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Communication strategies supporting verbal health communication

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Laurea University of Applied Sciences
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“Health care providers have a duty to provide information in simple, clear, and plain language and to check that patients have understood the information before ending the conversation.”

(White House Conference on Aging, Mini-Conference on Health literacy and Health disparities 2005)

Laurea University of Applied Sciences **Abstract**
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The purpose of this thesis was to examine what communication strategies support the comprehension of verbal health messages as well as health care consumers' health literacy skills. The thesis was done for TULE-tietokeskus (information centre for musculoskeletal health), which is in the process of creating a health communication manual for its employees. The manual in question will focus on providing tools for understandable verbal and written health communication. Findings of this study provide a theoretical basis upon which TULE-tietokeskus can build the first part of the manual.

TULE-tietokeskus seeks to increase its clients' knowledge and awareness of musculoskeletal symptoms and disorders as well as influence behaviours and attitudes towards musculoskeletal health. This thesis is valuable for TULE-tietokeskus as transferring unclear health messages can lead to misunderstandings and adverse health outcomes. It is important to create guidelines through which TULE-tietokeskus' employees can work in a coherent and theory based manner.

The theoretical framework of this thesis focuses on defining communication, health communication, health education and health literacy, as well as discussing their impact on health outcomes. The empirical part of the thesis consists of a literature review of guidelines focusing on verbal health communication and health literacy. Thematic analysis was used in order to examine the content of the guidelines.

It was concluded in the empirical part of the thesis that basic communication skills play a vital role in delivering an understandable verbal health message. Providing health information suitable to all health literacy levels requires paying attention to multiple factors of effective communication as well as tailoring the message according to individual needs, skills and wishes of the consumer. Having an open mind and creating an understanding environment were both seen as factors supporting comprehension and health literacy. Feedback is needed in order to determine how well the health care provider has managed to convey his message. Rephrasing should be used when misinterpretations occur. It was also concluded that verbal health messages are best understood when accompanied with written materials or illustrations.

In addition to the communication strategies, three special health literacy techniques meant for clear verbal health communication were recognised: Teach back, Ask Me 3 and Health Literacy Universal Precautions.

Keywords: Health Literacy, Health Communication, Verbal Health Communication, Health Education

Laurea-ammattikorkeakoulu **Tiivistelmä**
Otaniemi
Terveyden edistämisen ylempi AMK-tutkinto

Päivi Saarinen

Verbaalista terveysviestintää tukevat kommunikaation keinot

Vuosi 2015 Sivumäärä 66

Tämän opinnäytetyön tarkoituksena oli selvittää millä kommunikaation keinoilla voidaan tukea terveyspalveluiden käyttäjien ymmärrystä ja terveyden lukutaitoa verbaalisen terveysviestinnän yhteydessä. Työn taustalla on aikomus luoda TULE-tietokeskukselle terveysviestinnän manuaali, joka antaa konkreettisia keinoja ymmärryksen varmistamiseen ja terveyden lukutaidon edistämiseen sekä verbaalisen tiedonjaon että kirjallisen materiaalin kohdalla.

Opinnäytetyön viitekehys keskittyy pääasiallisesti käsitteiden kommunikaatio, terveysviestintä, terveysneuvonta ja terveyden lukutaito avaamiseen. Lisäksi pyritään selvittämään näiden käsitteiden merkitys terveyteen liittyvään hyvinvoinnin kannalta. Opinnäytetyön tutkimusosion tulokset puolestaan luovat teoriapohjan, jonka avulla manuaaliin on mahdollista kirjata ohjeet terveyden lukutaitoa ja ymmärrystä tukevaan verbaaliseen kommunikointiin asiakkaan kanssa. Ohjeet on kerätty kirjallisuuskatsauksen tuloksena löytyneistä terveysviestinnän oppaista. Löydetyt oppaat analysoitiin sisällönanalyysin periaatteita soveltaen.

TULE-tietokeskuksen toiminnan tavoitteena on kartuttaa yksilön tietoja tuki- ja liikuntaelimistön hyvinvointia koskien, sekä auttaa omaksumaan TULE-terveyttä tukevia asenteita ja toimintatapoja. Työ on merkityksellinen TULE-tietokeskukselle sillä sen toiminnan vaikutukset perustuvat ymmärrettävään terveysviestintään.

Opinnäytetyössä tehdyn tutkimuksen tuloksista pääteltiin suositeltujen terveyden lukutaitoa tukevien kommunikaatiokeinojen perustuvan vahvasti tehokkaan kommunikaation perustaitoihin. Kaikille sopivan terveysneuvonta vaatii viestin räätälöintiä asiakkaan yksilöllisten tarpeiden, toiveiden ja kykyjen mukaan. Asioiden tarkastelua asiakkaan näkökulmasta ja siihen läheisesti liittyvää avomielisen ja hyväksyvän ympäristön luomista suositeltiin. Sanallista viestiä tuli tukea kirjoitetun materiaalin, kuvien, mallinnuksien ja esimerkkien avulla. Ammattilaisen vastuulle kuuluu myös selvittää, onko asiakas ymmärtänyt, mistä on kyse eli kerätä palautetta. Mikäli terveysviesti on käsitetty väärin, tulee ammattilaisen toistaa viestinsä uudelleen muotoiltuna.

Kommunikaatiostrategioiden lisäksi tunnistettiin kolme terveyden lukutaitoa tukevaa metodia: Teach back, Ask Me 3 ja Health Literacy Universal Precautions.

Asiasanat: Terveyden lukutaito, Terveysviestintä, Terveysneuvonta, Suullinen terveysviestintä

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1 Introduction

Health literacy as a research field is comparably new. As a term health literacy is used to describe as the skills a health care consumer needs in order to find reliable basic health information, decode it and comprehend its content. It is also used in the context of health care consumers being able to locate health services and utilise them appropriately. Low health literacy levels have been proven to be connected to the inability to comprehend written or oral health communication. (Williams, Davis, Parker & Weiss 2002, 283-284.)

Health behaviour change can happen through increased health literacy level. The health literacy skills of an individual can be improved by means of health education. Vice versa in health education it is important to take into consideration individual's current health literacy level. Using the communication strategies of health communication can help in assuring information is provided in an understandable level. Communication strategies can focus for example on verbal communication or how to improve written health care consumer education materials. Distribution of information is not however just about presenting it, but also about getting feedback to make sure the information has been understood. Verbal health communication between consumers and providers is known to affect multiple aspects of consumers' ability to maintain good health (Nouri & Rudd 2015, 566).

Theoretical frame in this thesis focuses on the definitions and effects of health communication, health education and health literacy on health outcomes. TULE-tietokeskus and its purpose are explained as well as it is seen as important to the entity of this thesis. The research question on the other hand has a more practical approach to it: What communication strategies are recommended for interpersonal verbal health communication in order to support comprehension and health literacy? In order to answer this question, a review of guidelines was conducted from a sample of 3 English language guidelines published between 2010 and 2015.

1.1 Background of the thesis

Health care professionals tend to have their own culture and language. Adopting the health care field's culture and the language of one's speciality can however lead to communication gaps with the public. Health care consumers not understanding their health care providers or the instructions given can among other things lead to poor health decision as informed decisions can only happen through understanding of information. Consumers should be empowered with the knowledge they need so they can actively care for self safely while sustaining and progressing their health status independently.

TULE-tietokeskus is a health communication project in which verbal communication and health literacy are in a vital position. As the project manager of TULE-tietokeskus I feel it is important to create guidelines through which each and every employee of TULE-tietokeskus can work in a coherent and theory based manner. In order to ensure high-quality health communication, TULE-tietokeskus is producing a manual focusing on two intervention strategies: verbal health communication and health communication materials. Both intervention strategies are examined through health literacy. The manual itself will provide clear and concrete tools on how to ensure that the health information provided has been understood. This thesis is going to focus on the first part of the manual: verbal health communication strategies that support health literacy.

Health literacy in interpersonal communication is a relatively new approach. When doing the initial literature review for the manual it was noticed that many articles on health communication touched the subject of verbal communication strategies, but not in depth. Different methods were named, but not explained in detail. In fact, findings of a systematic literature search taking place early 2014 show how hard it is to find literature focusing on health literacy skills and its impact on verbal communication: the search resulted in 999 articles or which only 12 were accepted for the study (Nouri & Rudd 2015, 567). It felt necessary to take a closer look at the guidelines available in order to determine the final content of the manual. This thesis seeks to piece together the information found on recent guidelines targeted towards health communication and especially verbal health communication.

Models such as the EDUCATE model have been created for patient and family education, but they include notable amounts of recommendations not necessary in health communication settings such as TULE-tietokeskus. The goal was not only to extract verbal communication strategies from the guidelines found but also to evaluate and discuss their adaptability to settings outside of outpatient clinics and hospitals through TULE-tietokeskus' eyes.

1.2 Terminology

Communication by default needs to happen in all health care consumer education situations. These situations can be examined through the discipline of health communication. In health communication there are strategies that can – if delivered effectively – have a positive effect on the outcomes of consumer education. This is, as health communication in itself is directed towards improving consumers' understanding of factors affecting health and to support health behaviour change. As health education and health communication connect in so many levels and are sometimes used almost as synonyms to one another, they are used somewhat in conjunction in this thesis. The term "consumer" on the other hand refers to patients, clients, participants and other consumers of health and human services. "Provider" is used to refer

medical practitioners, social workers, educators, patient advocates, physical and occupational therapists, home health care workers etc. However, when referring to an article and seen suitable, the terms included in that specific article are used to describe the individual in need of health information and the provider.

2 TULE-tietokeskus

TULE-tietokeskus (information centre for musculoskeletal health) was created to meet the goals set for a project called "TULE tutuksi" (TULE = musculoskeletal system, tutuksi= to become familiar with). TULE tutuksi is a 4-year (2013-2016) collaborative project between four musculoskeletal health associations located in Turku region. The project is funded by the Finland's slot machine association (RAY) and is administrated by Turku region's Spine Association (Turun Seudun Selkäyhdistys ry.). Other associations involved are Turku region's arthritis association (Turun Seudun Nivelyhdistys ry.), Turku region's Rheuma association (Turun Seudun Reumayhdistys ry.) and Turku region's Osteoporosis association (Turun Seudun osteoporoosiyhdistys ry.).

TULE-tietokeskus' mission is to make reliable information about musculoskeletal health and disorders more available to anyone interested. The main emphasis is on increasing people's knowledge about preventative measures, relationships between lifestyle factors and health outcomes as well as services available for those already suffering from musculoskeletal disorders. National musculoskeletal-programme (Kansallinen TULE-ohjelma) 2008-2015 states that in order to achieve more efficient and cost-effective preventive measures as well as treatment and rehabilitation plans, extensive collaboration between different organisations and actors needs to be implemented. Services offered by TULE-tietokeskus are complementary to those provided by the private and public health care sectors and aimed primarily towards the working age population. (Bäckmand & Vuori 2010, 5.)

2.1 TULE-tietokeskus' services

TULE-tietokeskus' services can be divided into three groups: services provided in TULE-tietokeskus, services provided outside of TULE-tietokeskus and collaboration between associations, volunteer and peer-to-peer work. Services provided in TULE-tietokeskus vary depending on the needs of the individual. While some consumers are only interested in the printed materials TULE-tietokeskus offers, some prefer to speak with an employee or guest expert. Most commonly people look for information about different musculoskeletal disorders or symptoms, their underlying causes and how to self-manage them as well as safe forms of exercise, nutrition, factors affecting the quality of sleep, who or where to go to, suitable exercise equipment, ergonomics and other preventative measures. All services provided by TULE-tietokeskus are free for its customers.

Services provided outside on TULE-tietokeskus – although somewhat the same as in TULE-tietokeskus – are directed more towards reaching new target groups and arousing interest among the working age population about factors affecting musculoskeletal health. These functions can take place for example in offices, events or exhibitions. The services are most commonly executed in collaboration with TULE-tietokeskus' affiliates or as small projects in collaboration with physiotherapy students from Turku University of Applied Science.

The third group's actions - collaboration between associations, volunteer work and peer-to-peer work – are aimed towards reducing duplicate actions between the associations involved and making services provided by the third sector health care organisations more known. The goal is also to offer more peer support for those already diagnosed with a musculoskeletal disorder or those showing symptoms of a disorder. These services are provided to everyone, one does not have to be a member of an association. Main responsibility for these actions lays on the shoulders of the associations involved in the project.

Services provided in TULE-tietokeskus	Services provided outside of TULE-tietokeskus	Collaboration between associations, volunteer and peer-to-peer work
What? Handouts, instructions, test and measurements, support and counselling, literature to read, explaining symptoms and mechanisms causing the symptoms, assisting in finding professionals/help needed...	**What?** Distributing information, motivating/arouse interest, reaching people, counselling, giving advice, tests, lectures...	**What?** "Association days", support, courses, excursions and events.
Who is responsible for? Project workers, experts and students/interns.	**Who is responsible for?** Project workers, affiliates and students.	**Who is responsible for?** Main responsibility lays on the associations.
Where? In TULE-tietokeskus.	**Where?** Offices, events, exhibitions, public locations.	**Where:** In TULE-tietokeskus and elsewhere.
To whom? Everyone interested in his or her musculoskeletal health.	**To whom?** Working age population.	**To whom?** Members of the associations, TULE-tietokeskus' consumers.

