Health Workers for Change: developing the initiative

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This paper describes an intervention developed in South Africa for health workers at the health facility level, and designed to explore interpersonal relations among health workers and between health workers and female clients. Several participatory methods to explore the provider–client relationship were tested with health workers. Health workers identified many constraints to the provision of adequate health services and that these constraints affected their work in general and their relationship with women clients in particular. Constraints included inadequacies and inefficiencies in management and the lack of gender sensitivity training. The participatory approach was found to be acceptable to the participants and effective in exploring interpersonal relationships.

Introduction

The poor relationship between health providers and their clients has been reported frequently. The relationship between health care provider and client has been a specific area of study within the quality of care framework used to assess family planning services (Bruce 1990). Research in South Africa has also indicated that this is a problem (Fonn et al. 1995; Gready et al. 1995; Rispel et al. 1995a,b,c). Where services are described as good, a positive health provider–client relationship contributes significantly to patients' perception of high quality services (Rispel et al. 1995d). There is, however, a paucity of research on health workers' perspectives on this problem. It is very unlikely that health workers set out to treat patients badly. Thus there must be reasons why the end result of the provider–client relationship often turns out to be negative.

The Bangladesh Women’s Health Coalition is a successful non-governmental organization (NGO) providing good quality, women friendly, health services. Part of its success may be ascribed to the principle that:

‘...positive treatment of clients begins with positive treatment of staff. Good management means creating an environment where staff feel they have a voice in making decisions and where they are treated with respect. This, in turn, has a positive effect on the way staff interact with clients. Participatory management style engenders responsiveness to and communication with clients, both of which are essential to the provision of quality health care services.’ (Kay et al. 1991)

The majority of people using primary health care services in South Africa are women. This is because of their biological reproductive function and because it is usually women who take children to health services. These services have tended to concentrate on women’s reproductive functions, especially pregnancy and contraception, and on their children, rather than on the health of the woman in a more holistic sense (Vlassoff 1994). Research has shown that maternal education in general, and health knowledge in particular, has a positive impact on children’s and family well-being (Cleland and Van Ginneken 1988); hence it follows that empowering women with information about their own health is also worthwhile. This entails focusing on women as clients in their own right apart from their gender roles as mothers or caregivers. However, a gendered understanding of women and women’s health is important in making services appropriate to women’s needs.

Clearly, a positive relationship between health providers and women would benefit the woman herself and the family for which she is responsible. For these reasons the Women’s Health Project (of the University of the Witwatersrand, Johannesburg) developed a series of workshops for health providers to better understand their relationship with women clients from the providers’ perspective. This was done to determine what interventions are needed to improve the provider–client relationship.

Exploring the relationship between providers and clients from the provider perspective needs to be approached with sensitivity. Thus the methodology used various management and change management tools. The experiential method of self and group exploration best popularized by Paulo Freire was the background for this workshop series (Haaland 2000). This model describes conscientization as a social process where people achieve increasing awareness of the socio-cultural reality that influences and shapes their lives and develops their ability to transform their society. The growth of self-awareness involves being critical of social, economic and political conditions in an effort to change existing institutions so that full humanization takes place (London 1973). In practice it involves the following steps: obtaining the active participation of the group, breaking through apathy and developing a critical awareness of the causes of problems. It is based on an understanding that people operate on different levels of consciousness, that there is a direct link between
emotion and motivation to act, and that it is important to have the participants themselves define the terms of reference of the activities to be undertaken. Participatory management styles have been found to promote responsiveness to and communication with clients, both of which are essential to the provision of quality health care services. Participatory supervision is one method of effective management that can lead to efficient service delivery (Valadez et al. 1990; Loevinsohn et al. 1995). Practical examples of these methods are provided in Hope and Timmel (1994), some of which were used for this workshop series. In addition, new methods were developed with participatory principles in mind.

