Health Workers for Change as a health systems management and development tool

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In this paper we draw overall conclusions concerning the Health Workers for Change (HWFC) methodology as a management and health systems development tool. We examine how HWFC has contributed to an elucidation of the four main themes with which this special Issue is concerned, namely: the value of participatory training; the need for gender sensitivity in health services; the impact of the HWFC intervention on gender sensitivity and quality of care in health services; and the ability to replicate the HWFC intervention in a variety of cultural and geographical sites. The paper concludes that HWFC is a useful health systems development tool, discusses other applications of HWFC beyond those reported in this Issue and makes several recommendations concerning its future use.

Introduction

This special Issue has addressed four main themes:

- the value of participatory training in peripheral health settings;
- the need for gender sensitivity in health services;
- the impact of the Health Workers for Change (HWFC) intervention on gender sensitivity and quality of care in health services; and
- the ability to replicate HWFC in a variety of cultural and geographical sites.

In this paper we examine the extent to which HWFC has contributed to our understanding of these issues.

Participatory training in peripheral health settings

A key characteristic of HWFC is its participatory nature. Rather than prescribing how the workshop series should be conducted, HWFC is a methodology to assist facilitators to encourage participation, break down hierarchical structures, and explore health and health services within the local social and organizational context. Within the six workshop sessions the choice of participatory exercises involved (role play, poems, etc.) is optional and left to the discretion of the facilitator. The manual describes the methods to be employed. The content is generated both by facilitators creating locally appropriate scenarios and, more importantly, by the participants themselves, who bring to each activity and discussion their own reality.

As was noted in the introductory paper (Haaland and Vlassoff 2001), it is only since the 1990s that the value of participatory methods has been accepted in mainstream development theory and practice, especially in the area of education. Its application to health education and health services is still little appreciated: didactic top-down methods of training and supervision have been the norm. The lack of opportunity to have input into decision-making about policies that affected their work was a frustration expressed in most research sites described in this publication. Similarly, the lack of attentiveness by authorities to the concerns of health workers was a common complaint. In Argentina, for example, health workers stated that there was no one they could talk to at higher levels because supervisors came to give orders rather than to listen (Pittman et al. 2001). In the original application of HWFC, barriers between literate and non-literate workshop participants were eroded by recognizing the different skills of both groups and demonstrating their complementarity in reaching a common end. This challenge to hierarchical norms took the form of clinic meetings attended by all levels of staff, and a rotating meeting chair (Fonn and Xaba 2001). This hierarchical structure also applied to health worker–client relationships, a structure that was broken down as a result of HWFC. An underlying assumption in HWFC is that working in a non-responsive environment is likely to lead to primary care providers being unresponsive to clients and that a responsive working environment could lead to improved provider–client relations. In Kenya, clients referred to the opportunity to ask questions in consultations as a positive change in health workers’ attitudes towards them since the introduction of HWFC (Onyango-Ouma et al. 2001a).

Despite their lack of familiarity with participatory methods health workers in all settings responded well to them and, in many cases, asked for them to be repeated (Fonn et al. 2001). The comparative paper by Onyango-Ouma et al. (2001b) indicated that participants found the workshops enjoyable and left the sessions feeling invigorated and recommitted to their work despite their difficult circumstances. In Argentina the positive responses of the health workers’ to the HWFC workshops was recognized by the authorities, who expressed interest in continuing to work with participatory methods in
future training modules. However, their failure to respond to many of the changes initiated by the health workers eventually led to frustration, illustrating that methodologies such as HWFC should be conducted only when there is genuine commitment to change – to reinforcing positive responses, listening to the recommendations of the health workers and, where possible, following up on them.

Gender sensitivity in health services

An important motive underlying the HWFC initiative was the growing understanding, at least at the global level, that gender roles have a significant impact on health status (Vlassoff 1994; Doyal 1995). Research was beginning to reveal several areas in which gender differences in health had a direct influence on health outcomes. Examples include the underdetection of women and girls at health centres because of restrictions on women’s movements and, as a result, greater severity of some conditions for women and longer recovery periods (Baljaev et al. 1986; Bonilla and Rodriguez 1993; Santow 1996); male preference in some societies, resulting in differential access to nutritious food, care and other basic necessities; women’s lower status and lack of autonomy, which may prevent them from expressing their concerns at health facilities or from asking questions when they do not understand the information received (Long et al. 1999; Khan et al. 2000); women’s multiple duties that prevent them from attending health services on a regular basis (Kutzin 1990; Velez 1997); and the inferior treatment they may receive in health services. There was also increasing evidence that health services, particularly in developing countries, were often unsupportive of, and even hostile to, their clients, the majority of whom were women (Fonn et al. 1995; Gready et al. 1995; Rispel et al. 1995a,b,c).