Table 1: Tule-tietokeskus’ services

2.2 TULE-tietokeskus as a health communication project

TULE-tietokeskus seeks to increase its clients’ knowledge and awareness of musculoskeletal symptoms, disorders and impairments as well as influence behaviours and attitudes towards musculoskeletal health. By demonstrating healthy practices and challenge misconceptions about musculoskeletal health and self-management TULE-tietokeskus tries to plant a seed of information and curiosity into an individuals’ mind in the hopes of it later on growing into actions beneficial to different areas of health.

Knowledge can be considered as a tool through which people are more able to take care of their health and self-manage when struck down by illness. Cognitive skills in essence bare high relation to one's motivation and ability to gain access to as well as understand and use information to promote one's health. TULE-tietokeskus' vision is that providing information leads to more knowledgeable and resourceful citizens. Citizens, that are able to navigate the health care system and manage their health with great confidence and understanding.

The type of information TULE-tietokeskus provides includes not only facts about what affects one's musculoskeletal health but also the measures one needs to take in order to have control over these factors. This including finding the right health care professionals and support networks when facing a musculoskeletal illness. TULE-tietokeskus' goals vary depending on the health status and needs of the individual seeking advice. The need of information may vary substantially from one consumer to another. TULE-tietokeskus' customers vary not only in age and information need but also on their health literacy skills. Employees of TULE-tietokeskus need to be able to ensure every consumer gets guidance and answers on a level suitable to their understanding. This in turn creates a need for communication methods that ensure the information given has been internalised.

2.3 TULE-tietokeskus' importance

The U.S. Department of Health and Human Services (2005) states that people with lack of knowledge or misconceptions about the human body or the nature and causes of disease might not understand the link between lifestyle choices and health outcomes. Even with the increasing amount of evidence found, risk factors most commonly linked to musculoskeletal disorders are not well-acknowledged or understood among Finnish health care consumers. This lack of understanding in turn bears a heavy fee on the on the national economy. The responsibility for actions targeted towards improved health literacy lay mostly on public health professionals and public health systems. However, there is an ever-growing consensus surrounding third sector health organisations needing to direct their resources towards health promotion actions as well. (U.S. Department of health and Human Services 2005; Bäckmand & Vuori 2010, 9.)

With great likelihood consumers with musculoskeletal disorders and low health literacy levels face difficulties in terms of using health services and controlling their illness. For example, a study focusing on illiteracy in rheumatoid arthritis patients showed that patients with lower health literacy levels had three times more clinic visits than those with higher health literacy. However, comprehensive reviews of health literacy and health outcomes in patients with musculoskeletal disorders are scarce and therefore it is hard to prove there is an airtight

connection between musculoskeletal health outcomes and health literacy levels. (Gordon, Hampson, Capell & Madhok 2002, 752; Loke, Hinz, Wang, Rowlands, Scott & Salter 2012, 2.)

2.3.1 Musculoskeletal system's health affects all areas of life

Musculoskeletal system comprises of bones, joints, muscles and related structures, such as the tendons and connective tissue. Musculoskeletal system plays a part in our movements and mobility as well as provides stabilisation and support in different positions. It also protects us from external stress. Musculoskeletal activities are not limited to mere mechanical functions. Their performance is also related to people's daily activities and being an active part of the society and its functions. (Suomen Tule ry 2007, 2.)

There are three main characteristics associated with good musculoskeletal system performance: agility, muscle strength and endurance. Contributors to musculoskeletal health include age, hereditary factors, individual lifestyle choices and health status as well as living/working conditions and socio-economic status. Healthy musculoskeletal system is the ground upon which it is possible to build good work and physical performance statuses. It is a fundamental requisite for many other body systems' health and ability to function and consequently effective prevention of the most common national diseases requires effective prevention of musculoskeletal disorders. (Suomen Tule ry 2007, 2; Bäckmand & Vuori 2010, 10-20.)

2.3.2 Musculoskeletal disorders bear a heavy fee

"The World Health Organisation considers chronic musculoskeletal conditions to be a major source of morbidity and disability with substantial adverse economic impact on health care resources, and the patient's ability to earn a living." (Loke et al, 2012, 2.)

Not engaging in health-enhancing physical activity as well as high work stress factors are known to be among the most common risk factors for musculoskeletal symptoms, disorders or impairments. Other significant risk factors include smoking, obesity, nutritional deficiencies, poor muscle strength and balance, accidents and matters acting as agonists for accidents (such as excessive use of alcohol, poor state of alertness and defective senses). Exercise and daily physical activities on the other hand can be considered as the preferred method of preventing musculoskeletal disorders. (Bäckmand & Vuori 2010, 9.)

Musculoskeletal disorders are considered to be a national disease as well as the leading cause for pain and work absences due to illness in Finland. Every fifth person in need of outpatient care suffers from a musculoskeletal disorder. Out of the approximately half million surgeries

done in hospitals per year, every fourth is a musculoskeletal related operation. It is also alarming that one fourth of 12-18 year-olds in Finland suffer from recurring back pain and every third 18-year old female in northern Finland experiences neck, shoulder and lower back pain. The overall costs of musculoskeletal disorders are annually over 2,5 billion and direct costs closer to 600 million. Musculoskeletal disorders are also considered to be the number one cause of chronic disability. (Bäckmand & Vuori 2010, 8-9; Global Alliance for Musculoskeletal Health 2014; Suomen Tule ry 2007, 1.)

3 Communication

"The discipline of communication focuses on how people use messages to generate meanings within and across various contexts, cultures, channels and media" (National Communication Association).

3.1 Communication process and skills

It has been said, that communication is what makes us who we are as humans. It is our way of sharing information. Communication interventions are affected by cultural, social and individual factors, to name but a few. Individual and social prisms determine how information is received and processed. In a communication intervention the message sent and the one received can be two very different things. The two main reasons for this being that usually the message sender and the receiver have different exposures to the intervention, and that people process information differently. (Rimal & Lapinski 2009.)

The process of communication can be divided into elements. These elements can be named "Communicators", "Sender", "Idea", "Encoding", "The message", "Communication channel", "Noise", "Decoding", "Context" "Receiver" and "Feedback". "Communicators" refers to the fact that at least two people need to be involved in a conversation for any communication to occur. In this context it would be easy to understand communication as a one-way-street, where one person is the "sender" (the person who constructs and attempt to convey a message) and the other is the "receiver" (the person receiving the message). While one speaks, the other listens. In real life communication is more complex. It tends to be simultaneous in the sense that people send and receive messages to and from each other at the same time. It is an interactive process, where the listener can send feedback in the form of for example body language while listening. (Chand [n.d.]; & O'Hara [n.d.], 4-11; SkillsYouNeed 2015.)

"Idea" is what is wanted to convey. "Encoding" is the process of converting the intangible idea into signals or symbols such as words, tone, gestures, facial expressions and other non-verbal language, i.e. "The message". "Communication channel" is the medium through which the

sender wants to send the message. Face-to-face this would mean speech and vision. “Noise” in communication has a quite different meaning in communication theory, especially when compared to the more traditional understanding of the word. In a traditional sense noise refers to physical noise, such as a phone ringing in the middle of a conference. In communication theory it however refers to matters such as complicated jargon, unsuitable body language, lack of attention or interest and cultural differences. (Chand [n.d.]; Dixon & O’Hara [n.d.], 4-11; SkillsYouNeed 2015.)

“Decoding” is the process through which the receiver tries to extract meaning from the symbols the sender has sent. We all have our own understanding of the world and beliefs that can interfere with the message being understood the way it was meant to. “Context” in turn influences all communication. Context can allude to the situation where the communication takes place, but also to social factors, emotional climate and expectations of the participants. Social context can be examined through the relation or the communicators: what are their roles, responsibilities and relation to one another. “Feedback” in essence is how the message receiver reacts and what he or she replies. It is a way to ensure that the message has been received and understood in the way the sender meant it. Feedback can range from plain verbal statements to more subtle hints like facial expressions or changes in posture. These might indicate dissatisfaction with the message or that the receiver is in some way at unease with what she or he heard. Feedback is crucial as it gives an opportunity for the sender to fix misinterpretations. (Chand [n.d.]; Dixon & O’Hara [n.d.], 4-11; SkillsYouNeed 2015.)

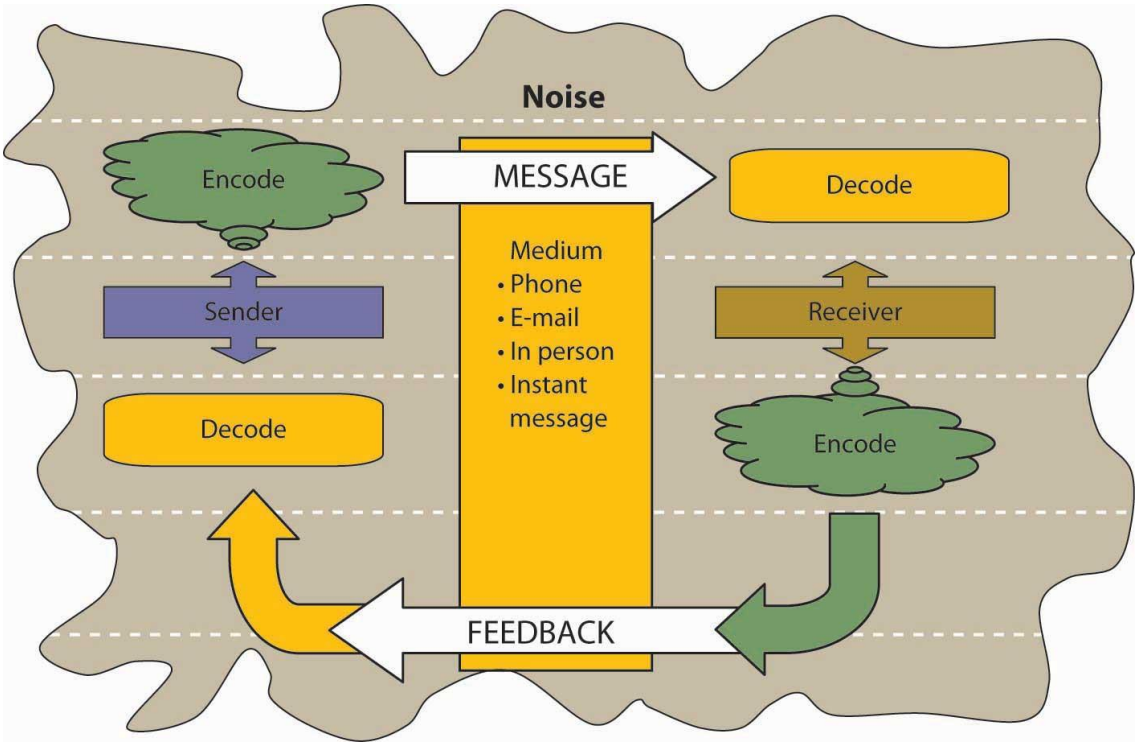

Figure 1: Process Model of Communication (Carpenter, Bauer & Erdogan 2015.)

Effective communication can be seen to occur when the receiver derives the same meaning from the message as the sender had when sending the message. As recognised before, meaning of the message does not rely solely on words: non-verbal cues, situation, context and the communicators involved all play their part in the big picture. Matters such as being able read non-verbal cues of others as well as being aware or one's own body language is of great importance. Equally important is to pay attention to how things are said and to what is actually being said. (Dixon & O'Hara [n.d.], 4-11)

Effective communication requires more than speaking skills. It also requires listening, non-verbal and writing skills. It is to be reminded that hearing and listening are two very different things. Listening involves the willingness to understand what the other person is saying: a mind-set of respect and acceptance as well as open-mindedness in order to try and see things from the other person's perspective. Listening requires notable amounts of energy as it requires us to examine the world through someone else's eyes. No judgement should be cast. Listening offers valuable information to understanding. (Windle & Warren [n.d.])

