

Health Workers for Change: a tool for promoting behaviour change among health providers

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منهجية «العاملين الصحيين من أجل التغيير»: وسيلة لتعزيز عملية تغيير سلوك مقدمي الرعاية الصحية

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الخلاصة: لاتزال توعية مقدمي الرعاية الصحية باحتياجات المراجعين وبصحة المرأة تمثل تحدياً أمام النظام الصحي في باكستان. وقد ثبت نجاح منهجية «العاملين الصحيين من أجل التغيير»، في تحسين العلاقة بين مقدمي الرعاية وبين المتلقين لها، في بعض بلدان أفريقيا وأمريكا اللاتينية. وتتناول هذه الورقة بالوصف تجربة الاستفادة من الحلقات العملية التشاركية التي عُقدت في باكستان، حول منهجية «العاملين الصحيين من أجل التغيير»، في توعية مقدمي الرعاية الصحية من الذكور والإناث حول القضايا المتعلقة بخصائص الجنسين. وقد حدّد مقدمو الرعاية الصحية الاحتياجات التي لا تتم تلبيتها بالنسبة للمراجعات من النساء، بوصفها دالة على العوامل الفردية والأسرية والمجتمعية، دون الاقتصار على العوامل المرتبطة بالمرافق الصحية كما هو الوضع بالنسبة للتجربة الأفريقية مع هذه الوسيلة.

ABSTRACT Sensitizing health providers to customers' needs and women's health remains a challenge to the Pakistani health system. The Health Workers for Change methodology has been demonstrated to improve provider-client relationships in certain African and Latin American countries. This paper describes the experience of using Health Workers for Change participatory workshops in Pakistan to sensitize male and female health providers to gender issues. Health care providers identified the unmet needs of women clients as a function of individual, household and societal factors, and, unlike the African experience with this tool, not predominantly confined to factors associated with the health facility.

Les agents de santé vecteurs du changement : un instrument pour promouvoir un changement de comportement chez les prestataires de santé

RÉSUMÉ Sensibiliser les prestataires de santé aux besoins des clients et à la santé des femmes demeure un défi pour le système de santé pakistanais. Il a été démontré que la méthodologie des Agents de santé vecteurs du changement améliorerait la relation entre le prestataire et le client dans certains pays d'Afrique et d'Amérique latine. Le présent article décrit l'expérience pakistanaise qui consiste à sensibiliser les prestataires de santé, hommes et femmes, aux questions de sexospécificité à travers des séminaires-ateliers participatifs « Agents de santé vecteurs du changement ». Les prestataires de soins de santé ont identifié les besoins non satisfaits des clientes comme dépendant de facteurs individuels, domestiques et sociaux, et contrairement à l'expérience africaine réalisée avec cet instrument, ne tenant pas essentiellement à des facteurs associés à l'établissement de santé.

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Introduction

Despite major technological advances in health, many poor people express feelings of powerlessness and dependence concerning their experience with the health services, especially in the public sector [1]. As in many other developing countries, the government health care system of Pakistan faces the problem of a poor relationship between health providers and clients, especially women.

Improving the provider–consumer relationship and the quality of services are among the most daunting challenges faced by the health system in Pakistan. In the total annual budget of Pakistan, 3.1% is earmarked for social sector development and just 0.8% of the gross domestic product (GDP) is spent on health care, which is even lower than in Bangladesh and Sri Lanka [2–4]. Poor quality of services and absence of appropriate sociocultural orientation in a health facility contribute to its under-utilization. It is, therefore, not surprising that almost 80% of the health expenditure goes in accessing private health care [5,6].

Pakistan is one of the few countries in the world where men outnumber women [7]. This unfavourable ratio could mainly be attributed to a high mortality of young girls and women of child-bearing age (340/100 000 live births) [8]. Added to this is the poor social status of women in Pakistan, ranking 135th out of 174 countries in the United Nations Development Programme (UNDP) gender-related development index (GDI), and 100th out of the 102 countries on the gender empowerment measurement (GEM) [9].