Primarily the methodology aims at ‘problem posing’, presenting back to health workers their own conditions and asking them to reflect on them. In order to do this trust had to be developed between the researchers and the research subjects. In the feminist tradition of research (Bhavani 1993) account was taken of the power imbalance between the researchers and the health providers. To alleviate this, where possible, the researchers participated in activities with the workshop participants. In addition, both researchers had themselves worked in the rural public health system and this common experience assisted, to some extent, in breaking down barriers. Where barriers did exist, one researcher being white and a doctor, they were explicitly noted and discussed. Methods that were participatory, enjoyable and different from the health workers’ usual experiences were chosen, allowing people to open up without feeling threatened. Within the framework of the workshop, attitudes, opinions and behaviour were discussed without being personally linked to any individual. A variety of methods were tested and the strengths and weaknesses of each evaluated. The methods that worked well were further developed into a protocol for testing in a multi-centre study in Africa (Fonn et al. 2001, this volume).

Objectives of the workshops

The overall objective of the initiative was to develop a methodology to address the interpersonal aspect of quality of care. It sought to explore with the health workers their perceptions about the interpersonal aspect of quality of care. The exploration was intended to provide an opportunity for health workers to critically analyze provider–client relations, to sensitize health workers to how gender relations may impact on health and on provider–client relations, and to assess whether interventions to improve this aspect of quality of care could be developed by health workers themselves. The workshops attempted to take health workers through a process by which they could reach these objectives. Recognizing the strict hierarchy that characterizes the health sector, the workshops included all health workers and support staff, irrespective of skill level or station.

Six workshops were conducted, lasting about 2 hours each, and focusing on specific objectives. The objective of each workshop was to help health workers:

1. identify the factors that motivated individual health workers to choose their occupation and how these may influence the client–provider relationship;

2. describe their perceptions of how their clients see them;

3. describe and explain their perceptions about women, female clients and women’s health problems;

4. describe their understanding of the structure and lines of authority in the health service in which they work;

5. identify and rank the factors that affect them either negatively or positively in carrying out their work;

6. identify practical interventions to ameliorate those factors that negatively influence their work.

The research site

This workshop series took place in a rural clinic situated 52 km away from the base hospital to which it refers its patients and from where it is managed and receives support. The staff did not all come from the village in which the clinic was located: some commuted while others had relocated and were provided with housing adjacent to the clinic. Communication with the base hospital was via radio, which was not always functional. For transporting patients and receiving supplies the clinic was dependent on the hospital-based transport. Maintenance of the clinic was carried out by the hospital’s works department. The staff complement of the clinic was 16 people and included senior professional nurses, nurses, a midwife, nursing assistants, nurse aids, cleaners, clinic guards and clerical staff. The clinic provided comprehensive care and had a 24-hour maternity unit. All staff participated in at least some of the workshops but not all staff were present at each workshop.

Methodology

Each objective could be met by using one or more methodologies. The most important criterion was that the method chosen should be appropriate to the subject matter, easily applied and capable of yielding results that could be discussed and analyzed. Similarly, the workshops could have been sequenced differently.

For the first workshop, on choice of occupation, a diagrammatic representation of an individual’s life events in the form of a river (‘river of life’) was chosen. This is a form of abbreviated life history described in Hope and Timmel (1994).

The second workshop explored health workers’ perceptions of their clients’ perceptions of them using four methods:

- role plays;
- questionnaire exercises, in which health workers were asked to construct questionnaires that they could in theory conduct with clients to ascertain their opinions;
- presentation of a series of quotes from focus group discussions on contraceptive services done in South Africa, which health workers read and discussed with respect to whether these applied to their own situations and, if so, why and how;
- presentation of a journal article (Aubel et al. 1991) on the poor communication between doctors and clients in a North African country due to their having different frames of reference for diarrhoea. Again health workers were asked to discuss the article and whether any issues pertained to their own circumstances.
In the third workshop, health workers’ perceptions of women and women’s health problems were explored by the following methods: presentation of three poems on the position of women in society including women’s access to education, women’s role in the family and the distribution of household resources, and women’s economic independence (Sall, in Fonn and Xaba 1996). Workers were asked to discuss the way that women were described in the poems, their relevance to South Africa and how they might impact on women’s use of health services. Some health workers could not read and could not operate comfortably in English. These staff drew the life history of a woman they knew. Thereafter the life histories were compared and common elements discussed. For workers who did not want to draw, role plays were done. Nursing staff were asked to recall their training and exchanged stories about the way in which women are depicted in nursing training. These methods allowed for a gender analysis of women in society.