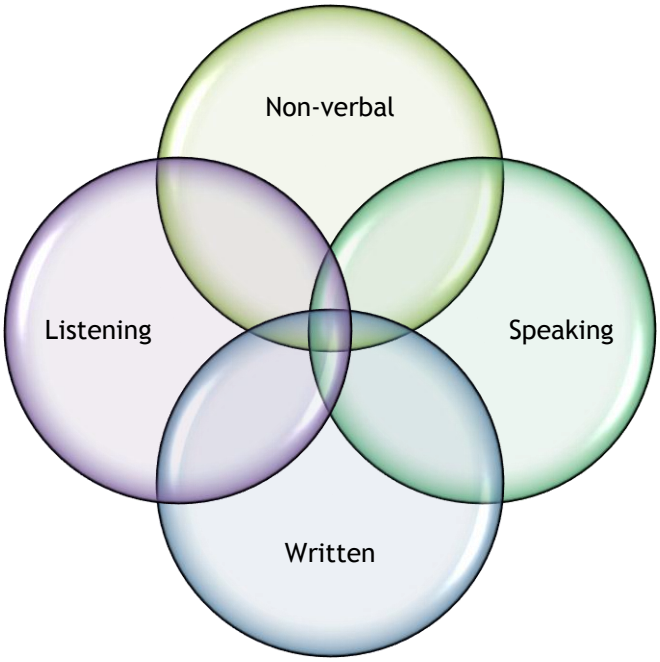

Figure 2: Skills required for effective communication

3.2 Interpersonal communication

Face-to-face conversation is often referred as interpersonal communication. In fact, all information exchange between individuals, sharing of feelings and giving meaning through verbal and non-verbal communication count as interpersonal communication. From provider-consumer communication perspective especially listening plays a crucial role. Interpersonal communication can be used for various reasons. It is a way of sharing and receiving information or influencing attitudes and behaviours. It is the way in which we establish and keep up relationships as well as understand the world and our perceptions of it. The old saying of "ask and you shall receive" is very true. Interpersonal communication is used for this very purpose. It is a way for us to tell what we need and grasp what others are in need of. It is also the medium through which it is possible to obtain and give emotional support. We need communication for decision-making and problem solving as we do to foresee certain behaviours and regulate power. (De Negri, DiPrete Brown, Hernández, Rosenbaum & Roter 1997, 7-8; SkillsYouNeed 2015.)

- Give and collect information
- Influence the attitudes and behaviours of others
- Form contacts and maintain relationships
- Make sense of the world and our experiences in it
- Express personal needs and understand the needs of others
- Give and receive emotional support
- Make decisions and solve problems
- Anticipate and predict behaviour
- Regulate power

Table 2: Uses of interpersonal communication (SkillsYouNeed 2015)

3.3 Barriers in communication

At any point the process of communicating individuals can run into barriers that prevent the message being received the way it was meant to. “Noise” by another name. For example using lingo or jargon of over-complicated technical terms can stand in the way of understanding if the receiver is not familiar with the terms being used. Whatever the reasons behind it, emotional barriers and taboos can hinder effective communication as well. Some things are just not talked about. In close relation to these barriers is the possible barrier of culture. Culture on its own might include taboos, but taboos are not the only speed bump subsumed in culture: the way we interact varies from one culture to another, and so does how we show emotions. (SkillsYouNeed 2015.)

The ability to get one’s message across can also be affected by the recipient’s lack of interest or attention. Distraction such as the recipient finding the message irrelevant can affect the recipient’s ability to understand the message correctly. Differences in viewpoints can affect the message in a similar way. As people tend to hear what they expect to hear, prejudice attitudes and expectations cause limitations to receiving the message as it was meant as well. Physical disabilities should also not be forgotten from the list of barriers affecting communication. Hearing and speech difficulties affect understanding the same as language differences and complications in understanding different accents. Last but not least communication barriers can rise from physical barriers: not being able to read non-verbal cues such as body language. (SkillsYouNeed 2015.)

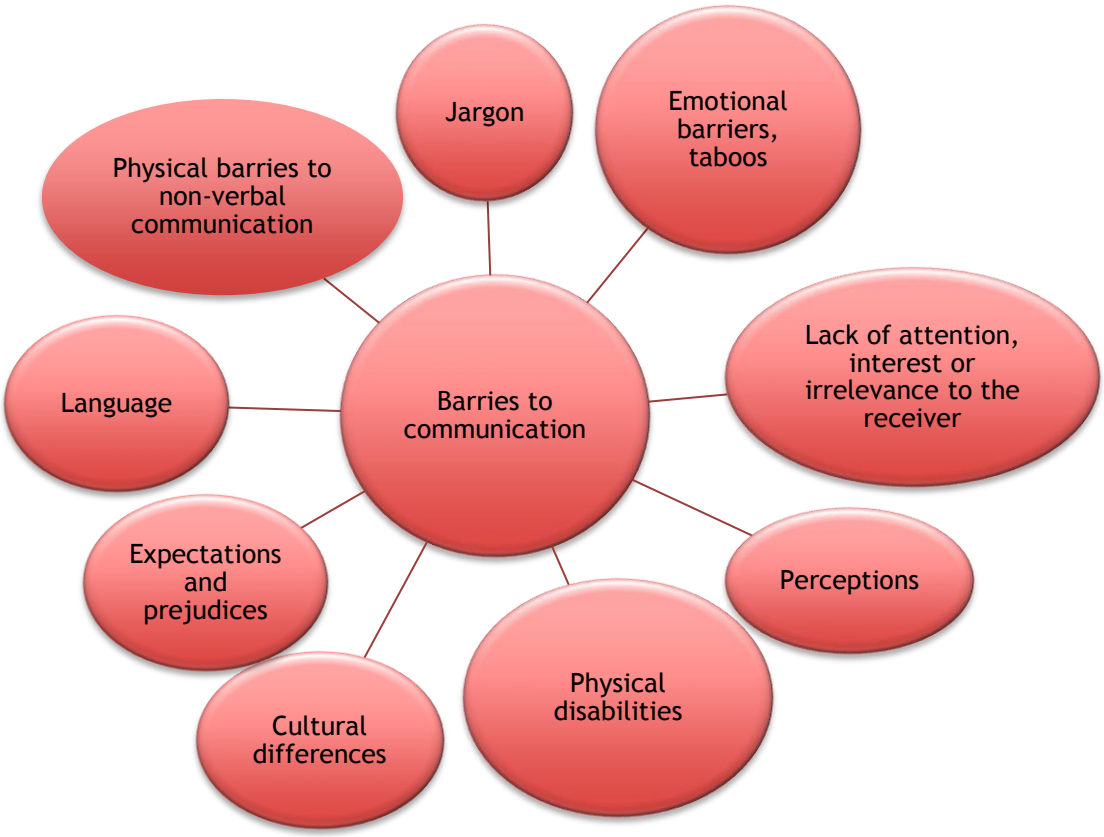

Figure 3: Barriers to communication

The aforementioned barriers to communication can also be categorised in six different types. Language barriers consist of not only different languages, but the use of jargon as well. Psychological barriers are understood as the mental state of the communicators at the point of conversation. Emotions such as anger can substantially affect the course of conversation. Stress and low self-esteem are also recognised as psychological factors affecting communication. Physiological barriers include physical disabilities. Physical barriers on the other hand may be viewed as the literal distance between the two communicators. Luckily nowadays modern technology makes it easier to communicate in spite of geographic distances. Attitudinal barriers are behaviours and perceptions standing in the way of effective communication. Lack of interest to name one. Systematic barriers in turn affect on a level of structures and organisations with unsuitable information systems or communication channels. (SkillsYouNeed 2015.)

4 Health communication and health literacy– definitions and connections

4.1 Health communication

Health communication is the study and practice of sharing promotional health information within provider-consumer interaction, public health campaigns and health education. All intervention efforts aimed at influencing decisions and behaviour change are in essence communicative acts. In the Healthy People 2010 objectives health communication is considered to have an effect in almost all aspects of health and well-being. Which is no wonder, as the blame for various challenges facing health care yet today, is put on failings in communication. Yet at the same time communication in health care is seen as a potential solution. (National Communication Association, Rimal & Lapinski 2009; Edgar & Volkmann, 587; Friedrich 2014, 1; Ruben 2014, 1.)

Throughout time consumer-provider communication has seem to be immune to improvement attempts. The inability to translate communication theory for health care practise is seen - if not as the root or the problem - at least as a significant part of it. Communication process is celebrated for its complexity among those who study it. However, when adapted to the health care field the complexity is often brushed under the carpet, all the while to focus is being moved towards much more simple information-exchange perspectives. Over the years the role of the consumer has been increasingly emphasised. Today consumers are seen as astute, committed and influential health care users and decision makers as well as possible partners and utilising consumer-centric communication is a natural consequence of it. (Ruben 2014, 2.)

4.2 Health literacy

The most common understanding of literacy includes reading, writing and oral skills. Numeracy skills are either considered as a complement to the set of skills included in literacy or as a part of literacy itself. In a broader sense literacy has however been used to refer to competencies such as health literacy, media literacy and information literacy as well. (UNESCO 2006, 149-150.)

Health literacy still today is a comparatively new field of research. Research conducted in this field began with finding a link between the literacy skills of health care consumers and health outcomes. Poor reading skills were connected for example with increased hospitalisations and decreased use of preventative services. Current research on the field has on the other hand taken into account a wider range of literacy skills. Writing, speaking, listening and math have been included. Out of the current definitions of health literacy, perhaps the most comprehensive is the one also used by the World Health Organization: “Health literacy

represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health" (Nutbeam 1998, 10). This definition gives a broader perspective, deeper meaning and purpose of literacy for people than some of its predecessors. (Nutbeam 2006, 259-263; Rudd, Rosenfeld & Simonds 2012, 16-17.)

Health literacy today is seen to affect people's ability to locate - and communicate with - health care providers as well as engage in self-management and understand mathematical concepts (needed for example in understanding medication dosages). It is relative to the communication skills of both health care consumers and professionals as well as their knowledge of health topics. Health literacy is also dependent on culture, not to mention the demands of the situation and health care systems. In recent years health literacy has been increasingly raising scientific and clinical interest due to its apparent link to people's health. There are also indications that health literacy skills have an association to participation in health promoting behaviours. (Van der Heide, Wang, Droomers, Spreeuwenberg, Rademakers & Uiters 2013, 173; Möttus, Johnson, Murray, Wolf, Starr & Deary 2014, 164; U.S. Department of health and Human Services 2005; Rudd et al. 2012, 16-17.)

There are assessments designed specifically to recognise consumers' health literacy levels. The most common ones being: the Wide Range Achievement Test (WRAT), the Rapid Estimate of Adult literacy in Medicine (REALM) and the Test of Functional Health Literacy in Adults (TOFHLA). The Health Literacy Skills Instrument (HLSI) on the other hand is seen as a more modern and comprehensive evaluation instrument to its predecessors. However, all of these tests can take up to an hour to perform, which is more time than most consumers are willing to spend - or professionals are able to spend - on an appointment. Other assessment tools that can be used include the Health Activities and Literacy Scale (HALS) and The Newest Vital Sign (NVS) by Pfizer. As the amount on instruments possible to use tells, the field of health literacy is still lacking a coherent and complete standard tool for health literacy evaluation. (Pontius 2013, 248; Pfizer 2005; Van der Heide et al. 2013, 174; Rudd et al. 2012, 20-21.)

4.3 Connecting health literacy and health communication

Health communication as a discipline is seen to have an impact in virtually every spectrum of health and well-being, this including health promotion. Health education in turn – albeit infrequently used as a synonym for health promotion – is a key component and action in the field of health promotion. Health promotion, education and communication can be directed towards improving health literacy. However, low fundamental literacy levels also need to be taken into consideration in all of the functions of aforementioned disciplines, as they can pose noticeable barriers in receiving and processing the message. (Nutbeam 2006, 259-263;

Palmgren, Jalonen, Jurvansuu, Kaleva & Tuomi 2008, 23; Brega, Barnard, Mabachi, Weiss, DeWalt, Brach, Cifuentes, Albright & West 2015, 1-2.)

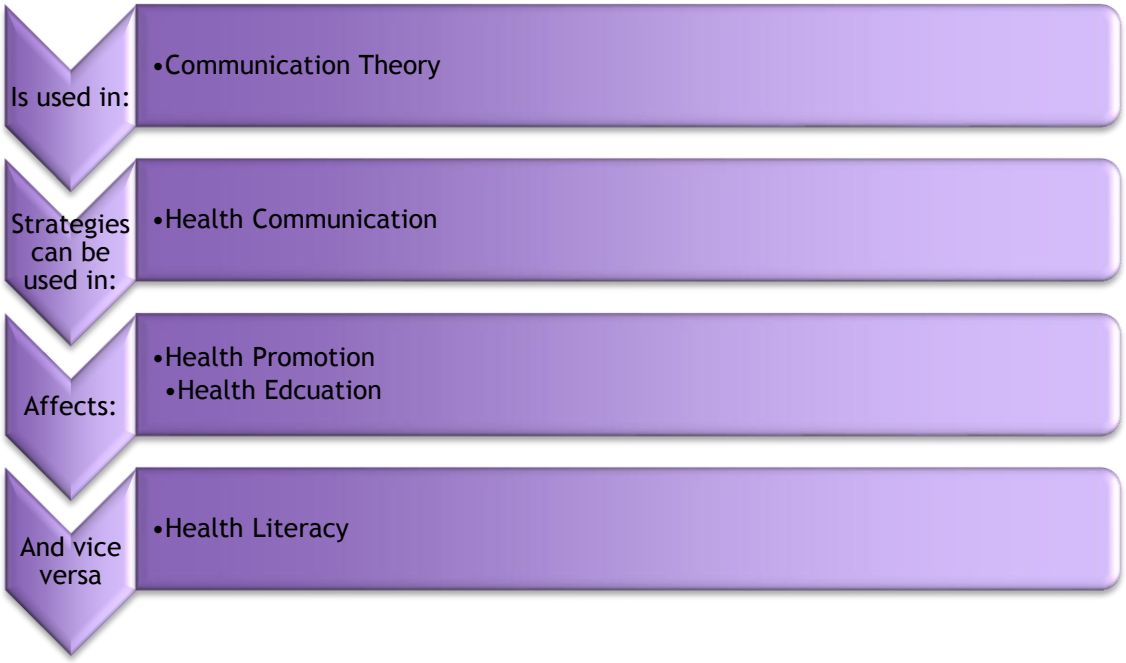

Figure 4: Influences of communication theory

Consumer-provider communication can be considered as the corner stone of consumer education. In the past in provider-consumer communication, limited health literacy skills have rarely been considered. Providers have also been known to be ill-prepared to communicate effectively. Nowadays, the need for consumer education is however well acknowledged in the medical community and more attention is being paid towards communication skills and effects of health communication. No comprehensive and tested guideline on how to communicate differently with consumer of high or low levels of literacy skills exists of today. Instead, providers are encouraged to use strategies that are proven to enhance communication. Communication is considered to be effective when consumers receive correct and clear information at the right time. (Behar-horenstein, Guin, Gamble, Hurlock, Leclear, Philipose, Shellnut, Ward & Weldon 2005, 482-483; Cara 2014, 482-483; Kripalani 2006, 888; Rudd et al. 2012, 22.)