The HWFC initiative was based on the premise that an increased understanding of the social determinants, including gender, of health, illness and health-seeking behaviour, would increase providers’ understanding of how gender roles may affect clients’ use of their services and their adherence to treatment. An important component of HWFC was therefore to elicit information on the degree to which health workers in the study areas were aware of gender issues and took them into account in their interactions with clients.

The findings of the original research on HWFC as a methodology to address constraints in health service delivery, discussed in Fonn and Xaba (2001), provided considerable information on gender and other social, cultural and economic determinants of health, and also that these were largely neglected in the training of health workers and in the way services were offered. The findings also indicated that the workshop series created a space in which health workers began to explore these issues and to see more clearly the perspectives of their clients and the constraints under which they lived and sought health care. For example, in South Africa health workers recognized that women faced many difficulties because of their low status and poor education. However, they also acknowledged that they treated uneducated women differently because they did not expect such women to understand their instructions. As a result of ‘problem posing’ during the workshops, these health workers were able to analyze the reasons for their prejudices, and also to see that they were not adequately prepared in their training.

One of the recommendations emerging from HWFC was therefore that an understanding of gender roles as a determinant of health and health seeking behaviour should be an integral part of health providers’ curricula. In other countries where HWFC was tested, similar results were found. In exploring women’s unmet needs, health providers mentioned the need for counselling on issues such as violence and rape and the effects of HIV and AIDS. They recognized that their training did not provide them with adequate tools for dealing with these issues, and hence that the services they offered were inadequate (Fonn et al. 2001). The gender focus within the HWFC workshops identified many issues that are frequently grouped under the rubric of quality of care. The research indicated that HWFC managed to raise gender inequality as an issue in and of itself, with the aim of promoting greater gender equality and human rights. However, the gender lens of HWFC also contributed to improving quality of care.

Impact of HWFC on gender sensitivity and quality of care

The above examples indicate that HWFC is indeed useful for identifying gender issues and for exploring gender sensitivity in health services. The degree to which HWFC can also have an impact on gender sensitivity and quality of care is addressed in this section.

Quality of care is a major focus within HWFC. Part of the complex of quality of care includes interpersonal relationships (Bruce 1990) and recently increased attention has been directed to this element of quality of care (Haddad et al. 1998a). Service users perceive the interpersonal aspect of care to be more significant in contributing to good quality care than do service providers, and users have been described as very sensitive to the interpersonal aspect of the complex called quality of care (Williams 1998; Haddad et al. 1998b). HWFC homes in on the interpersonal element of quality of care.

There were several indications that, as a result of the HWFC workshop series, health workers were able to integrate their heightened understanding of gender issues into their daily practices. For example, in the sites of the HWFC acceptability studies, health workers described many situations in which they had blamed women for coming late to their facilities for treatment, although they recognized that gendered power relations often prevented women from coming earlier (Fonn et al. 2001). This increased understanding led, in most cases, to measurable, positive changes in health workers’ relationships with their clients and improved the delivery of services in a number of ways. For instance, in the impact studies reported in Onyango-Ouma et al. (2001b) positive changes in relationships between clients and health providers were noticed in four countries. These included increased privacy for female patients, greater promptness in services, improved availability of drugs and supplies, greater cleanliness and improved communication.
In these studies health providers revealed many of the reasons for the poor quality of care delivered in their health facilities. These included factors within the health system itself such as inadequate infrastructure and supervision, heavy workloads, poor remuneration, monotony and lack of stimulation or incentives in the working environment and, in some cases, the introduction of major changes in the health system without consultation of those involved. This was a problem in Argentina, for example, where structural adjustment plans to reduce public sector expenditure presented a looming threat of job loss and resulted in mistrust of the authorities. Such problems caused frustration among clinic staff and often led to a negative impact on the quality of care provided.

By focusing attention on these generic health system issues the health workers were able to identify interventions which were within their power to address, those which they could try to bring about through requests to others (but which ultimately were not in their power to control), and those that were totally beyond their control. The Plans of Action developed by the health providers as a product of the workshops delineated these areas. In Nigeria-Kaduna, for example, the areas identified by the staff in which they themselves could take action were in fact implemented, and the improvements were carefully monitored by staff through regular meetings. Concurrently, a number of areas not identified in the plan also improved including drug supplies and system level responses.

