perspectives as well as to better understand the opinions and perspectives of the person who took the picture. Notice should always be served and permission obtained before taking pictures. Ethical rules have to be respected.

Photovoice: Community members and health care workers take pictures.

6 See also the original publication "Photovoice: concept, methodology, and use for participatory needs assessment." from 1997: https://doi.org/10.1177/109019819702400309

Doing a Blitz Interview

A rapid appraisal can consist of three or four questions about an IPC topic or assumed IPC challenges which colleagues will be asked during duty of work. This method can help to get into contact with staff and to inquire into their perspectives. Maybe your colleagues see other priorities of change from what you see as an observer or maybe they have other explanations for the circumstances or situations you observed. This method is a good instrument to easily explore and open your mindset and get a first idea of the environment and the actors.

Write down the questions you are interested in and start interviewing people in the context of interest. Maybe you can record the answers with your smart phone or take notes during the interviews. Please, don't forget to introduce yourself in a friendly way and explain what you are doing and why. This activity can be taken up by all CA team members. In a following team meeting compare your results and discuss your findings. This activity can serve as a first needs assessment and inform the next steps you will take.

Observe Clinical Practice in Action

Sometimes the best way of assessing current clinical practice in an organization is by observing individual behaviours and interactions. This is especially appropriate if you are looking at events that happen quite often, for example, hand washing. This method has a number of advantages, for example:

- It enables detailed analysis of current behaviours in context.
- It eliminates reporting bias.
- It can provide a useful method for monitoring progress, if repeated on a regular basis.

From the PALS point of view, it is indicated to openly speak about the observed behaviour without blaming the people in order to understand better why it happens, what are the reasons behind the observed behaviour. Such attitude will immediately open the discussion because the ones observed will start to defend and justify their acting. Make sure that your objective is inquiry and not blaming!

There may be some disadvantages of this method, for example:

- It can be difficult to gain consent from the people you want to observe.
- People can alter their behaviour when they know they are being watched.
- Methods of data collection need careful consideration.

A more formal way of doing an observation is through an audit.

You can use the WHO hand hygiene observation tools in a reduced format to look more closely on the situation and to train your perception. It should not be a hidden observation after which you confront the observed colleagues with the findings, but an open, transparent observation of well-informed colleagues. Observation findings will be shared in a respectful and constructive way to get more insights into the working routine, to understand them better and to explore the reasons for their actions, solutions and alternatives. We emphasize to also focus on positive aspects, well done practice, interesting solutions found for challenges, etc.

Systemic View on IPC: The Four Factor Structure

The Four Factor Structure (4FS) can be used e.g., to analyse a challenging situation or a topic that needs more attention. It helps you to have a balanced view of the work: it keeps all colleagues engaged in the process and enhances teamwork and collaboration. The 4FS reminds you to analyse the infrastructural conditions of the task too and allows you to generate a complex and holistic view: a good starting point to fully understand a problem, to engage with more people, to plan activities and communicate in a proper and reflective way. The 4FS is developed to support change processes and personal growth as well as team building.

In the template of the 4FS in this chapter, the questions for each factor are related to the matter of concern in this example: IPC. The questions always need to be adapted to the specific matter of concern.

Template: **Systemic View on IPC: Four Factor Structure**

THEME / IT (your concrete IPC topic/ task):

What IPC topic do we want to work on?

Is it clear to everybody?

What does it mean? How does it work? What do I already know about it?

Does everybody (in the unit or health facilities) agree on the importance of this topic for IPC improvement?

What type of competences and concrete working steps are needed?

→ Supportive factors / hindering factors

GLOBE (environmental effects for all factors):

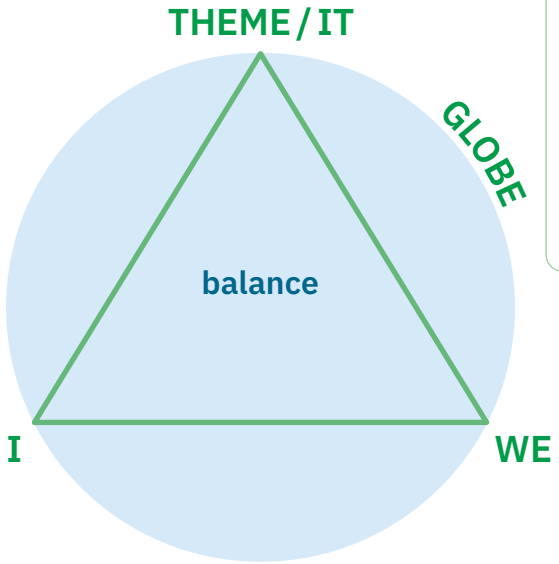
How does the concrete working environment affect our task (THEME, ME, WE)?