Poverty and negative cultural practices are among other factors that have an impact

on the health of women in Pakistan, making them the most vulnerable members of society. Coupled with a shortage of human resources to cater for women clients, this has led to poor client–provider communication and a deterioration in the quality of care provided [10]. Another important reason for the poor health of women in Pakistan are the inadequate services that fail to fulfil women’s health care needs. The primary health care services largely consist of a network of over 5000 basic health units and rural health centres. However only 25% of them are manned by trained female staff and have the logistics to provide appropriate care [11,12]. The questions are: How much do the service providers, especially the frontline health workers, know about the real needs of their women clients? How do they interact with their clients? Are they sensitive to the health care needs of women? Do they “listen” to women? Do health managers know how to change the attitude and behaviour of health workers toward women?

Health Workers for Change is a World Health Organization/World Bank/UNDP training tool that uses a series of participatory workshops with health care providers to sensitize them towards issues such as gender [13]. Originally an initiative in Africa, the impact of its use has been demonstrated in various studies [14–17]. This paper presents the experience of using this tool in Pakistan. This study by the Department of Community Health Sciences of the Aga Khan University aimed to initiate a process of reflection and analysis of women’s needs among health providers, helping them to explore the reasons for the poor quality of care and identify solutions towards improving the quality of health service delivery.

Methods

Study sites

The study was carried out between June 2001 and July 2003 in 7 field sites, both urban and rural, in all the 4 provinces and the Federally Administered Northern Areas (FANA) of Pakistan. This included Malir and Metroville (Sindh), Turbat (Balochistan), Uch Sharif and Lahore (Punjab), Peshawar (North-West Frontier Province) and Gilgit (FANA). In most of the sites, either a government or partner nongovernmental organization (NGO) health facility was used as a venue for the workshop.

Study team

The research team included public health researchers, social scientists, anthropologists, community development specialists and health systems specialists. Besides these, there were research teams composed of staff and volunteers of the partner organizations: the Health and Nutrition Development Society, the Marie Stopes Society and the Aga Khan Health Services Pakistan.

An orientation workshop and training of the study team on participatory approaches, facilitation of activities, data gathering and documentation was conducted. The sessions were documented on activity forms as both process and analysis. This format required the involvement of 2 note-takers, meaning that the workshops were conducted and documented by 3 people including the facilitator.

Participants

Health care providers from both the public and private sectors were invited to participate. A total of 45 female and 36 male health workers participated in the workshops: 19 doctors, 16 lady health visitors, 13 community health nurses, 18 field workers and 15 health managers of junior and senior levels (Table 1).

The tool

The Health Workers for Change tool was adapted and modified on the basis of the analysis of data gathered from health providers in the field. Some modifications were made to the manual to make it more relevant to the Pakistani culture and system. To meet each objective of the workshops more than one methodology was used. The most important criterion was that the method chosen from the African context should be appropriate to the subject matter, easily applied and capable of yielding results that could be discussed and analysed. A participatory approach during interactive workshops enabled a wide range of underprivileged people from diverse cultures and conditions to share their views and contribute to the concepts and content of the tool.

Workshops

Various themes blending into 6 workshops were introduced to the health care providers. The same themes were used in all the study sites without any change in the process. A social scientist conducted the workshops, assisted by the research assistants for note-taking. The workshops required different amounts of time ranging from approximately 2.5 to 4 hours. The objective of each workshop was to help health workers to:

- categorize the factors that inspired individual health workers to choose their occupation;

Table 1 Distribution of participants who attended the workshops

Sites	Government health personnel	Non-government health personnel	Total
Urban	17	28	45
Rural	7	29	36
Total	24	57	81

- express their perceptions of how their clients see them;
- describe and explain their perceptions about women clients, their status in society and their problems;
- explain the unmet needs and the problems of the women and how to overcome them;
- identify the factors and obstacles that affect their work; and
- suggest solutions to these problems to ameliorate their working conditions.

For the 1st workshop, the “river of life” exercise was used to create a representation of an individual’s life events in the form of a river. In the 2nd workshop, role plays and a questionnaire were used to ascertain the clients’ opinions about the health providers and the quality of services rendered. Story and role play in the local language and in a Pakistani context were used for the 3rd workshop to explore perceptions about women and women’s health. For the 4th workshop, again story-telling was used as a method. In the 5th and 6th workshops, brainstorming and group work were carried out, writing the main ideas on wall charts. “Ice breakers” and team-building exercises were used throughout the workshops.