Health literacy promotion techniques are important in health communication programs as the utilisation of commonly used health literacy tools can help avoid misunderstandings in health communication situations. Most health care consumers need help in interpreting and understanding medical information. Even the most highly educated consumers prefer easily accessible verbal information and easy-to-read materials as they are considered less time-

demanding. Also, being well educated does not necessarily make someone health literate. Rapidly progressing medical science and health information overflow can cause confusion and it is very likely for information given in a stressful or unfamiliar situation to be forgotten once the situation is over. (Pontius 2013, 247-248, U.S. Department of health and Human Services 2005; Rudd et al 2012, 20-21.)

4.4 Linking education and health literacy to health outcomes

The 2003 National Assessment of Adult Literacy included an assessment of health literacy on American adults 16 and above. The assessment showed that 53% of the focus group had intermediate, 22% basic and 14% below basic health literacy level. Only 12% of the focus group had proficient health literacy. This means that 9 out of 10 adults may not be able to manage their health and prevent disease sufficiently enough. (Kutner, Greenberg, Jin & Paulsen 2006, 10; U.S. Department of health and Human Services 2005.)

In a study conducted by van der Heide et al. (2013, 176-178) a linear regression analysis gave indications that the less educated individuals were the lower health literacy levels they had. Showing an association between health literacy and education. In the same study the association between health literacy and health outcomes was measured through self-reported general health, physical health and mental health. Higher health literacy meant better outcomes in all three. Heide et al. (2013, 178) also attempted to evaluate whether the effect of education on health is mediated by health literacy. Their findings show that the effect of education is partly mediated by health literacy. The mediation effects of health literacy can be seen on all three health outcomes. It was also concluded that health literacy plays a greater part among those with lower education levels.

In 2012 Loke et al. conducted a systematic literature review in order to estimate the prevalence of low health literacy and to evaluate the causation between low health literacy and health outcomes on patients with chronic musculoskeletal disorders. Their findings did not however offer much support to the assumption that there is a link between low health literacy skills and poorer functional outcomes in patients with chronic musculoskeletal disorders. This study was however restricted to English-language articles which among other data extraction factors may have led to sample sizes not being large enough to be able to detect significant associations. Most of the studies were cross-sectional which also stood in the way of interpreting causal relationships. In another study examining the associations between health literacy and objective health outcomes in older people results indicated that there was a link between low health literacy and poorer health mostly because health literacy reflects general cognitive ability, educational and occupational levels. (Loke et al. 2012, 3-4; Möttus et al. 2014, 164.)

Education indeed plays a crucial role in an individual's ability to manage his or her health as there is strong scientific evidence base on the association of education and health outcomes. Yet the mechanism through which the level of education affects health outcomes remains unclear. Health literacy has been suggested as one possible pathway between the two as it is seen to connect with a vast range of poor health outcomes. Individuals with low health literacy are often found to be of poorer health, inefficiently able to deal with chronic illnesses and have less understanding about health. (Van der Heide et al. 2013, 173; Rudd et al. 2012, 19-20.)

Recently more and more attention is being paid towards the discrepancy between existing literacy skills and the expectations of the health care sector and the providers within. This discrepancy is seen to have a negative impact on health outcomes. This has shifted interests towards examining the health system's demands and the communication competences of health professionals through the lens of health literacy. Evidence has shown that the characteristics of consumer-provider communication indeed have an effect on health outcomes. This has led to paying more attention towards consumer-centric approach to communication. (Nouri, Rudd 2014, 566; Rudd et al. 2012, 19-20.)

5 Verbal health education

Although health communication and consumer education hold great value, not all education is effective. Communication gaps occur often and no matter how good intentions, consumer education that fails to educate could result in quite the opposite of what was intended. In a study conducted by Johnson and Sandford (2005, 427) the findings implied that the combination of verbal and written education lead to more satisfied and conscious parents than verbal education on its own. For this reason, and many others, it is recommended that verbal education should not be used alone as a method of conveying a message. It should be used together with other consumer education methods and on a level that supports the consumer's learning and comprehension. It should be taken into consideration as well that pictures alone are not a substitute for written or verbal communication. Pictures are best used as additional communication methods. (Weiss 2007, 32; Cara 2014, 483.)

5.1 Challenging aspects of verbal health education

Communication between consumers and providers is an irreplaceable component of health communication. Individual's gender, age, background (e.g. culture and religion), barriers such as emotional and communication related and internal factors (motivation, physical or cognitive limitations) are all aspects that can affect how a message is received and comprehended. Quality verbal education forms from understanding the consumer: what is his/her background, reading level and preferred method of learning? After mapping out these factors, it is possible

to apply suitable communication strategies to serve the unique needs of the consumer. Verbal education can be accompanied or replaced by instructional aids and methods of delivery that employ other senses, such as sight and touch. (Duggan 2006, 93-94; Cara 2014, 485.)

Health communication research defines the sharing of information, sensitivity in a consumer-provider situation and partnership building as predictors of better health outcomes on consumers. Showing empathy or concern is often associated with better communication quality. Unfortunately the verbal exchange between a health care consumer and health provider is often groundlessly viewed as interactive and caring. Results of studies show that in real life the interaction between a consumer and provider mainly consist of separate monologues. There is no real effort put into trying to understand the interlocutor's point of view. Often providers take the place of the information provider and consumers the role of the (often passive) listener. (Duggan 2006, 94; Cara 2014, 485-486.)

Ability to follow the instructions of the provider is often related to overestimation of the consumer's health literacy skills. It is not however always necessarily the educator's fault if a consumer has trouble retaining the information given. Sometimes consumers do not even realise they have not understood what was taught. It is not uncommon for individuals with comprehension deficits to not be aware of it. A study conducted by Cara (2014, 486) and his colleagues showed that only 20% of patients in the study reported difficulties in understanding, but about 78% of the patients showed comprehension deficiency in at least one are of their visits. Factors such as age can also play a role in information retention. In Duggan's study (2006, 98) it was suggested that research in the future should focus on researching the verbal and non-verbal cues consumers give when they do not understand what has been said as consumers may occasionally rely on indirect ways of conveying their confusion. (Duggan 2006, 98; Cara 2014, 486.)

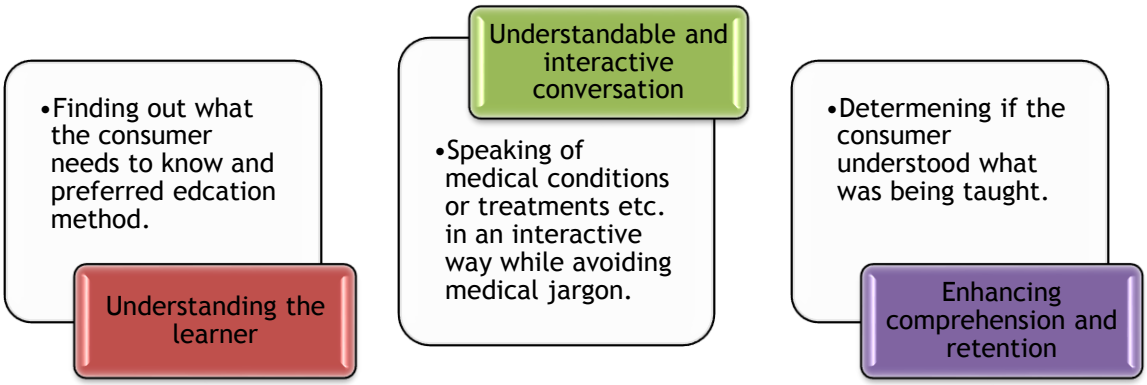

Figure 5: Challenging aspects of verbal education (Cara 2014.)

It is an understandable assumption that consumer-centric approaches take up much more time than more traditional approaches. Results of studies show otherwise. In a study analysing 264 patient-physician interviews, it was found that if patients were allowed to speak freely for as long as they wish for, on average they would speak for only one minute 40 seconds. If consumers feel they are at the centre of the conversation and are allowed to speak freely, they are more inclined to think their needs have been met. (Weiss 2007; Marvel, Epstein, Flowers & Beckman 1999, 285-286.)

The power of consumer-centric communication should never be underestimated, but it is not the only factor often overlooked. Providers still today have a hard time grasping how challenging it is for a consumer to understand what has just been said to them concerning their health. Providers tend to also overlook the stress consumers feel over asking about their health or health care, while also easily failing to recognise how important it is for an individual to have the opportunity ask about health matters concerning them. (Tasmanian Government 2014.)

- How much difficulty consumers have understanding what they are told about their health, including advice and instructions
- How worried consumers are about asking about their health and health care
- How important it is for people to ask questions about their health and health care

Table 3: Factors providers often under-estimate (Tasmanian Government 2014)

5.2 Consumer-centric approach

Since the instruments used to evaluate health literacy are so diverse and mostly used in research, it makes sense to go by the assumption that all health care consumers have some level of difficulty understanding health information. The Health Literacy Universal Precautions Toolkit provides valuable resources to improve health communication. Methods within the toolkit are seen as useful to both individuals with high and low literacy skills. (Rudd et al. 2012, 25; Lambert & Keogh 2013, 34.)

Consumer-centric education includes tailoring information to the specific needs and health literacy level of an individual, in other words consumer-centric education is suitable to its target audience. Although it is important to recognise individual differences in provision and exchange of targeted health information, there are some strategies that should always be in place. No one is an expert in anything unless they study the matter in depth. This including health. That is why it makes sense for health care provides to use “living room language” when speaking to consumers. Speaking as if you were speaking to your grandmother should ensure an equal chance for all to understand the information provided. It also creates an atmosphere where it is easier for the consumer to engage in the conversation and ask questions. (Weiss 2007, 30.)

6 Purpose of the thesis and research questions

The purpose of this thesis is to create a theoretical base upon which TULE-tietokeskus can build manual consisting of concrete health communication tools supporting consumers’ comprehension and health literacy skills. This is done by carrying out a literature review of guidelines focusing on verbal health communication and health literacy. Results of the literature review will contribute to the first part of the manual, focusing on verbal communication. Part two will describe health literacy techniques for written health communication.

Research question:

What communication strategies are recommended for interpersonal verbal health communication in order to support comprehension and health literacy?

7 Research implementation

The search, analysis and conclusions were conducted in May 2015 over a period of one and a half weeks. The search conducted focused on public guidelines for improving verbal health instruction and communication. Both guidelines aimed regionally and nationally were included. Due to the limited amount of guidelines found, the search was not restricted to guidelines focusing on musculoskeletal health communication.

7.1 Research method

Even though systematic literature review is categorised as theoretical research, it is possible to use content analysis as a supportive method in it. When doing so, a certain amount of research material, from which the information needed will be extracted and summarised from, is required. This study falls in to the category of qualitative research. Thematic content analysis was used for the analysing and synthesising process. (Tuomi & Sarajärvi 2009, 123–124.)

7.1.1 Qualitative research and literature review

One of the most important bases for qualitative research is to describe real life. It is impossible to divide real life into segments, thus making it qualitative research goal to examine the chosen subject as a whole instead. Detailed and multilateral examination without a hypothesis included in its general features. The intent is not to provide statistical generalisations, but rather to portray phenomena or occurrences, understand certain activities or to give theoretically meaningful interpretation to a phenomenon. Therefore it is in principle important, that the informants used in the study, know as much as possible on the study subject or have extensive experience on the matter. In this sense the process of choosing informants or information sources should not be random but rather premeditated and appropriate for the purpose. (Hirsjärvi, Remes & Sajavaara 2007, 157-168; Tuomi & Sarajärvi 2009, 85.)