How does leadership/management affect our task (THEME, ME, WE)?

How does the concrete neighborhood, community affect our task (THEME, ME, WE)?

Is the time right to start with this topic?

→ Supportive factors / hindering factors



I (as a person and a professional regarding the topic):

What are my competences regarding the IPC task?

What do I already know about it?

What do I want to learn about it?

Where are my strengths / weaknesses regarding the topic?

What are my personal beliefs and experiences regarding the topic?

Can I do more to improve the IPC task?

Which advantage / disadvantage do I have when the IPC task will be improved?

→ Supportive factors / hindering factors

WE (relational aspects regarding the topic):

With whom do I work together for better understanding and improvement on the IPC task?

Can we split up in working groups?

How do we communicate?

Are there hierarchical factors and interprofessional factors to keep in mind?

Have we already created an error friendly communication and working culture?

Do I feel comfortable with my colleagues?

Unspoken Rules

→ Supportive factors / hindering factors

Source: Theme-Centered-Interaction developed by Ruth Cohn

Brainstorming

Brainstorming is a creative method for problem solving. It invites all participants to contribute to the elaboration of a topic without immediately starting a discussion or interpretation of the comments. Brainstorming can be used as a first step of a needs assessment too. It's a relaxed and informal way to include people in a process from the beginning. Everybody who takes part in the brainstorming has the same right to speak up! This method promotes the exchange of thoughts, opinions, feelings, ideas and questions. It should be spontaneous – long speeches are discouraged.

During the first phase of a brainstorming session, it is absolutely forbidden to comment or criticize other arguments and inputs, even if they seem crazy or unsuitable. One or better two persons should simply write down all inputs in no particular order. Every input will be heard and written down. No exceptions!
The brainstorming session will be considered concluded when there are no more additions from anyone, or when the agreed time has been exhausted.
In a second step you can deepen the topic by clustering the inputs looking for relations between different inputs. Prioritization of inputs (according to time, importance, more realistic … "FIRST THINGS FIRST") is needed.
The brainstorming, followed by a discussion and systemization can be the take-off for planning an intervention as a solution for a problem or the beginning of a change process you will bring about.
You need

- Somebody who explains what the topic is and why the brainstorming has been chosen as a method.
- Somebody who explains the rules.
- Somebody who takes care that the rules will be respected.
- Somebody who writes down the inputs.
- Somebody who leads the second part, posing a good question and moderating the discussion.
- You need a big paper sheet to write down results and pencils.

How to Narrow Down Objectives: SMART

SMART is an acronym for various adjectives that together stand for realistic goals. This list should serve as a guide for developing goals, which are:

- **S**pecific (simple, sensible, significant): **What** do we want to accomplish? **Why** is this goal important? **Who** is involved? **Where** is it located? **Which** resources or limits are involved?
- **M**easurable (meaningful, motivating): How much? How many? How will I know when it is accomplished?
- **A**chievable (agreed, attainable): How can we accomplish this goal? How realistic is the goal, based on other constraints, such as time and financial factors?
- **R**elevant (reasonable, realistic and resourced, results-based): Does it seem worthwhile? Is this the right time? Does this match our other efforts/needs? Am I the right person to reach this goal? Is it applicable in the current socio-economic environment?
- **T**ime bound (time-based, time limited, time/cost limited, timely, time-sensitive): When? What can we do six months from now? What can we do six weeks from now? What can we do today? Is this the right moment to start?

3.2.2 Implementing PALSy Activities

The following methods and tools reflect possibilities to implement IPC activities in a participatory and holistic way.