The fourth workshop on work organization used three different methods: asking the group to draw up an organogram on a large sheet of paper; asking the participants to fill in a questionnaire on the objectives of their place of work and the degree of their participation in decision-making; and asking if there was anything about the organization of their work that they would like to change and, if so, what it was. Each individual completed the exercise in private and no names were attached to the replies.

For the fifth workshop on identifying and ranking helps and hindrances in doing their jobs, a group brainstorming and ranking exercise was carried out. Finally, for workshop six, practical solutions were identified by dividing the workshop participants into small groups. Each group was given one or two of the problems identified in the previous workshops and asked to suggest ways that these problems could be dealt with. The small group then reported to the larger group and people discussed whether these suggestions were feasible. Thereafter the interventions were prioritized.

During the workshop series, where appropriate, ice-breakers and team-building exercises were used. The detailed methodology of the workshop series is published elsewhere (Fonn and Xaba 1996).

**Results of workshops**

The results of each workshop are given below.

**Working as a health worker**

The major events in people’s lives that were depicted in the abbreviated life history revolved around four major themes: death, birth, poverty and education. Factors motivating people to be in their current jobs can be categorized as follows: wanting to do the work because of previous experiences which made them want the skills; needing to be in a job where they could earn money at the same time as studying; having no other option; needing to support other family members; and helping the community. While the job was not ideal for many people, advantages of staying in the job were that it provided an income. Successes of other family members, facilitated by the income generated by the health worker’s employment, were often described as sufficient reward. This was particularly so when health workers could support a child’s education. Additional bonuses were that becoming a professional nurse allowed one to study at university and that time off for higher training was possible. Lower categories of workers had fewer opportunities. However, employment at home, as compared to being a migrant worker, was listed as a positive feature.

Health workers’ motivation for choosing their occupations varied considerably, some were positive, some negative. Health workers noted that where the motivation was positive, it could lead to better client–provider relations than when it was negative. However, after years of working, the original motivation may no longer influence their relationship with clients.

**How clients see health workers**

This session confirmed that health workers were aware that patients saw the services they received as uncaring and sometimes punitive. They described the treatment they provided to patients as dependant on a variety of factors, including the personality of the individual health worker, the length of the waiting queue, if the health worker had been up late at a delivery the previous night, availability of equipment and support from doctors. Health workers at all levels described the absence of a positive role model as an important determinant of poor client–provider relations and uncaring attitudes towards one’s job: “If you work in a place with low standards, you meet the level they expect”.

**Women’s status in society**

This discussion explored the position of women in society. The group conlcuded that women were in a position of disadvantage because of factors such as the unequal distribution of household work and women’s lack of control over their bodies in relation to child-bearing and contraception. One participant summarized her feeling by saying, “Women have a triple shift: at work, at home and in bed – it is too much”. The discussion made it clear that this recognition of women’s unique difficulties in society was not always taken into account by the health workers when dealing with clients. While health workers acknowledged that women had restricted access to education, they also admitted that they treated women differently according to their educational level. For example, they felt that providing explanations to less educated women was not a good use of time as “they just can’t understand”. Further discussion revealed that health workers felt that they could improve their communication skills. They noted that their training rarely, if ever, took into account the social context of patients, that it was ‘Eurocentric’ and that it ignored gender issues. They also said that their training discouraged questioning and that they were therefore intolerant of patients who asked them questions. They felt that their training did not prepare them adequately for dealing with such challenges.
Lines of authority and communication within the health sector

Health workers lacked a clear understanding of the structure and lines of authority in the health service for paramedical and auxiliary staff. However, lines of authority between the various categories of nursing staff were clear, rigid and hierarchical. Group discussion revealed that they were unsure of how to use the structure in order to voice problems or achieve change. The way in which this affected provider–client relations was demonstrated when a nurse said, “If you want to get back at your superior, you will not do what she has told you, like taking a bed pan to a patient”.

