The Health Workers for Change impact study in Kenya

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This paper reports the detailed results of a study of the impact of the Health Workers for Change (HWFC) workshop series on clients’ perceptions of health services, relationships within the health centre and relations between the health facility and the district health system. The study was carried out in three stages: baseline, intervention and evaluation over a period of 20 months. Data, both qualitative and quantitative, were collected at three levels: client, facility and system. Results indicate that relations between health workers and clients improved greatly after the intervention while those between the facility and the system remained to a large extent unchanged. The paper concludes that, with external support and help, especially from the health system level, health workers can work towards improving health services and their job satisfaction, which can lead to better health worker–client relations.

Introduction

Provision of adequate health services in developing countries is adversely inhibited by factors such as inadequate funds, poor management and demoralized staff. In addition, optimal utilization of services is hampered by the relationships between providers and clients. Client satisfaction is an important element of the quality of health care, often determining patients’ willingness to comply with treatment and influencing the effectiveness of care (Gilson et al. 1994). These basic problems within the health system need to be addressed in order to improve health care and achieve health for all, especially in developing countries (Fonn and Xaba 1996).

The present study investigated the provision of services in a local health facility in Kenya with a view to examining provider–client relations and clients’ perceptions of services offered. The study focused on assessing the impact of the Health Workers for Change (HWFC) intervention on provider–client relations, on health facility functioning and on the relationship between the facility and system level in the district. Evidence from South Africa (Fonn and Xaba 2001) indicates that the intervention helps health workers to examine the way they relate to female clients and to identify ways and means to improve both the health services and their job satisfaction, leading to better health worker–client relations.

The health system in Kenya

The majority of health services in Kenya are provided, supervised and maintained by the Government’s Ministry of Health (MOH). Kenya’s health infrastructure has grown rapidly over the last 30 years and services have been decentralized, a process that is continuing (MOH 1994). There is a pyramidal health referral system from the dispensaries in the rural areas to rural health centres, to district and then provincial hospitals, and finally to the national hospital.

Decentralization involved the formation of District Health Management Teams (DHMT) with the responsibility of planning and coordinating health services at the district level. In 1989 cost sharing in government health facilities was introduced, requiring communities to contribute to the provision of health services. Of the funds collected, 75% is retained at the facility and can be used to procure drugs and undertake repairs within that health facility; 25% is sent to the district level for primary health care (PHC) activities within the community.

Study area and context

This study was carried out in Kombewa Rural Health Demonstration Centre (KRHDC), located in Kisumu District of Nyanza Province. The facility offers a wide range of services from curative and preventative care to health promotion. At the initiation of the study the total staff complement of 34 included 25 technical staff (a nursing officer, laboratory technicians, an oral health officer, family health educators, enrolled community nurses, public health technicians and clerical staff) and nine subordinate staff. The majority of the staff (76.5%) were women. All these staff had contact with patients; for example, while the main function of subordinate staff was cleaning and cooking, they were also involved in registering patients and sometimes gave injections. Fifty-nine percent of the staff (19) had some kind of in-service training, mostly only once, and in some cases this occurred many years previously. The subordinate staff had not had any in-service training. Of the 23 staff members who were interviewed six (26%) had primary level education, two had secondary level schooling and 15 (65.2%) had some college level education. Thirty-eight percent of the staff (13) had been working in the facility for over a year and seven of these for more than 6 years.

The catchment area of the study facility, KRHDC, was relatively wide since it acted as a referral centre for dispensaries in the region; on average 100 patients sought care everyday.
It was a typical rural facility in terms of the services provided and number of staff employed. Rural health centres such as this, in addition to offering usual services, serve as demonstration centres for medical college trainees. In addition, the study facility, like other health facilities with a wide catchment area in the district, participated in innovative programmes. For instance, during the study period there was a sexually transmitted diseases (STD) intervention involving chemotherapy and youth education in several health centres in the district including KRHDC. At the beginning of the study provision of services was inhibited by shortage of drugs, essential equipment like syringes and needles and patient clinic cards. This was partly due to a bureaucratic procurement procedure at the system level. Inefficiency was noticeable in the way clients spent time in long queues waiting for services. Poor provider–client relations accounted for lack of compliance with service demands and under-utilization of the facility.

Research design

This research project evaluated the impact of implementing HWFC in a primary care setting by using the research protocol described in Onyango-Ouma et al. (2001). The study involved collecting data from clients, health facility staff and health managers at the system level at baseline (T1), at 4 weeks after the intervention (T2) and at 9 months after the intervention (T3). At the client level, interviews and focus group discussions were held; at the facility level, observations, questionnaires and interviews were undertaken; and at the system level, interviews with key informants were done.

Table 1 summarizes the data sources for the study. The research aimed to assess the impact of the HWFC intervention on provider–client relations, on health facility functioning and on the relationship between the facility and system level in the district.

Results

The HWFC intervention

The HWFC workshops were carried out by independent facilitators after the completion of baseline data collection (T1). The researchers were blind to the content and outcome of these workshops until after completion of T3 data collection. However, they are presented here as part of the results as they provide the context within which the health providers at the facility were operating. During the workshops health workers identified factors that influenced, in any way, their relationships with clients. A summary of the part of the Action Plan that providers considered to be within their own control is presented in Table 2.