Inviting to a Round Table Meeting

A round table is a well-known format for participatory and systemic work. It brings people together who are involved in or affected by the issue or topic addressed and who have different perspectives on it - different because the participants differ in one or more relevant criteria in relation to the issue (e.g. age, profession, cultural background, positions and roles, different degrees of involvement, etc.).

For example, a round table session could start with a brainstorming exercise. As a second final step of the meeting, the ideas and topics discussed could be clustered and prioritised, for example. A first draft of a project plan can be created, working groups start to deal with individual aspects or a training session is requested.

Some General Hints to Plan a Meeting or a Training

1. It is important that you act as a team if you want to hold a meeting or a training session on IPC: set up a team meeting to start the discussion on what, why and how. It is helpful to plan each task, examining all possible factors in advance and accounting for them. For example, if you desire to intervene in a particular unit of the hospital to do a PALSy meeting, you must keep in mind some of the following:
    a. identify a specific issue to be discussed;
    b. think in advance who the stakeholders and participants are;
    c. consult with the head of the unit and hold a PALsy conversation: start discussing and planning together; find out if there are any permissions to be obtained;
    d. think about the target group more specific: who is involved in the topic and should be heard and benefit from the meeting?
    e. serve adequate notice;
    f. obtain all the basic items you need for the meeting (e.g. writing materials, any one pagers, etc).
2. Plan the meeting carefully and think about how you want to address the topic. Use any PALSy tools which seem helpful to engage with the participants in a participatory way and reflect the local situation in a holistic perspective. Check your PALS Training Book!
3. Document any other thing you have done as part of the planning, including any resources you had to look up or blitz interview you did in order to be better prepared to approach the task at hand.
4. Review the appropriate IPC documents, such as the five moments of hand hygiene, or other one pagers of WHO materials that are relevant to the specific task. And when you have done this, document it too.

Table 2: **Checklist for Reflection and Documentation**

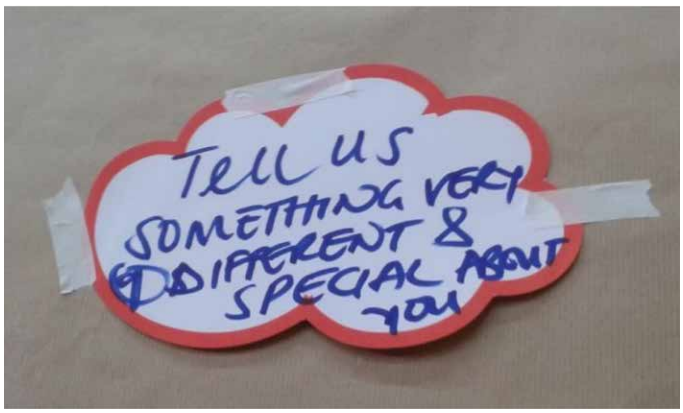
Planning a meeting or a training on IPC	Yes/ No	Comments, further explanations
a. Did you set up team meetings?		
b. Did you work as a team together (sharing ideas, responsibilities etc.)?		
c. Did you define the target group based on the Participatory Approach?		
d. Have you identified the relevant stakeholders and participants?		
e. Have you consulted with the head of the unit?		
f. Have you obtained any needed permissions?		
g. Have you served adequate notice to all concerned?		
h. Have you obtained all the basic items needed for the meeting (e.g writing materials)?		
i. Did you plan the meeting carefully related to content and form (e.g. use of a PALS tool to ease the atmosphere, use of the 4FS to analyse the problem in a holistic way)?		
j. Have you secured and prepared a venue?		
During the meeting		
k. Did you keep in contact with the participants to best understand their perspectives and engage with them on eye-level?		
l. Have you been aware of your communication style? Was it PALSy, non-threatening and welcoming?		
m. Did attendees have a chance to significantly contribute to the meeting?		
n. What was the focus and tone, was it constructive? Did you try to focus less on complains and blamings but develop pathways for solutions?		
o. Did you use the Systemic View to address challenges?		
p. Did participants see the bigger picture?		
q. Did everyone feel that their voice is important in the matter at hand?		