The issues health workers wanted to see addressed were problems of interpersonal relations among staff, particularly between staff categories, problems in accessing resources from head office and difficulty in receiving responses to requests for functions controlled from outside the clinic, such as maintenance of equipment.

Identification and ranking of problems at work and potential solutions

The problems identified during the workshops, as well as potential solutions (Workshops 5 and 6) are listed in Table 1 in their ranked order of importance. As can be seen, many issues were highlighted during the workshop series and certain of these were recurrent throughout – a sense of over-work and lack of support was frequently articulated. Inability to transfer patients, slow response from the base hospital to requests for clinic and equipment maintenance, poor communication about referred patients, isolation from the hospital – all of these were examples of the clinic staff’s feeling of isolation and the daily frustrations they dealt with. Furthermore, these are all examples of a poorly functioning or absent district health system.

Management problems among staff within the clinic and between the clinic and the rest of the health care system were another set of problems frequently discussed. The rigid hierarchy in some sections, combined with the lack of clear and effective lines of communication, made problem solving difficult.

Poor quality of care was ascribed to inadequate or inappropriate training, inadequate equipment or supplies and the absence of appropriate role models. Health workers were also frustrated because there was no mechanism for introducing new methods or services and there was no incentive for initiative.

During this workshop series an atmosphere of self-analysis was created and a sense of renewed commitment to improved services was engendered. This is evidenced by various initiatives that the clinic staff embarked upon subsequently.

Table 1. Problems and potential solutions identified during the workshops with health workers

<table>
<thead>
<tr>
<th>Problem</th>
<th>Potential solutions</th>
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<tbody>
<tr>
<td>Staff shortages</td>
<td>Use data to support claims that the clinic is short staffed</td>
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<td></td>
<td>Try to attract people who are looking for work to fill open posts</td>
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<tr>
<td>Lack of facilities and equipment</td>
<td>Refer problem to hospital and request response</td>
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<tr>
<td>Inadequate salaries</td>
<td>No clinic-specific action: to be taken up through other channels</td>
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<tr>
<td>Communication with hospital</td>
<td>Develop a system of recording all requests and responses and demonstrate</td>
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<td></td>
<td>to hospital administration when no action is taken</td>
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<tr>
<td>Co-operation among clinic staff</td>
<td>Group action</td>
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<tr>
<td></td>
<td>Develop conflict resolution skills</td>
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<tr>
<td></td>
<td>Hold a conflict resolution workshop</td>
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<tr>
<td></td>
<td>Don’t gossip</td>
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<tr>
<td></td>
<td>Confront the problems</td>
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<td></td>
<td>Create platform for discussion</td>
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<tr>
<td>Hours and working conditions</td>
<td>Clarify conditions of service</td>
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<tr>
<td>Sterilization of equipment</td>
<td>Refer problem to hospital and request response</td>
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<tr>
<td>Repair of staff housing</td>
<td>Refer problem to hospital and request response</td>
</tr>
<tr>
<td>Clinic water supply</td>
<td>Refer problem to hospital and request response</td>
</tr>
<tr>
<td>Food for patients</td>
<td>Clarify rations, assess how they are being used at the clinic and determine</td>
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<tr>
<td>Patients with no money</td>
<td>Clarify the rules regarding payment</td>
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<tr>
<td>Poor response to health education</td>
<td>Increase communication skills, use aids. Evaluate existing health education approach.</td>
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<tr>
<td></td>
<td>Ask patients:</td>
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<td></td>
<td>– why they come late to ANC</td>
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<tr>
<td></td>
<td>– what they think of the high rate of sexually transmitted diseases</td>
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<tr>
<td></td>
<td>– why partner notification does not work</td>
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<tr>
<td></td>
<td>– how they define normal and abnormal vaginal discharges</td>
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<tr>
<td></td>
<td>– their problems with injectable contraceptives and vaginal discharges</td>
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<tr>
<td></td>
<td>– why they do not want to use condoms</td>
</tr>
<tr>
<td>Additional skills needed</td>
<td>Counselling skills; dealing with infertility, violence, and depression</td>
</tr>
</tbody>
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regular staff meeting involving all categories of staff was initiated. These meetings elected a rotating chair, again including all staff categories. Further, the staff enlisted the help of an NGO to run a conflict resolution workshop.