Synthesis

During the workshops, following the note-taking, the main points were entered into log frames. A log frame comprised 5 columns detailing the problems or issue identified, a possible solution(s), person/authority to solve it, method to solve it and time needed to solve it. On return from the field sites, a synthesis workshop was held with partner NGOs to highlight the common trends and issues emerging from the workshops. Based on key findings, the specific site reports were then compiled and merged into the final study report.

Ethical approval

Besides institutional ethical approval for the whole study, free and informed consent of the participating health providers was also obtained.

Results

The participants participated actively in the workshops and provided their reflections on each theme as summarized below and in Table 2.

Why am I a health worker?

The workshop participants narrated multiple reasons for becoming a health worker, which included poor socioeconomic conditions, inspiration from others and a desire to serve humanity in general and the community in particular. These are very similar to those cited in Africa [15,16]. The most common reason cited for becoming a health worker, however, was the desire to be associated with a well-respected profession in society and to fulfil financial needs. The desire to serve their communities and the quest for spiritual peace also motivated some to become health workers. Some got inspired by other health workers, or took the profession as a family tradition or in response to family pressure. In some areas, the lack of availability of health care providers (especially females) also motivated women to become a health worker to fill the gap. Self-development, gaining social status and desire for research had also prompted some providers to opt for this profession.

How do our clients see us?

The participants of the workshop were aware of their client’s perceptions of health care providers. A mixed impression, having both positive and negative aspects, emerged from the discussion regarding the client’s

Table 2 **Problems and potential solutions identified during the workshops with health workers**

Problems identified	Solutions suggested
Workload and staff shortage	Planning and time management Create more posts Fill the existing vacancies
Lack of support from management	Encouragement for taking initiative Clear concept of essential and non-essential medicines System should have flexibility to look for alternatives if existing system is not working properly
Personal problems of the staff	Encourage sharing of problems Accept and provide support for genuine problems Counselling and alternate ways
Building a relationship with community to know more about them and address difficult issues, e.g. infertility, teenage sexuality, violence against women	On-the-job training on: Counselling skills Participatory research methods Incorporate research as part of making action plans

perception of health care providers. Health care providers mentioned that clients expect a proper understanding of their needs, satisfactory services and appropriate guidance. They also pointed out that clients had a considerable respect and trust for them. They said that the clients consider them as a *Messiah* (healer), a friend, someone who listens to their problems and solves them, a role model. Health workers reported that some of their clients carry negative feelings too and said, "Our clients think that we discriminate between the rich and the poor in health care provision, lack an empathetic attitude and competence to provide appropriate information and quality services." Such perceptions may well be just the tip of the iceberg, and require greater probing for a deeper understanding of client-provider relationships.

Women's status in society

The participants admitted that despite being called the "honour of the family", "symbol of love, faithfulness and fragrance" and "one who sacrifices for others", women have a very subordinate status in Pakistani society and are expected to be submissive. Providers repeatedly mentioned, "Women do not enjoy any decision-making rights, even in matters pertaining to their own health". During the workshop discussions, the position of the Pakistani woman in society was explored. Participants acknowledged the pivotal role of the woman within the family and the society. Lack of access to health care, education and information and a great deal of social restrictions were cited as factors hindering improvement of women's status. "Women are an untapped po-

tential in a society”, quoted the participants. Additionally participants listed household skills, education, physical looks and good character as desirable attributes in women. “A good woman is one who always sacrifices and doesn’t voice her problems,” health providers maintained. It also emerged that a woman’s status in society is a product of her family background, socioeconomic status, and father or husband holding high status jobs.

Unmet needs of women

There was a consensus among men and women health care workers at 7 sites about the unmet needs of women clients. Illiteracy, lack of proper nutrition and domestic workload, compounded by the practice of early marriages, jeopardizes their health status. According to them, women generally have inadequate access to education and information about health care. No specific health education programmes cater for women on health-related matters especially reproductive health. Participants mentioned that women’s needs were largely unmet because of their minimal “participation” and “power of decision” in any household matter. A participant quoted, “A woman will never be allowed by the husband to go and consult a male provider especially for reproductive health matters such as infertility, reproductive tract infections, family planning etc.” Thus, in this sample of health providers it was felt that unmet needs of women are a function of individual, household and societal factors, and, unlike the African context [15,16], not predominantly confined to factors associated with the health facility.