In the study report, it is important to bring forth the deliberation process of informant selection as well as how the choices made fulfil the criteria for suitability. It is possible to use self-made or already existing checklists or indicators to support the quality assessment of information sources. The quality of the guidelines used was assessed through a self-made checklist (appendix 1). In this the main emphasis was on the expertise of the party or authors involved

in the making of the guideline. It was ensured that the authors had a background in health literacy, health promotion, public health and/or health communication. (Tuomi & Sarajärvi 2009, 86; Kontio & Johansson 2007, 101).

1. Reference	**Edition/revised**	**Subject Suitability**
Health Literacy Universal Precautions Toolkit. 2015.	2nd edition	Designed to be used in any primary care setting, although some tools are applicable to other settings as well.
Quality evaluation	**Expertise**	**Peer-reviewed**
• Authors specialists in health literacy/health communication/health promotion/public health • 12 primary care practises participated in the testing of the toolkit	Methodological cores in Qualitative Science, Practice-based Research Networks, Biostatistics and Analysis, Shared Decision-making and Health Informatics/mobile health.	N/a

Table 4: Checklist example

This study, although applying the principles of systematic literature review, differs in ways that makes it more of a plain literature review. Systematic literature review is the secondary analysis of existing, carefully defined and chosen, studies. It differs from other literature reviews due to its specific purpose and particularly strict process of choosing, analysing and synthesising studies included. In systematic literature review every step of the process is carefully defined and documented in order to avoid errors and to enable repeatability. In the final stage of a systematic literature review, the results are analysed, conclusion drawn and possibly recommendations made. (Johansson 2007, 4-7.)

There are many connections between the method used in this study and the more traditional systematic literature review. The most prominent difference however is that due to the nature of this study the literature review focused on an analysis of public guidelines instead of secondary analysis on primary studies. As Johansson (2007, 3) has pointed out, the purpose of the literature review fundamentally influences the material included in the research. The intent here was to gather up and analyse guidelines on health literacy communication strategies

in order to answer a specific question: What techniques for improving verbal health instructions and communication do public guidelines for health literacy recommend?

The literature review done in this study differs from systematic literature review also in the sense that the process of including and analysing studies in systematic literature review requires the work of at least two researchers. This is considered vital for the quality and trustworthiness of the study (Johansson 2007, 6). This thesis was done alone and therefore the inclusion of guidelines and interpretations was based solely on the knowledge and views of one person.

7.1.2 Thematic analysis

In a loose theoretical frame content analysis can mean the process of analysing the contents of either written, heard or seen phenomena. Thematic analysis involves the identification of the most eminent themes in the literature and summarising the findings of different studies under thematic headings. Thematic analysis can be either data driven or theory driven. (Dixon-Woods, Agarwal, Jones, Young & Sutton 2005, 48; Tuomi & Sarajärvi 2009, 91.)

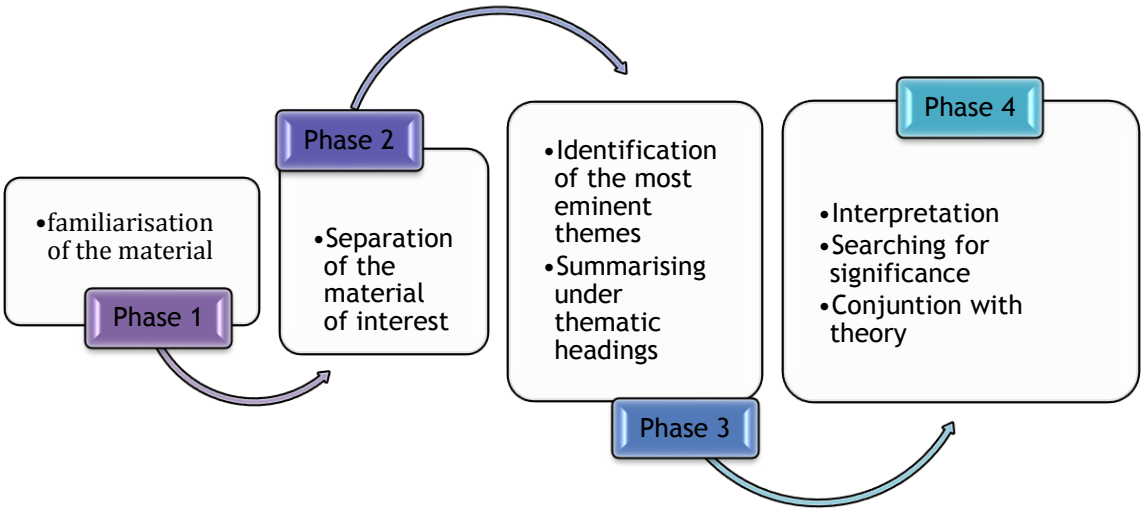

Figure 6: Phases of thematic analysis

7.2 Study design

This study was done in phases. First phase involved getting familiar with the material. This included the process of literature search and choosing suitable guidelines from the search results. Second phase focused on extracting all relevant information from the publications found and writing it out in simplified terms without losing their meaning. Phase 3 included grouping the terms based on their similarity and further on connecting these groups under suitable thematic headings. Phase 4 involved interpretation, searching for significance and conjunction of the findings with theory.

7.2.1 Literature search

In systematic literature review it is necessary to give detailed inclusion criteria for the primary studies included. They are based on the research questions and defined before the actual selection of the primary studies. The selection process takes place in stages, based on whether the studies found in the literature search match with the given inclusion and exclusion criteria. Their compatibility can be examined either on title, abstract or full text level. (Stolt & Routasalo 2007, 59.)

TULE-tietokeskus' main target group is the working age population. For this reason only guidelines focusing on the health communication towards adult population or general public were included. It was also mandatory that the guidelines approached the subject from more than one strategy's point of view. Focusing on other areas of health communication was not an exclusion criterion on itself, but it was required that verbal communication was covered as well. It was desirable that the guidelines were tailored for health care and focused on the client-professional perspective. Guidelines published between 2010 and 2015 were included. Language preference was either Finnish or English.

Exclusion criteria on the other hand included such factors as focusing on special groups such as immigrants or children. Also guidelines focusing on a specific illness were excluded. Guidelines approaching the subject from the angle of just one strategy (e.g. plain language) or focusing on solely other forms of communication were ruled out. Recommendations tailored for other fields or ones taking a perspective other than client-professional were ignored as well. Guidelines published in other languages than English or Finnish were not included.

Inclusion criteria

- Focuses on health communication towards adult population or applies to all age groups.
- Approaches the subject from more than one strategy.
- Focuses on verbal communication.
- Guidelines are tailored for health care.
- Focuses on the client-professional perspective.
- Published in the timeframe of 2010-2015.
- Published in either Finnish or English.

Exclusion criteria

- Focuses on special groups such as elderly, children, immigrants.
- Focuses on a specific illness.
- Approaches the subject from the angle of just one strategy.
- Focuses on other forms of communication, such as written materials.
- Guidelines are tailored for other fields.
- Focuses on other perspectives such as professionals-media.
- Published in a language other than Finnish or English.

Figure 7: Guideline Inclusion and exclusion criteria

In the initial search for literature on health communication and health literacy it was noticed that computerised bibliographic databases such as PubMed and CINAHL did not offer results on guidelines, but rather on – as they are supposed to – studies conducted in the field. This meant that in order to find suitable material, a little creativity was needed. A test search was conducted on different indexing Internet search engines such as clusty.com and PolyMeta in the attempt to map out suitable search engines.

Ultimately the literature search was conducted through PolyMeta, a universal Meta search and discovery engine. PolyMeta uses "conceptual and contextual analysis and clustering of retrieved content based on proprietary linguistic (lexical-morphological, syntactic, semantic and pragmatic) and statistical text processing techniques" (WebLib 2011). Search engines Google and Bing were included in the sources. An attempt to find the same guidelines later on PubMed and CINAHL, based on their titles, lead to zero results giving further affirmation to the original assumption of CINAHL and PubMed not being a suitable search engines for this type of literature search.

Search terms "toolkit health communication health literacy", "guide health communication", "guide health communication health literacy" and "health literate organization" were used. The last search term was included based on the previously done theoretical frame. One of the guidelines was found in this process and it felt appropriate to find out whether there was only one guidebook to be found under the aforementioned search term.

Search terms “toolkit health communication health literacy” lead to 57 results. The results were compared to the previously determined inclusion and exclusion criteria. 1 was included. 20 results were excluded based on title and 22 based on abstract. Two of the guidelines found did not match the given timeframe. 9 results were duplicates of guidelines already included and three results could not be accessed through the link given. “Guide health communication” lead to 75 results. 1 guideline was included. 49 were excluded based on title and 19 based on abstract. 2 were duplicates and 3 could not be accessed. One guideline did not match the timeframe. “Guide health communication health literacy” resulted in 78 hits. 53 were excluded based on title and 14 based on abstract. 11 results were duplicates of guidelines already included. This search lead to zero new guidelines. “Health literate organization” in turn turned up with 59 results. 1 new guideline was included. 40 were excluded based on the title and 14 based on the abstract. 1 duplicate was found and 3 links did not work.

Search terms:	"Toolkit health communication health literacy"	"Guide health communication"	"Guide health communication health literacy"	"Health literate organization"
Total number of search results	57	75	78	59
Excluded based on title	20	49	53	40
Excluded based on abstract	22	19	14	14
Excluded, duplicate	9	2	11	1
Excluded, published earlier than 2010	2	1		
Could not be accessed	3	3	0	3
Included based on the full text	1	1	0	1
Titles of publications included	Health Literacy Universal Precautions Toolkit, Second Edition. 2015.	Communication and Health Literacy Workplace Toolkit. 2014.		Building Health Literate Organizations: A guidebook to Achieving Organizational Change. 2014.

Table 5: Results of the literature search

Some of the search results were links to sites portraying resources and reading materials for subjects like health promotion, health communication, health literacy etc. A secondary literature search was done through these sites. Eight sites were included. Ultimately none of

the guidelines found matched the inclusion criteria. One guideline not yet included in the study was found, but it was published in 2007.

Total number of sites searched	8
Publications included based on a secondary search (sites found on PolyMeta)	0

Table 6: Results of secondary literature search

During the initial stages of the thesis only one Finnish guidebook on health communication was found. It was published in 1993. Even before the actual literature search, it was relatively eminent that all the guidelines eventually included in the study were going to be in English. A search was however conducted in Finnish with Finnish equivalents of the search terms. Search terms included "terveysviestintä suositus" (health communication guideline), "terveysviestintä terveyden lukutaito" (health communication health literacy) and "terveysviestintä suositus terveyden lukutaito" (health communication guideline health literacy). As assumed, no guidelines were found.

Search term	"Terveysviestintä suositus"	"Terveysviestintä terveyden lukutaito"	"Terveysviestintä suositus terveyden lukutaito"
Total number of results	37	41	43
Accepted publications	0	0	0

Table 7: Search results with Finnish terms

7.2.2 Analysing the guidelines

Thematic content analysis was used to help with the process of analysing the results. First step was to identify the recommendations and extract them from the material. At this point, all the strategies focusing on communicating treatment plans were left out, due to the fact that TULE-tietokeskus does not offer services of such kind. The recommendations found were written out in simplified terms and divided into groups based on the similarity of their content. This was followed by a summary under thematic headings. The thematic headings used in this study rose from Cara's (2014, 485-486) thoughts on the challenging aspects of verbal education.