For the most part, however, generic health systems issues were the pre-eminent areas of concern that acted as obstacles to providing better quality services and influenced the way health workers perceived their work and the satisfaction derived from it. They also determined, to a large extent, how many additional challenges and responsibilities health providers were prepared to assume. For example, it is understandable that health workers may be reluctant to provide gracious and good quality services when they have not received their salaries on time or when they are expected to provide services with irregular or no electricity supply, poor water supply and unreliable or no transport for referral of emergency cases.

By contrast, positive changes in quality of care were particularly evident when the health system itself was undergoing positive reforms in other areas. Research elsewhere has also found a link between investment in health services and participatory management styles, on the one hand, and provider job satisfaction and quality of care on the other (Halal et al. 1994; Arnetz 1999). This was true in the case of Kenya where the positive impact of HWFC coincided with ongoing health sector reform activities so that their combined impact was probably greater than either could have been alone. For instance, the request made by health workers after the workshops for additional staff appeared to have been answered with the arrival of a new and efficient supervisor; but it is also possible that health sector reform activities had already included plans for a new supervisor. Whatever the explanation, the net perception of staff in the facility was that the system was more responsive to their needs, which also contributed to improved motivation and quality of care (Onyango et al. 2001a). The opposite was true in the case of Argentina, where the motivation and excitement created by HWFC were dampened by the intrusiveness of the health system (Pittman et al. 2001). These illustrations demonstrate what we have argued throughout this volume; namely, that changes brought about by HWFC cannot be expected to be sustained on their own and will only lead to frustration if the environment in which health workers function remains inflexible and unresponsive. Improved quality can be achieved through a range of interventions but should include (in addition to technist interventions such as check lists that are currently being exclusively employed) a focus on providers’ understanding of the social, including gendered, determinants of health, responsive management and investment in the health sector.

**Replicability of HWFC**

This Issue reviews a considerable amount of research on HWFC, including studies of its acceptability in different cultural settings (Fonn et al. 2001). While the workshop methodology follows a clear structure and logic and recommends that this logic be followed systematically, it is also flexible in terms of the examples and techniques that may be used for the exercises and in the sequence of most of the workshops. This flexibility was stressed in the training workshops for the acceptability study described in Fonn and Xaba (2001) and in the comparative multi-country impact study. Interestingly, the examples used in the different settings were, for the most part, interchangeable and, apart from translation, required very little modification. Researchers agreed that the examples were appropriate within different contexts because the essential problems of gender and quality of health services were very similar and experienced in all sites.

The research tool developed to investigate the impact of HWFC, described in Onyango-Ouma et al. (2001b), was also replicable in a variety of settings and was significantly modified only in the Argentina study, which used the tool within the context of a larger study on quality of care.

**HWFC as a health systems development tool**

While this is the first time the research findings on HWFC are being published, the methodology in the form of a manual has been available since 1996 when, on the basis of the positive findings of the acceptability study, TDR/WHO undertook to distribute it widely. It has been used as a health system development and change management tool because it was found to generate a large amount of information on the quality of health services and various aspects of the larger health system quickly and cost effectively. An example is its use in the Transformation of Reproductive Health Services Project (TRHSP) (Fonn et al. 1998a). This project, through a series of data collection and change management tools in three provinces in South Africa, was designed to, among other things:

- enhance the managerial capacity of clinic and district health staff to improve the provider–client relationship;
• improve the relationships between the providers and between levels of care; and
• increase awareness among health workers of reproductive rights, women’s health, gender and the provision of comprehensive integrated health services.

Part of the intervention involved training 35 health workers as HWFC facilitators who then ran workshops in the provinces reaching 820 primary care staff over a 9-month period.

In an independent evaluation of the TRHSP by Lund (1997), HWFC was described as a positive intervention: ‘It is rare to find a training manual and management tool which has such impact’. People trained as facilitators gave examples of the effects of the training on their lives and performance either at work or outside. They noted that they had experienced increased personal growth and bringing out of latent skills, which had been recognized by others during the workshops (e.g. being called upon to organize and run other training). Participants also gave examples of the initiatives they had undertaken as a direct result of the workshops such as ordering equipment, travelling around with condoms and being more responsive to youth groups.