General perspective		
r. What is your general impression on the meeting: Did it work well? Did you feel comfortable while facilitating?		
s. Did the topic shift during the meeting from the pre-selected one to a more important one for the target group?		
t. What was the output? Did you develop any action plan or start a process to improve the IPC challenge on ground?		
u. Did you assemble all needed materials for the meeting (e.g. one pagers, PALS tools)?		
v. Did you plan the meeting carefully enough before you started it? What will you do differently planning and implementing the next PALSy IPC meeting?		

Think Tank

The Think Tank presents a method for self-introduction in a group organized by questions of interest. In the frame of the participatory and systemic work the Think Tank is a strong signal of a resource and theme oriented and respectful working approach. The participants of a meeting or training get time and attention to present themselves and to get focused on the specific topic and matter at stake. Everybody gets on stage. It also makes it easier to talk to one another about common themes. The quality and meaningfulness of the exercise depend on the questions and on the moderation.

You can use the Think Tank to show and share all the experiences, competences, backgrounds of the participants. These are the important resources brought into the training or meeting.



A typical think tank question: Tell us something very different and special about you.

All participants of the activity in place are invited to present themselves using different questions about their specific work experiences for the matter on focus, the role/function, their or other interesting items and questions! Think about four or five questions: What do you want to know about them? What is helpful to know for the activity you are offering and the matter at hand? What should they know from one another? Which question allows a person to add a specific personal competence?
The participants get ten minutes time to write down the answers on cards. During their presentation, the cards are stuck to the wall. In the end you have the Think Tank, the “resource pool” of this group!

During the presentation you have to moderate the situation carefully. You can ask several questions in order to deepen your understanding if you want to know more. Relate the participants to each other: Maybe there are interesting differences or common aspects regarding the topic of discussion.
Explain why you took all the time to do the Think Tank: What does it have to do with the Participatory Approach and Systemic View? Rules of communication and important principles can be introduced.
Time management: When concentration goes down, have a five minutes break or a short physical exercise; control presentation time and avoid story telling…
Materials needed:

- Plenty of cards (number of participants multiplied with number of questions)
- Pencils
- Scotch tape
- Big paper sheets as underground to write the questions and stick the cards onto

Make sure that the Think Tank will stick properly on the wall for the next few days! If you have more than 15 participants think about two parallel Think Tanks. A Think Tank with 15 people will take at least 60–90 minutes.

For you as a CA and facilitator of an activity, this method gives you the opportunity to get to know the participants, to immediately establish the basic ideas of PALS and to have an overview of all the different resources and backgrounds of participants for grouping them up during the next sessions.

Quick Dating

Quick dating is a tool you can use for different scopes: to get people in the beginning of a course into contact, to let them talk about personal issues, to let them raise questions on a specific topic or to do a recap of the previous day. In other moments you can use it for stimulating questions, for re-energizing a group, for smoothing difficult topics or basically to get the group in touch with each other.

According to your objective think of three to five questions you want the participants to talk about. The group walks around in the venue – you can play some music to make it more playful and engaging. After a while you signal everyone to stop and tell the participants to pair up with a person they are standing next to. Now you give the first question for the couple to talk about: each person has one minute to explain, one after the other. After four minutes the quick dating of this couple is over, you signal people to walk around again or to dance in the venue and after some minutes of walking a new quick dating with a new couple and a new question starts.

If quick dating is used for doing a recap, it should finish with the question: What is unclear from yesterday's work or which question would you like to discuss in the plenary session?

You will experience a lively and engaged group discussion after this exercise. This tool supports even shy people to get their voice heard.

Small Chats

As a participatory facilitator, you want the participants to take over: get them thinking, commenting, communicating; support them in talking to one another, to notice, that there are different opinions and views, things in common...

For example, to start a discussion after a presentation you can invite the colleagues of a training session or a meeting to take five minutes to talk to his/her neighbour about the topic of the presentation or about a question you raised. In such small chat settings it is easier to come up with questions or comments. After the small chat, each pair can share some of their ideas and thinking with the broader house in plenary and the debates starts ...