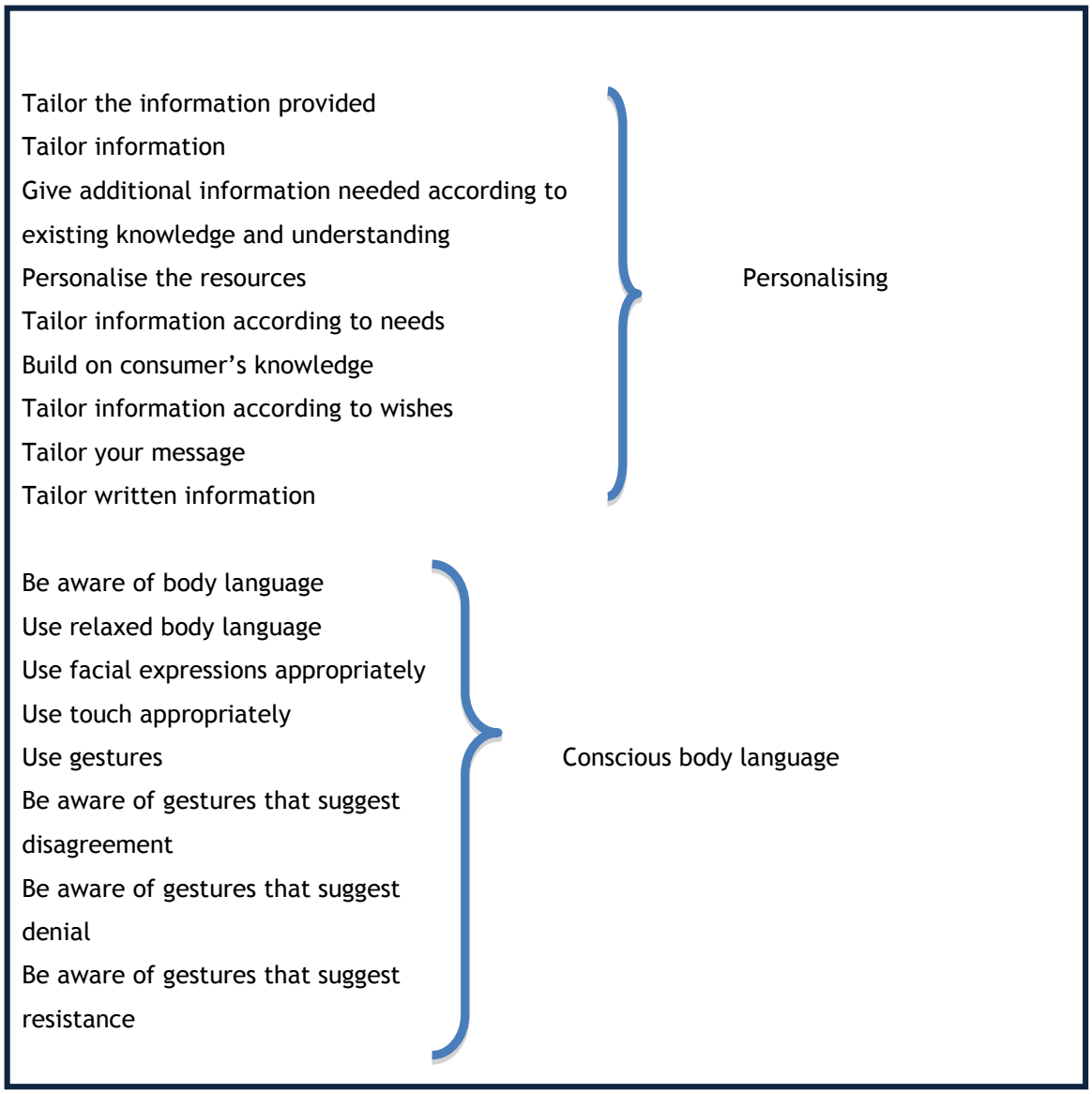

Table 8: Example of recommendation grouping

8 Findings

Dividing the advices identified from the material, and carrying similar meaning, lead to the recognition of different 12 groups. These groups were given names that describe their content. There is no order of importance between them as it was not the intent of this thesis to examine their importance in relation to one another. These groups were then divided under three thematic headings: “Understanding the learner”, “Understandable and interactive communication” and “Enhancing comprehension and retention”. The research question was: “What communication strategies are recommended for interpersonal verbal health communication in order to support comprehension and health literacy?”

8.1 Understanding the learner

8.1.1 Showing interest

The guidelines used in this study placed importance on how providers act towards consumers at initial encounter. It was suggested that not only should providers show friendliness towards consumers with a smile or friendly greeting, but that they should have a welcoming attitude as well. Giving the sense that the provider has time, is interested and willing to listen were mentioned as well. Importance was placed also on showing that the provider has energy.

8.1.2 Mapping out

In order to ensure that the communication and sharing of information was on an understandable level to the consumer it was recommended that providers ask questions to assess the consumer’s level of understanding. Checking for previous knowledge through soliciting questions and paying attention to past experiences seemed to be advisable. Taking note of the words the consumer uses and becoming familiar with them was recommended. It is no surprise that it is important to pay attention to the level of health literacy as well. Defining the type of information wanted as well as paying attention to the physical and emotional state of the consumer were mentioned as well. At this point identifying incorrect information is also of importance.

8.1.3 Active and open-minded listening

Closely related to the process of “mapping the consumer out”, is the practice of active and open-minded listening. Making eye contact and nodding when appropriate was suggested. Asking questions and paraphrasing were recommended to ensure staying on track with what the consumer is saying. It was however noted that interrupting is not advisable. Being attentive,

paying attention, looking and listening all were named as qualities of a good listener. Avoiding leaning back and instead leaning slightly forward was considered as important. Showing empathy and non-judgemental attitude, by placing personal beliefs aside, were considered as good qualities in the provider. In other words the process of understanding the problem from the consumer's point of view is important. Making the consumer feel comfortable by using a caring tone, displaying comfortable body language and being physically at the same level was recommended.

8.2 Understandable and interactive communication

8.2.1 Interactive conversation

Active listening alone is not enough. There are also requirements and recommendations for the actual conversation happening between the consumer and the provider. Encouraging questions and involvement in the conversation were highlighted. The conversation was though to be interactive when consumers were encouraged to make statements like "tell me more". The use of Ask-Tell-Ask-method was also seen as important.

8.2.2 Familiar language

The language being used plays a vital role in keeping the conversation going and not losing the consumer's interest. Avoiding jargon and using non-medical language was highly recommended. Being consistent with word use and modelling, as well as using, clear language were advised. Using common everyday words, preferably words the consumer uses, was advised as well. Plain language was highlighted and so was using active voice instead of passive voice. When it was not possible to use "living room language" or the consumer had difficulties in understanding even the most basic words, using examples to explain uncommon and unfamiliar words was recommended. When presented with a literal language barrier, it was advised to use interpreters.

8.2.3 Avoiding ambiguity

Using uncommon words can cause misinterpretations, but there are other reasons for misinterpretations too. This is why the guidelines reviewed in this study recommend confirming understanding before moving to the next point and reviewing key points with the consumer at the end of the conversation. It is also recommended to give the consumer time to absorb the new information. In other words it is important to slow down, keep the pace suitable for the consumer and pause after key points. Rephrasing and re-explaining when needed is seen as a good way to go.

If the consumer has a lot of questions it makes sense to repeat the key points after every answer. Not just at the end of the conversation. However, if there is too many questions, utilising the Ask Me 3 is recommended. Explaining in a specific and concrete way is advisable. As is speaking clearly, clarifying and reflecting on the information provided. Using non-shaming open-ended questions was mentioned to be very important. Open-ended questions are question to which the consumer cannot answer just “yes” or “no”. Last but not least it was highly recommended for providers to emphasise that it is their responsibility to explain clearly.

8.2.4 Personalising

Tailoring the information provided was seen as a helpful tool in ensuring consumer’s understanding. Not only did this mean tailoring the message to understandable form but tailoring it according to the needs and wishes of the consumer. Building on consumer’s knowledge and personalising the resources, whether it be written information, visualisations or verbal knowledge, was recommended. When the consumer exhibited some previous knowledge on the matter at hand, it was recommended to give additional information needed according to the existing knowledge and understanding. Provided the existing knowledge and understanding were correct.

8.2.5 Respectful communication and supporting self-efficacy

The guidelines used in this study reminded that it is equally important for the provided to pay attention to his or her tone, pitch and emphasis while speaking to a consumer. Using a positive, respectful and friendly tone was recommended. Respectful communication was also seen as building a partnership with consumers and informing them in a respective and friendly way. Confirming and offering praise on what the consumer had already done or understood and encouraging finding more information were recommended. When encouraged to find more information it was seen as important to also show where to find further information. It was recommended also to help consumers learn to Teach Back for further encounters with health care providers.

8.2.6 Using conscious body language

In general it was recommended that providers pay attention to their non-verbal communication. It was suggested that providers use relaxed body language and facial expressions. The appropriateness of facial expressions and touch emphasised. Using gestures was recommendable, however when it came to the non-verbal communication of the consumer,

providers should pay close attention to gestures that suggest disagreement, denial and/or resistance.

8.2.7 Using supportive techniques

Suggested methods for supporting verbal communication included many different ways of illustrating what had just been said. Using visual aids such as pictures, 3-D models and demonstrations as well as written information, such as brochures and booklets, were recommended. There is not necessarily always an opportunity to use ready-made materials. It is also possible that the handouts “at hand” are not suitable as such to the needs of the consumer. It is then recommended to write down key points or help the consumer to write down important information. Or in the case of less suitable material, write down additional information. Tailor the material at hand.

8.3 Enhancing comprehension and retention

8.3.1 Prioritising

Results of the study show that “chunking” information, as in limiting it to 3-5 points at a time is smart. Preferably three. Focusing on need-to-know information instead of nice-to-know information was preferred. Drawing attention to the most important information and highlighting key points was seen as a helpful tool in ensuring understanding. Focusing on the main problem was followed by focusing on the main action that needs to be taken and explaining why. Using methods as Ask Me 3 were mentioned.

8.3.2 Collecting feedback

It was recommended that providers would collect feedback to check whether they had communicated effectively or not and to confirm consumer’s understanding. It was preferred to check for understanding after each “chunk” of information and re-teach if needed. According to the guidelines the consumer can either explain or demonstrate what the provider said. Asking the consumer to repeat back in own words what was taught, the Teach Back method, was highly recommended. Inviting questions and paying attention to both verbal and non-verbal clues can give the provider valuable feedback on how he or she has done as an educator.

9 Conclusions

Verbal health communication that takes into account the aim of improving individual's health literacy skills seemed to be strongly influenced by the general rules of good and effective communication. It could be concluded that providers need to take in to consideration multiple factors of communication in order to provide health education suitable to all health literacy levels. Successful verbal health communication is more than just choosing the right words. It was seen as necessary to also take into consideration the way the provider conducts in the situation and the unique requirements of the consumer.

The common theme that rose from these guidelines was, that provider-consumer communication aiming towards better comprehension needs to happen in the consumer's terms. Consumer-centric approach to communication is known to have positive effects on mapping out the consumer's concerns and beliefs, the level of empathy show by the provider and consumer's perception of attentiveness (Nouri & Rudd 2015, 566). Verbal health communication supporting health literacy also requires the sender to encode the message in a way that takes into account factors affecting the receiver's decoding processes.

All tree guidelines placed emphasis on communication strategies that improve provider's understanding of the consumer and his or her individual needs, as well as strategies that help the process of communication to be more understandable and interactive. As in all communication, strategies that enhance comprehension and retention were considered vital as well. Results were consistent with previous research findings on the importance of verbal communication strategies always being used in conjunction with other health communication and health literacy strategies.

9.1 Creating an understanding environment

The guidelines used in this study emphasised that the health communication process starts the minute the consumer walks up to the provider. Before any verbal communication has even occurred, the provider can win over the consumer's trust and attention by mere gestures. Showing interest and that the presence of the consumer is not an inconvenience to the provider might make the situation more comfortable for the consumer. As the consumer relaxes and opens up, it is easier for the provider to map out the consumer and this way try to ensure that the messages sent are received the way they were meant to.

Mapping out included the process recognising and familiarising the words that the consumer uses. This again is a prerequisite for communicating a clear, "consumer friendly" message. Emphasise was also placed on the provider's ability to recognise communication barriers and –

if possible - dissolve them. In order to tailor the message to a suitable level, the provider needs to chart the consumer's current level of understanding and previous knowledge on the matter. Especially those with lower literacy seem to learn better when the information is personalized (Nouri & Rudd 2015, 568). Current health literacy level can be assessed, but it was more recommended to assume everyone has some level of difficulty in understanding health information.

In order to be able to map out the consumer the communication strategy of active listening needed to be in place too. This included both verbal and non-verbal actions. Non-verbal actions included cues such as nodding to indicate that the provider is listening and understanding what is being said. On the other hand non-verbal cues that indicated indifference, such as leaning back on a chair, are to be avoided.

Verbal actions meant asking questions and paraphrasing when needed. Basic communication skill such as not interrupting and finding a suitable place for further questions were also on the list of strategies needed. In other words in order for effective verbal health communication to happen, the provider needs to know how to conduct in the message receivers' end as well. For example, giving feedback that supports right conceptions of the consumer.

Putting personal beliefs aside and seeing the problem from the consumer's point of view helps the communication process in general, as it is easier for the consumer to accept information that she or he can relate to and is not judgemental. Using other actors to show acceptance was advisable as well. Strategies such as using a caring tone and displaying comfortable body language can make all the difference in how the message is being received and understood. This can help consumers feel they have control over their own health as well as help them feel non-stigmatised and motivated (Ennis, Hawthorne & Frownfelter 2012, 150).

9.2 Conveying a clear and concise message

Provider-consumer communication requires an interactive dialogue where active listening and speaking take turns. Encouraging the consumer to take part in the communication process and to solicit questions was seen as important. It was seen suitable for providers to use the Ask-Tell-Ask-method. In Ask-Tell-Ask the provider first determines the consumer's current understanding of the issue, then tells in a straightforward way what needs to be told and finally checks for understanding (Bodenheimer, MacGregor & Sharifi 2005, 9-10). In fact, Ask-Tell-Ask is what connects interactive conversation to the process of mapping out the consumer.

The guidelines recommended the use of familiar language, which is one way of avoiding (some of the) noise. The use of familiar language – preferably words that the consumer uses - was

connected to keeping the conversation going, not losing the consumer's interest and to supporting overall understanding. Being consistent with word use helps in avoiding confusion. Using "living room language" instead of jargon or medical lingo was reasoned not only through better understanding but better compliance to health behaviour changes. Using plain language and active voice were recommended as they make the message more connectable and help the consumer to find the information she or he needs the first time she or he hears the message. This is highly important as research shows that health care providers tend to speak on a higher grade level as well as use longer phrases and more passive voice than consumers (Nouri & Rudd 2015, 568). Taking time to explain uncommon words and recognising when an interpreter is needed were seen important in message conveying process as well.