A strategy for relating to the hospital maintenance department was embarked upon, resulting in the installation of a washing machine that had been ordered and delivered to the clinic more than a year before. A formal relationship with the hospital administration was forged. The degree to which this will be maintained will depend on the amount of support that the clinic staff receive and the degree to which the health system is willing and able to accommodate their needs.

The workshops demonstrated that, given a more responsive and open management and a supportive environment, health workers will respond in a positive and creative way and with renewed commitment. What has, as yet, not been demonstrated is that this will automatically lead to improved provider–client interactions. However, evidence from other parts of the world suggests that it could (Onyango-Ouma et al. 2001, this volume).

**Discussion**

The aim of this intervention was to find a method to explore the poorly researched interpersonal aspect of quality of care. Further, it was intended to move beyond research itself to practical interventions derived from this increased understanding. The methods relied on and reinforced the methodology popularized by Friere (1997), as discussed in Haaland and Vlassoff (2001, this volume). The process indicated that a series of factors – the hierarchical system in which people worked, societal norms, the method of training to which they were subjected, the physical and interpersonal circumstances of the facility – all contributed to the way health care providers related to clients. These initial workshops indicated that it was possible to develop a method that allowed people not only to explore these issues but also to generate solutions.

The methods proved to be acceptable to workshop participants and were often enjoyable. They allowed for open discussion of a difficult topic without the health workers feeling victimized or blamed. It was their first opportunity to express some of the frustrations they experienced in their jobs and participants saw this as a positive feature of the workshop series. As a result, health workers expressed a renewed commitment to their work. It was also the first time all clinic staff, irrespective of level and function, participated in a common activity.

Some of the methods worked particularly well, others, less so. Those that worked well were the pictorial history, the role plays, the questionnaire for clients that the health workers generated, the poem, the quotes from the focus group discussions with women on contraception, and the group ranking exercise. The ice-breakers and team-building games were successful and an essential part of the series. The difficult task of breaking down the barriers between literate and illiterate members of staff was to a large extent successful. This was achieved, for example, by emphasizing the different strengths and contributions of people – some people could not read but could speak several languages, while others could read but spoke only one language. By planning complementary activities directed towards a common end, all workshops members could contribute to the discussion.

Methods that worked less well included the journal article, because participants found distilling the pertinent points difficult. While the description of nursing training was largely verbatim and uncritical, it was nonetheless useful in the discussion. However, this method was found to be too complex for a short workshop session. The questionnaire on job satisfaction gave the option of one of three responses – yes, sometimes, no – with the majority of participants choosing the non-committal middle option most frequently. This therefore yielded little useful information. Perhaps this exercise would be more useful if a five-point Lickert scale were used.

The success of the workshop series is highly facilitator dependant. Training of facilitators is possible and has been done extensively. Information on selecting a facilitator is contained in Fonn and Xaba (1996).

These workshops identified various needs within current health services, as follows:

- Training needs to be reoriented to provide health workers with the knowledge and skills to provide a client centred and caring service.
- Health workers themselves need to be included in a participatory management system where their contribution, problems and suggested solutions are taken seriously and acted upon.
- A reorientation of funding to develop a district health system with adequate and dynamic relations between primary care centres and their referral institutions, and active support of primary care centres, including human resources, drug supply, repair of buildings, referral systems and communication, with special attention to services in remote areas, is essential to the provision of a high quality service.
- When health workers feel they are working in a dynamic system that recognizes and supports their contributions, the potential for improved provider–client relations is greatly enhanced.

This initiative suggested that this methodology, which later became known as *Health Workers for Change*, could be useful as a research tool to understand provider–client relations and thus, quality of care. The methodology assisted participants in understanding the social, including gender, determinants of health. It also pointed to the need for further research to assess the application of this methodology in other settings and to assess if, once applied, it results in improved provider–client relations.

**References**


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