Annex

1. Further Readings and Information

Wright, Michael, Block, M, Unger, H von. *Participatory Quality Development. Concepts, Toolkit and Case Studies.* Gesundheit Berlin e.V. Accessed 01.11.2023 https://www.iqhiv.org/fileadmin/stuff/pdf/Tool-PQD-EN.pdf

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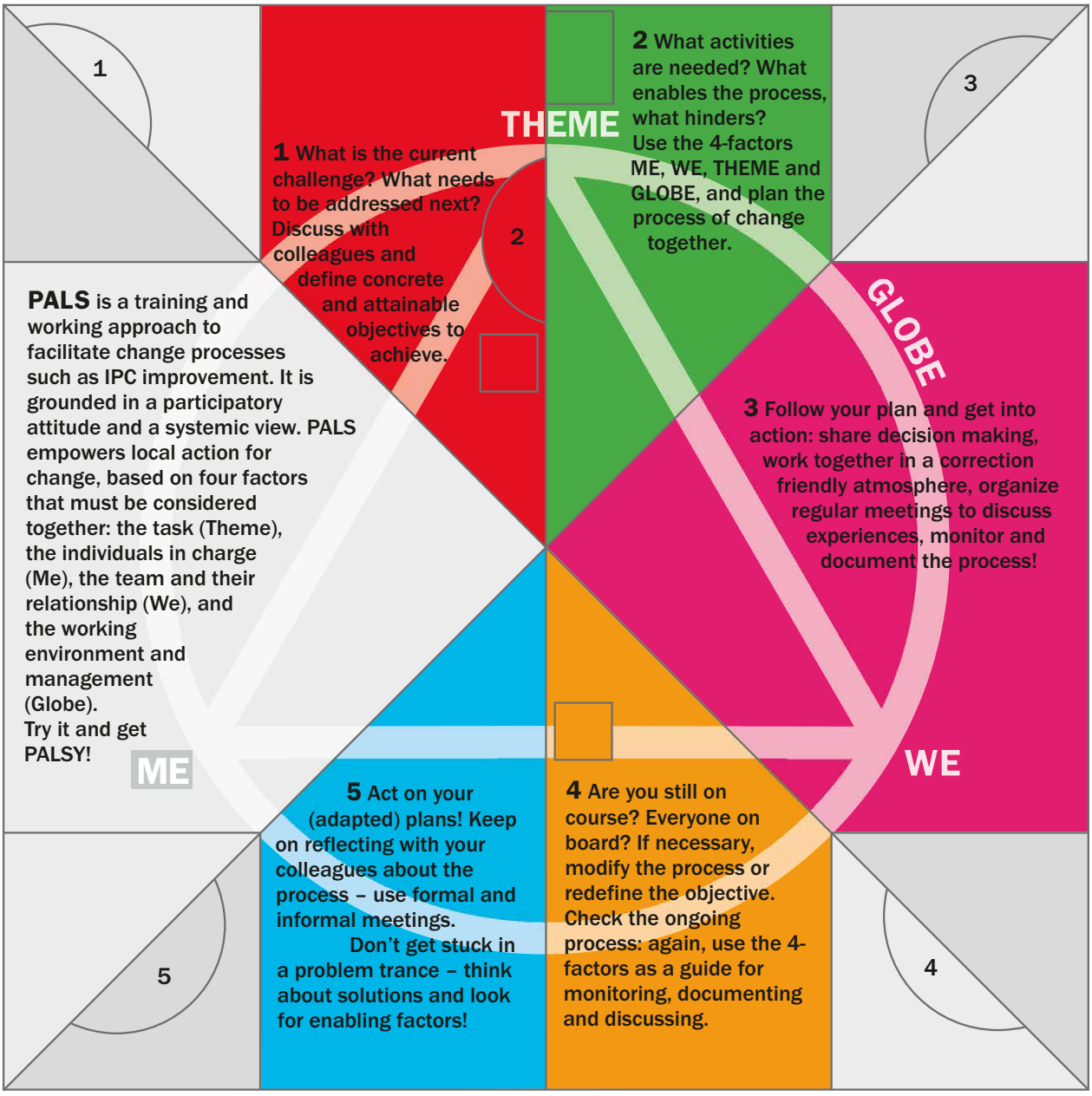
The **World Health Organisation** (WHO) promotes different tools and resources on infection prevention and control: https://www.who.int/teams/integrated-health-services/infection-prevention-control