A way of ensuring no misinterpretations have occurred is to check for understanding before moving to the next point and reviewing key-points at the end of the conversation. It is also a known communication strategy to slow down and keep the pace suitable for the consumer, even when faced with a long list of questions. Giving time to absorb the information and the possibility to ask further questions can help the consumer to understand the, sometimes complex, health message. Speaking in a concrete and specific way is seen as a helpful strategy as some times words can have double-meanings. Rephrasing and re-explaining is an obvious way to ensure no misunderstandings have happened. Reflecting on what has been told is thought worth of consideration as well. Sometimes consumers will say they understand when in reality they do not. In such situation it is suggested that non-shaming open-ended questions are used in order to evaluate how much the consumer really understands. It is emphasised though that the responsibility for the consumer's comprehension always lies on the provider. It should be stressed that that it is the provider's responsibility to explain clearly.

Using different channels to support the verbal message was of high importance. According to the guidelines graphics of any kind can be used as long as they are target group suitable and preferably tailored to each individual. This makes sense as studies have shown that the use of pictographs as supportive methods can increase the correct recollection of spoken medical instruction up to 85% instead of the 14% of spoken instructions alone (Pontius 2013, 251). Written information in the form of ready-made brochures, self-made notes or ready-made notes with additional self-made notes can be used as well. The same principle of tailoring information applies here. Tailoring however does not mean only the transition of information into understandable form, but also the process of finding out and moulding the message according to the consumer's needs and wishes. Building on existing knowledge is seen vital.

As verbal messages hardly ever rely solely on words, attention towards other aspects of verbal and non-verbal communication was drawn. Based on the guidelines body language, facial expressions, tone and pitch of voice and the emphasis the provider puts on his or her words all

affect the way the consumer reads the message. Gestures can helpful in two ways: they can support the message being send as well work as clues to the provider on consumer's disagreement or denial. The relation between consumer's and providers is nowadays seen as a partnership. As in all partnerships the willingness to receive and understand messages from one another is dependent on the level of respect shown among the partners. Informing in a friendly way and offering praise (when the consumer gets it right) can increase the willingness to listen. Supporting self-efficacy through teaching effecting communication techniques such as the Teach back can support the consumers understanding and health literacy later on as well.

People tend to remember about half of what told to them in a situation (Williams, Davis, Parker & Weiss 2002, 283). This is why the guidelines recommend choosing words wisely and prioritising the content, as in limiting the amount of information or messages given at one time. Usually three points at a time was seen as suitable for each chunk of information. Being an expert means having crystallised knowledge on the matter of interest, however when in a provider-consumer communication situation it is best to focus on the need-to-know information rather than the nice-to-know. Adverse Ask Me 3 can be applied: focus on the main problem, main action and explaining why.

Although providing numerous strategies to improve understanding, it seemed to most important message the guidelines were trying to convey was, that unless you check for understanding through feedback, there is no way of knowing whether the consumer comprehended what was said or not. Seeking to understand meanings imposed by the consumer via processes such as actively listening to feedback were of great importance. Being open to feedback was something that should be done throughout the communication process. After each chunk of information the provider should stop to collect feedback. Feedback in this instance does not mean the consumer giving feedback on the provider's personality, but the verbal and non-verbal cues the consumer demonstrates on whether the message was conveyed clearly or not.

Three actual evidence-based comprehension supporting health literacy techniques were included in the results: Ask Me 3, Teach back and Health Literacy Universal precautions. The rest of the strategies were more consistent with what is considered basic communication skills. Ask Me 3 highlights the importance of consumers asking three core questions at clinical consultations: What is my main problem? What do I need to do? Why is it important for me to do this? When it comes to guiding the consumer-provider conversation, Teach back has been considered as the golden standard. It is used both to measure the clarity of the presentation and to ensure the consumer is following and understanding what is being said. Health Literacy Universal Precautions on the other hand are based on the recommendation that it is appropriate to assume everyone has some level of difficulty in understanding health related information. (Rudd et al. 2012, 25; Lambert & Keogh 2014, 34-35.)

10 Discussion

It took notable time and research to come up with the eventual aim of the thesis. In fact, it took a significant part of the time reserved, leaving a lot less time for the actual conduction of the study. Due to limited time resources it was not always possible to write out every aspect of the theoretical frame as in depth as it should have been. However, the research done prior to the actual study lead to much more knowledge and understanding of the health literacy field than was expected. This in turn will serve a great purpose in the work done in TULE-tietokeskus. It is fair to say that this thesis constitutes only for a small proportion of the actual new knowledge gained and utilised in TULE-tietokeskus. The goal of overall professional development was gained and once again the author of this thesis was reminded that the more you know, the more you understand the limitations of your knowledge.

Having just one person working on this thesis was both an advantage and disadvantage. Advantages included not having to worry about other people's timetables, but at the same time progress only happened when the sole author had time. There is no disagreement on the content or process of analysing the results when working on one's own. One might however end up being blind to one's own text and it would have been helpful to have someone read what was produced every now and then. The author of this thesis by nature tends to contemplate things quite a lot and at times it was notably hard to continue working on the thesis when feeling unsure and questioning one's self.

10.1 Discussion of the findings

As all the strategies focusing on communicating treatment plans were left out, and the main focus of the results was on basic communication skills, the majority recommendations found seemed suitable to TULE-tietokeskus. Especially all the health literacy techniques mentioned are very suitable to settings such as TULE-tietokeskus. Even Ask Me 3 can be adapted to suite health organisations in the third sector. However, even more value is seen on teaching this method to health care consumers and customers of TULE-tietokeskus. This way the next time they are at a doctor's appointment or in the hospital they will know how to make sense of what has been said. In the absence of a comprehensive health literacy evaluation tool, it makes sense to use a bit of time in the beginning of every encounter in order to evaluate the health literacy level of that specific consumer with the means possible. As it is not appropriate for the employees of TULE-tietokeskus to utilise health literacy evaluation tools as such, the idea of assuming that all people have some level of difficulties with health related information, is compelling.

It is worth noting that verbal communication strategies should always be used in conjunction with other health communication and health literacy strategies. This is the intent of TULE-tietokeskus as well. Focus here was on verbal communication and identifying most suitable strategies for TULE-tietokeskus, but the actual manual will take into account other consumer education and health literacy assessment strategies as well. Research done here will work as a guideline for the current TULE-tietokeskus in ensuring an effective and valuable service for health care consumers. The manual, however, can also be used as a point of reference for those third sector health organisations considering starting up a new project in the field of health literacy communication.

Regardless of their primary target group, the guidelines used and the recommendations extracted from them are easily adopted and suitable for other health communication settings as well, third sector health organisations included. However, It was expected that the guidelines found would go much deeper into the matter of verbal communication strategies. Deeper literature research in to communication theories, in order to understand the complexity of communication strategies in relation to health communication better, is in place. Due to limited resources, such as time, this was not however possible at this point.

10.2 Trustworthiness

The suitability of the method used in the literature research can be questioned. However, when compared to the aims of this thesis, and as proved in the literature search process, using PolyMeta can be considered as the most suitable literature search method. Originally this literature search resulted in 7 guidelines. It was however later on decided that only the most current ones are kept. Reasoning behind the decision was that publications older than five years are usually considered as outdated. Although a relative small number of guidelines were found for this study, it can be said that it was enough. The information in the guidelines started to repeat itself relatively fast, causing a state of saturation. No new knowledge was provided in the third guideline. Documenting the inclusion and exclusion criteria helps with the repeatability of the study and also brings additional quality to the study.

Research method in itself is never reliable or unreliable; the trustworthiness of the method is determined in relation to what is being examined (Perttula, 1995, 97). Thematic content analysis made sense as a method of examining the phenomenon. In order to examine the importance of the recommendations in relation to one another, the principles of quantitative research could have been applied. It was relatively easy to see what strategies were highlighted above others, but in order to see how much more importance was placed on those strategies, some form of quantitative research should have taken place.

It is true that one of the most critical stages of content analysis is forming the categories (Sarajärvi & Tuomi 2009, 93). Had there been more time, the way in which the information was grouped might have been revised. It is not to say that it would have resulted in changing the original grouping, but one has to wonder if there would have been a clearer way to group the results. It would have most certainly made the process of drawing conclusions a lot less superficial and a lot easier. Unfortunately as it was relatively hard to draw conclusions from the results, the reliability of the study suffered a bit. On the other hand the congruence of the guidelines made it is easy to find common themes from them. It was easy to make generalisations, which can be applied to various situations.

Having references to theory in the conclusion phase was not only an ethical decision. From trustworthiness point of view it made sense to find extra support from other's theory as there was only one person interpreting the results. It is sometimes believed that no absolute state of objectivity can be obtained in qualitative study and therefore it applies here too. Although trying to remain as objective as possible, some subjectivity, without a doubt, can be seen throughout the thesis. Through the lens of coherence theory of truth the conclusions are true if they are coherent or consistent with other conclusions already verified as true. In this sense this study and its conclusions can be seen as relatively true. Same goes for pragmatic theory of truth in which the belief is true if it works and is salutary. The communication strategies that resulted from this study are highly examined in communication theory and are based on evidence. (Tuomi & Sarajärvi 2009, 135.)

10.3 Ethical considerations

Ethical considerations are not something that is acknowledged only at the end of a study, they are to be contemplated already prior to the actual conduction of the study. Thinking, functioning, choices, examining and solutions all affect the way we perceive and experience the world. Based on this, every action that a researcher does is an ethical one. In qualitative study the way in which the researcher forms the research question and chooses samples as well as decisions regarding subjects that are involved or left out, references and study foci, are all considered as actions producing new meanings and therefore directly ethical resolutions. Varto 2005, 49.)

It could be argued that at least one Finnish guideline should have been included in the study as the guidelines used are published in countries where low literacy levels are a much bigger problem. However, as concluded in many studies, high literacy levels do not automatically guarantee high health literacy skills. Finnish citizens struggle with health information just the same. The principles borrowed from systematic literature review for this study include thoroughly documenting the process of choosing, analysing and synthesising guidelines found.

It could be said that all in all the author did try to make an effort towards justifying the choices of this study.

Ethical requirement is usually defined as the process of considering the wholeness and complexity of the phenomenon being examined (Varto 2005, 175). References in this thesis were chosen keeping in mind the need to capture the complexity of the phenomenon under examination, but it is fair to say that the choices made were, to some extent, affected by the author's perception on what is needed and what is not. Author's values and beliefs did not however interfere with the results of this study. The way in which the author understands the world obviously affects the way conclusions are made, but no moral stand on the matter was presented. When words like "should" were presented in the conclusions, they were based on the opinions of the authors responsible for the guidelines.

It is also worth noting that referring to theory in order to support the conclusions was utilised here and there throughout the whole process of making conclusions. This was done to show that the conclusions are not based solely on the author's understanding, but also on theory produced by others. Albeit on could argue that the author's perceptions do affect the way in which the theory is understood as well. Whether the interpretations of the theory were objective, partially objective or fully subjective it was still seen as ethically important to give credit to those responsible for the theory. This applied to the theoretical frame of thesis as well: other's ideas are not to be presented as one's own.

10.4 Future challenges

Further study should be done into how these methods and strategies are utilised both in the immediate health care field and in the third sector health organisations aimed at health communication. Especially on an individual level, i.e. how doctors utilise them in different settings or nurses in a school environment. The study of health literacy has firm roots in United States, but judging from the minimal amount of current studies conducted in Finland, this matter is only starting to raise its head in Finland. The fact that all three guidelines were highly congruent with each other tells of the strong belief in these methods. However, they seem to move on a very basic communication skills-level, which makes one wonder how well the true complexity of communication has been taken into consideration in health communication. Further studies in this field are needed as well.

The aim was to deepen the author's understanding of health communication, its relation to health literacy and to map out strategies that can support the act of verbal health communication as well as the comprehension and literacy skills of the health care consumer. Albeit this study did not offer much new information, it did serve the purpose of creating a

theoretical base to be implemented in TULE-tietokeskus' health communication manual. The information extracted from the guidelines might be considered as "common sense", but without conscious effort, these tools might not be used as often as we think. The suitability of the results to TULE-tietokeskus was discussed here in a theoretical level. Further research should be put into determining their functionality in real life situations of TULE-tietokeskus.