Managers, while excluded from the workshops, were aware of the intervention and saw it as a useful management tool. A Northern Province senior manager explained: “This management tool is so impressive that it will be used for all staff in a big hospital. It will be used in planning and restructuring; it will especially enable the attitudes to become more workforce centred. I have been through many management training courses and this one is different. They have made a complex process seem simple. They understand that change must come from within individuals.”

In Latin America the HWFC methodology piloted in Argentina has been further adapted and translated into Spanish by the Pan American Health Organization as a manual, Trabajadores de la salud por el cambio: Guía de talleres para mejorar la calidad de atención (PAHO/WHO 2000). Interestingly, the guidelines and illustrations used in the original manual, which were based on African examples, were only slightly modified for the South American text.

Other applications of HWFC

In addition to the above-mentioned applications of HWFC, it can also be easily adapted to address disease-specific and other health problems. In 1997 an addendum on gender and substance abuse (TDR 1997) was produced as a collaborative effort between the Women’s Health Project, University of the Witwatersrand, Johannesburg, South Africa, the Special Programme for Research and Training in Tropical Diseases (TDR), and the United Nations Drug Control Programme (UNDCP). The addendum can be used in conjunction with the HWFC manual. It gives examples of gender issues in substance abuse, which can be substituted for the themes of some of the workshops and which sensitize health workers to the special needs of clients affected by substance abuse, either as users themselves or as relatives or friends of substance abusers.

The methodology also lends itself well to exploring social or health problems that are difficult to address openly because of their hidden or stigmatized nature. Because issues can be acted out in role plays, or discussed in allegorical ways through stories or poems, sensitive issues such as violence against women could be investigated through HWFC workshops. The Pan American Health Organization (PAHO) is currently exploring the possibility of using results from studies on violence to develop an addendum along the lines of the substance abuse addendum. In South Africa the HWFC methodology was used to increase provider acceptance of, and clients’ access to, abortion services (Varkey et al. 2000).

In South Africa HWFC is now being used routinely as a health systems development tool at the sub-district level. In addition, discussion is underway concerning the use of HWFC to address quality and attitudinal issues in providing health services to adolescents, maternal health services, services for people with HIV and services for survivors of violence.

Conclusions and recommendations

HWFC is a useful tool for both health systems development and gender sensitizing. It begins to address the interpersonal aspects of quality of care and demonstrates that it is possible and effective to include or mainstream gender issues into health systems development – something that many existing interventions are unable to do. The methodology itself is empowering for participants and develops problem-solving skills and encourages health workers to take initiative. It is also a simple tool that can be used by local facilitators and is flexible in content, allowing for the introduction of various participatory exercises and locally developed and relevant case studies and examples. While this is true, in its present form it was also interesting that the acceptability studies found that examples tended to be cross-culturally useful and that often there was little need for adaptation.

HWFC has a role to play in health systems development. The HWFC workshop process ends with a set of action plans that read like an action plan for district level managers. Issues such as improved drug ordering, equipment maintenance and improved supervision are examples of the kind of issues that have been generated as a result of running these workshops (Fonn et al. 1998b). These are exactly the issues that have been identified as essential to building well functioning health districts. We postulate that should a health manager take up the issues as generated by the staff he or she manages and act on them, the manager will improve the functioning of the health system and build a relationship of trust between him/herself and the district staff by delivering on expectations they have. While in any given situation externalities such as inadequate funding will limit what is possible, there will be some no cost or low cost options that can be implemented. Within a health system that is responsive to what the HWFC workshops generate, the workshops can be used as a method of building the health system. On the other hand, when they are implemented without that kind of response it is possible that raising and not meeting expectation can be counterproductive.
The findings from the studies reported in this volume also indicate that HWFC is not a panacea for health sector reform and that its potential impact should not be overstated. With respect to the future use of this methodology we would recommend the following:

- HWFC is useful in eliciting gender issues in the context of health services but it should not be used as a gender sensitization tool alone. As a separate initiative outside a broader commitment to health systems development, improved attitudes or actions are unlikely to be sustained.
- HWFC should be applied as a quality of care intervention only in the context of commitment to health sector reform based on communication and participatory management.
- Implementing positive change such as that stimulated by HWFC will usually require that higher-level personnel change the way they do things. It is therefore essential that they are fully briefed from the start, and their commitment to HWFC is obtained, recognizing its broader implications for health sector transformation.

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