- Monitoring tools for hand hygiene: https://www.who.int/teams/integrated-health-services/infection-prevention-control/hand-hygiene/monitoring-tools
- Tools on IPC core components, including monitoring tools such as IPCAF and assessment of minimum requirements in health facilities: https://www.who.int/teams/integrated-health-services/infection-prevention-control/core-components

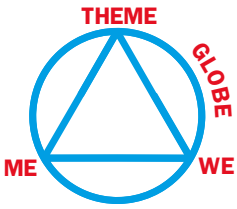
The website of the **Participation, Inclusion and Social Change Cluster at the Institute of development studies** provides different resources to generate ideas and action for inclusive development and social change: https://www.participatorymethods.org/

Further information about the PALS programme and the NiCaDe IPC project, as well as project updates are published on the **PALS website**: https://nicadeipcpals.ncdc.gov.ng/

2. Template for the PALS Pop-Up Flyer



The 4-factor-model by R. Cohn: a systemic view



The structure identifies 4 factors of a lively and effective change process of individuals, teams and organizations.

ME = every single person
WE = team, partners
THEME = task, topic
GLOBE = environment, management

If you want to know more or to become a PALS trainer please contact: Dr. T. Okwor: tochi.okwor@ncdc.gov.ng
Dr. U. Zocher: ute.zocher@gmx.net
https://ghpp.de/en/projects/nicade
https://ncdc.gov.ng/projects

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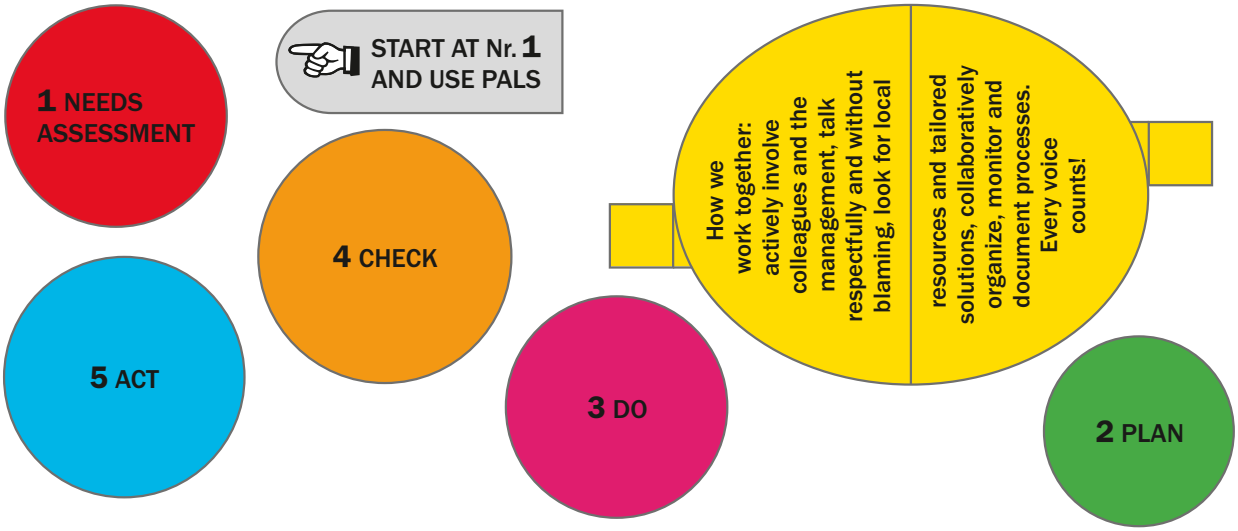
PALS
Participatory Approach to Learning in Systems

... every voice counts

ROBERT KOCH INSTITUT

NCDC
NIGERIA CENTRE FOR DISEASE CONTROL AND PREVENTION



The Change Agent Training Book is designed to stimulate and help participants of the PALS IPC Change Agent Training Programme to deepen their understanding of the "Participatory Approach to Learning in Systems (PALS)". It presents the PALS concept for improvement in infection prevention and control in health facilities and describes its theoretical underpinnings, gives an overview on communication and collaboration methods and models which help to translate PALS into practice in health facilities and offers a practical toolbox with tools and exercises that are used in PALS trainings.

PALS cannot be taught, it has to be experienced!

… every voice counts