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Figures

Tables

Appendices

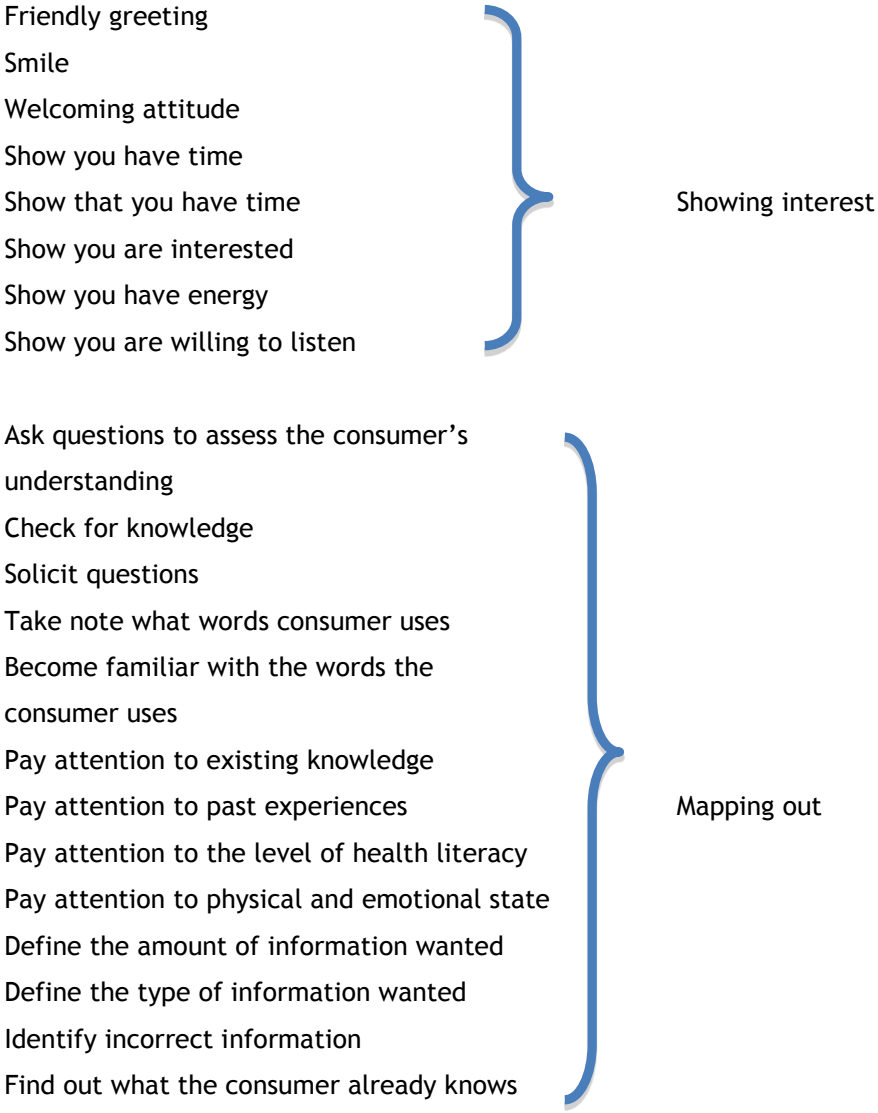
Appendix 1: Quality assessment of the guidelines

1. Reference	**Edition/revised**	**Subject Suitability**
Health Literacy Universal Precautions Toolkit. 2015.	2nd edition	Designed to be used in any primary care setting, although some tools are applicable to other settings as well.
Quality evaluation	**Expertise**	**Peer-reviewed**
• Authors specialists in health literacy/health communication/health promotion/public health • 12 primary care practises participated in the testing of the toolkit	Methodological cores in Qualitative Science, Practice-based Research Networks, Biostatistics and Analysis, Shared Decision-making and Health Informatics/mobile health.	N/a

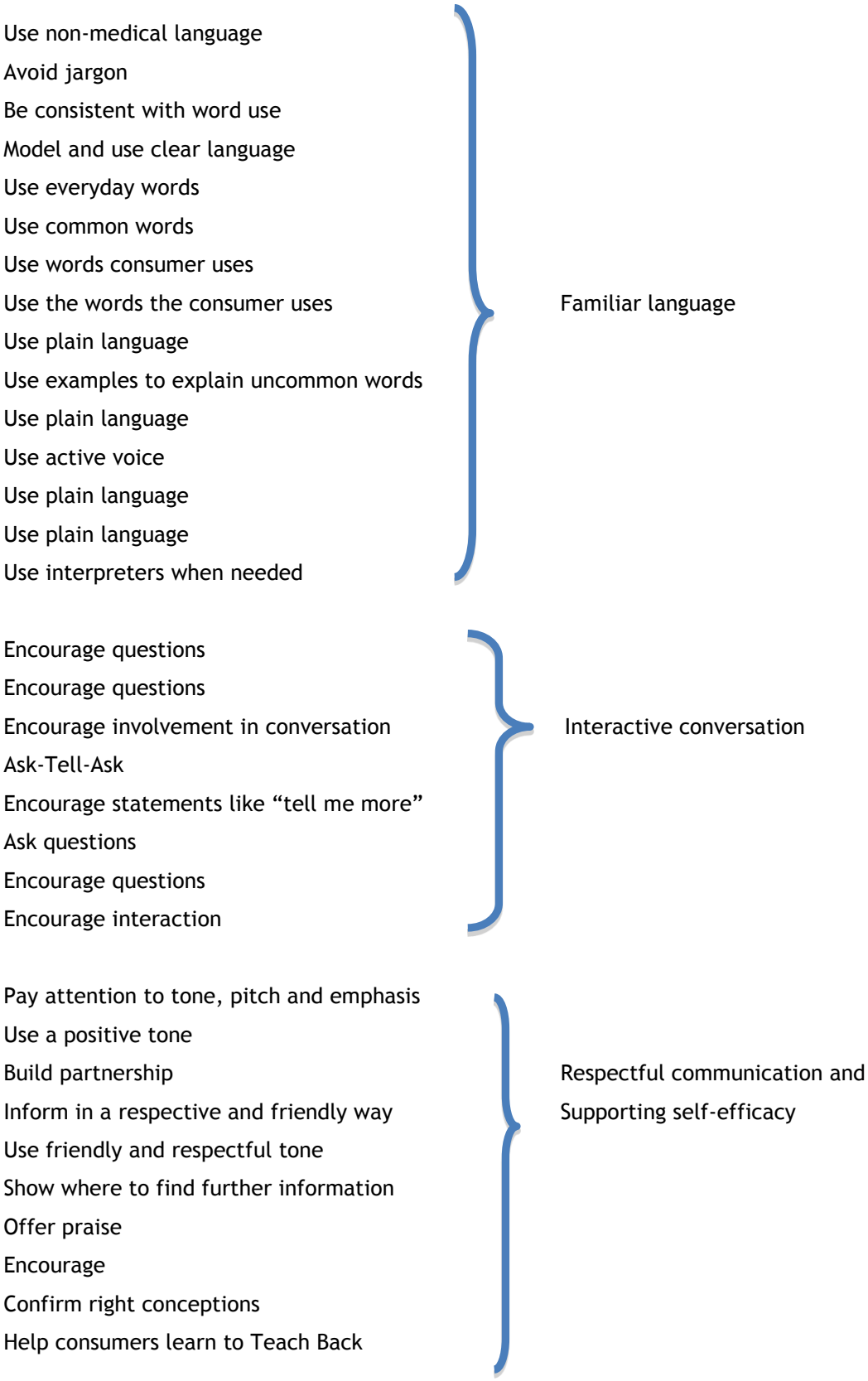
2. Reference	**Edition/revised**	**Subject Suitability**
Building Health Literate Organizations: A guidebook to Achieving Organizational Change. 2014.	1st edition	Designed for health care organisations.
Quality evaluation	**Expertise**	**Peer-reviewed**
• Extensive reference list including: National standards and Peer-reviewed articles. • Based partly on health literacy education experiences in wide range of real life settings	UnityPoint Health is the nation's 13th largest non-profit health system and the fourth largest nondenominational health system.	N/a

3. Reference	**Edition/revised**	**Subject Suitability**
Communication and Health Literacy Workplace Toolkit. 2014.	1st edition	Developed for people providing government health and human services, but is useful for anyone in the health care sector.
Quality evaluation	**Expertise**	**Peer-reviewed**
• Input from variety of staff across health and human services in Tasmania	Setting polices and delivering or funding programs. Monitoring the health status of Tasmanians to help inform decision-making and health priorities.	N/a

Appendix 2: Understanding the learner



Appendix 3: Understandable and interactive communication



Appendix 3: Understandable and interactive communication (Page 2/4)

Listen actively
Make eye contact
Be an active listener
Nod when appropriate
Ask questions and paraphrase
Eye contact
Make eye contact
Do not interrupt
Be attentive
Pay attention
Make eye contact
Look and listen
Avoid leaning back
Lean slightly forward
Show empathy
Make eye contact
Avoid being judgmental
Put personal beliefs aside
Try understanding the problem form consumer's point of view
Make person feel comfortable
Use caring tone
Display comfortable body language
Listen actively
Be at the same level (physically)

Active and open-minded listening

Tailor the information provided
Tailor information
Give additional information needed according to existing knowledge and understanding
Personalise the resources
Tailor information according to needs
Build on consumer's knowledge
Tailor information according to wants
Tailor your message
Tailor written information

Personalising

Appendix 3: Understandable and interactive communication (Page 3/4)

- Support verbal communication with written information
- Use visual aids
- Draw pictures
- Use models or demonstrations
- Use written information to support spoken communication
- Use handouts
- Use pictures
- Use models
- Use demonstrations
- Draw pictures
- Use illustrations
- Demonstrate with 3-D models
- Write down additional information
- Illustrate with drawings
- Write down key points
- Help consumer to write down points
- Use models or props to demonstrate
- Supplement verbal communication with visual tools
- Use brochures and booklets
- Use supporting material
- Use visual descriptions
- Use visual aids
- Support with written information

→ Using supportive techniques

- Be aware of body language
- Use relaxed body language
- Use facial expressions appropriately
- Use touch appropriately
- Use gestures
- Be aware of gestures that suggest disagreement
- Be aware of gestures that suggest denial
- Be aware of gestures that suggest resistance

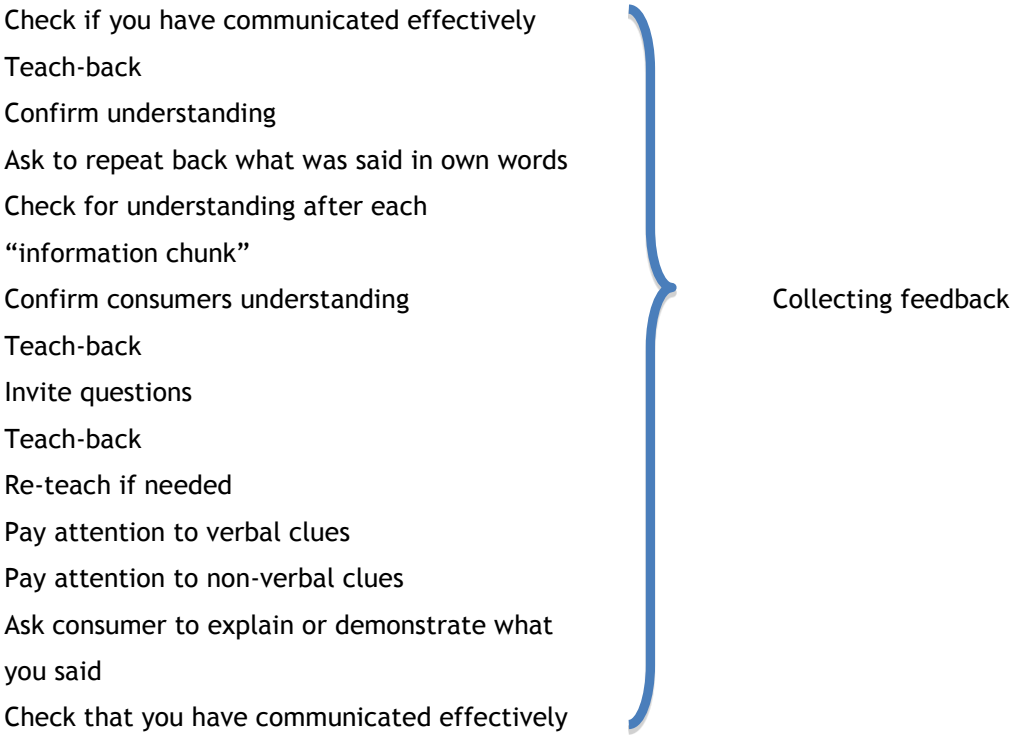
→ Conscious body language

Appendix 3: Understandable and interactive communication (Page 4/4)

Review important points
Confirm understanding before moving to next point
Rephrase and re-explain when needed
Give time to absorb the information
Use non-shaming open-ended questions
Avoid “yes” or “no” questions
Speak clearly
Speak at a moderate pace
Keep the pace suitable for the consumer
Be specific and concrete
Repeat key points
Clarify
Speak clearly
Avoid asking questions with “yes” or “no” answers”
Use open-ended questions
Use open-ended questions
Explain
Emphasise that it is your responsibility to explain clearly
Use open-ended questions
Slow down
Use open-ended questions
Pause after key points
Reflect on the information given
Ask Me 3

Avoiding ambiguity

Appendix 4: Enhancing comprehension and retention



Appendix 4: Enhancing comprehension and retention (Page 2/2)