Overcoming obstacles at work

Certain obstacles were identified that affect the performance of health workers. The impediments were categorized as logistical, managerial, social and behavioural. Quite

similar to the African context [15,16], poor logistic arrangements, inadequate training and skills, lack of appreciation and mismatch between workload and salaries of the health care providers emerged as the common constraints affecting their performance. “At times senior colleagues and administration are very rude to us,” narrated the participants, highlighting the communication gap between the managers and the frontline workers, and lack of amicable working environment. One participant said, “If we don’t provide the medicines to the clients, a message will be passed on in the village that the health provider is not caring. We are answerable to the community. Mismanagement in drugs provision brings a lot of problems. Trust between clients and providers is lost. Those higher up have to understand it.”

Solutions

For initiating the process of women’s empowerment, participants argued that equal opportunities for women in health, education and income are essential. “A change in the attitude of men would be a requisite to bring about any improvement in women’s health status.” They suggested that there is an immense need to involve men in all matters pertaining to women’s health.

The workshop participants strongly reflected that the identified problems could be resolved through a process of consultations with each other and information sharing. “Health worker’s ongoing training is essential. If she/he has new information, only then could patients be helped properly, otherwise our relationship with our clients will not be worth it”, quoted the providers. One of them said, “Steps should be taken to address our problems at the workplace, to improve our fate and to alleviate our plight.” Better logistic arrangements at the work place, minimizing the communication

gap between the supervisors and workers, timely appreciation of good work, keeping aside the personal problems from the professional work, and rationalizing the workload of the health workers are the proposed solutions. They emphasized, "A participatory approach and consultative processes to find solutions of the problems at work creates a friendly environment." Dignity and recognition of work was more important for providers than a raise in salary or income. They also mentioned that the existing system needs to be changed; however, a careful determination of the inefficiencies and strengths in the existing system is required before initiating any change. "We collaborate with government but we don't get the equal welcoming support from their side," quoted one participant.

Discussion

The objective of the study was to judge the effectiveness of the Health Workers for Change tool in sensitizing health care providers to women's health issues and enabling them to reflect in a participatory way to identify solutions towards improving quality of health service delivery. The role-plays and story telling techniques of the tool worked well and were found to be useful. Participants enjoyed the process and got deeply involved, sometimes leading to prolonged sessions. The process seemed to be flexible enough to be implemented in different cultures and the majority of the methodologies used in the African context worked well in the Pakistani setting.

The workshops enabled a reflective thinking process among the health care providers, allowing a frank discussion, irrespective of the type of health worker, without victimizing anyone. The workshops allowed difficult issues such as prejudice,

bribery and negligence on the part of providers to be discussed openly, fostering an open attitude. The result was a renewed commitment to work, with health providers expressing better motivation and willingness to examine their own practices critically in an effort to improve the quality of care. The participatory process of Health Workers for Change also enabled the providers to identify many constraints in the provision of adequate health services and how these affected their work in general and their relationship with women clients in particular, and to develop practical plans.

Effective use of Health Workers for Change requires training in participatory methods, familiarity with the social model of health and good communication skills. This endeavour in Pakistan reconfirms that methodology and techniques such as role-plays and story-telling can be used in different settings and cultures. It also showed that the Health Workers for Change tool is likely to contribute towards reorientation and strengthening of the health system, particularly in the areas of provider-client relationships and problem-solving abilities of health workers. This will initiate a thought process in health workers to become more conscious and empathetic while dealing with women clients. In other words, this could be a step towards initiating a behaviour change process. With the involvement of health providers, an "enabling environment" to access health care particularly for women must be created. Such initiatives also tend to generate information for health policymakers about what health care providers' problems and issues are and how to devise policies to re-orient the health care system and service delivery. Moreover, besides designing the interventions, integrating knowledge on social determinants of health within public health policy and practice is essential.

Investing in improving women's health has become an international concern and is seen as a way not only to reduce poverty but also to improve the welfare of the entire family, especially the children [18]. It demands a focus on the determinants of health and health-seeking behaviour, particularly of women, by comprehending their position and status in society [19,20]. Effective change will thus require a shift from a physician-dominated system to a client-centred model. Similar strategies have been proposed by the World Bank a decade ago and are still very much achievable [21]. Continuing education and capacity-building initiatives for health providers are imperative for improving health care delivery in a highly pluralistic health care system and gender-sensitive culture. However, to see the real impact of such endeavours, more in-depth qualitative research would be required to gauge any improved trends in health services utilization.

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