Provider–client relationships

The relationship between providers and clients is an important element of service provision. This was also underscored when the providers identified in their Action Plan relationships with clients as a priority area that they needed to improve. Results of the impact of HWFC on provider–client relations during the study period are presented below, based on providers’ views, clients’ perceptions and experiences, as well as objective observations made by the researchers. The results are limited to provider–client relations as an aspect of quality of care influenced by time spent in services, interpersonal communication between providers and clients, provider attitudes, improvement in service provision and clients’ opinions about the providers.

Time spent on services

At the initiation of the study it was observed that the overall time taken in the process of seeking care was unnecessarily long; there was reluctance in taking fast action, and slow moving queues were common. Clients were annoyed by the fact that providers reported late for duty but still went for breaks while people were waiting in the queue. At T1 the average overall time spent in the process of seeking care was two hours. At T2 and T3 there was a general reduction in the overall time spent in the facility by clients to 1 hour 27 minutes and 1 hour 19 minutes respectively as shown in Table 3. During T3 patient waiting time was studied to find out what accounted for the overall time spent. Waiting time was defined as the period from the time a client joined the queue until she was admitted to be seen by the provider. The average waiting time was found to be 21 minutes but depended very much on the service sought. In the maternal child health unit (MCH), where children (and in some cases mothers) were weighed, the waiting time (33 minutes) tended to be longer than in other units. For example, in the laboratory clients spent only an average of 10 minutes waiting because the provider just took the specimen from the patient. However, there was double waiting in the laboratory because the patient had to queue for the specimen to be taken and then wait again for the results.

Staff reporting time changed positively after the HWFC workshops. This could be attributed both to the Action Plan and to the posting of a new in-charge to the facility who required health workers to provide a letter of explanation if they came late. A reduction in the overall time spent, fast moving queues and timely staff reporting led to an improvement in the relations between providers and clients. In line with this, clients’ opinions on time spent in the clinic changed during both T2 and T3. Waiting time was said to depend on whoever was working at a particular time and that some health providers were efficient while others were not. Generally, clients saw providers as more efficient and committed to their work than before.

Communication between providers and clients

Communication at T1 was characterized by the providers’ impoliteness, which kept some clients away from the facility. Clients interviewed reported having witnessed providers using derogatory language in addressing women at the MCH, especially to those who reported late or defaulted on follow-up visits. By contrast, during T2 and T3 communication between providers and clients improved both in style and content. In addition to talking to clients in a respectful way, health workers gave advice that clients felt was more adequate...
than before. Better communication also led to greater adherence by clients; for example, they were more likely to comply when referred to the district hospital and when told to buy requirements such as gloves and syringes/needles. Clients who had difficulties in explaining their problems were assisted accordingly. Economic difficulties were cited as the remaining obstacle to achieving full compliance.

The data from observation of interactions between clients and providers at the curative care, antenatal and child welfare clinics showed an improvement in communication. Although the results are based on few observations, there were clear indications that after the intervention (during T2 and T3) the providers were more polite and gave adequate responses and clear instructions. It was observed that the approach was more polite and friendly than before and instructions given were also appropriate and helpful. For example, in the observed interactions at the MCH, where impoliteness was reported at T1 with only 47% of the clients (n = 19) receiving appropriate advice, 77% (n = 47) received clear instructions and appropriate advice at T3.

There was no marked change with regard to greetings and in some places, such as the child welfare clinic, the number of clients who received greetings even decreased from T2 to T3. It was explained that health providers normally offered
greetings mainly to the clients they personally knew. By contrast, some clients, in anticipation of good services in return, offered greetings to providers before explaining their problems. The response from the provider tended to be determined by his or her mood at that particular moment.

According to clients an opportunity to ask questions was given during the health talk sessions rather than during consultations. Health talks were conducted every morning before service delivery began. Topics depended on what health problems were prevalent at the time, but mostly concerned child welfare, basic hygiene and the need to comply with providers’ instructions. The researchers observed that, while an opportunity to ask questions was available during consultation, clients rarely asked them; they mostly took instructions.

Client interview data showed a change in the number of clients who received explanations regarding the purpose of their medications. In 90% of the interactions observed at the curative care room at T3, providers made efforts to explain the purpose of medication and this elicited client satisfaction. However, explanations regarding possible side effects were rarely given.

**Provider attitude change**

There was a positive change in attitude towards clients after the intervention. In the focus groups health providers reported showing empathy: “We discuss with a lot of respect and we treat our patients well, much better than before”. Clients confirmed this change, which was given as one of the reasons why they liked the clinic at T3. Clients noted that they were being given attention and even respect. One woman in a client focus group asserted: “Since you people visited they are now better in treating the patients”. During T2 the case of a client who delivered at home and was attended by a traditional birth attendant was given as an example of providers’ attitude change. To her disbelief, when the woman later took her baby to the clinic, she was attended to in a friendly way. She did not anticipate this because previously (at T1) the nurses refused to accept babies delivered at home and this change of attitude surprised her.

Clients reported that a lack of confidentiality and privacy in the health service made them feel embarrassed at both T1 and T2. By contrast, at T3 clients noticed that health workers were more sensitive to issues that could cause embarrassment and these were handled with care. For example, a woman might be asked to bring a kanga (linen cloth) to cover herself during the next antenatal visit whereas previously such a woman would be scolded for not bringing one.

The health workers also acknowledged having undergone an attitude change towards their clients, especially female clients. According to them there was a noticeable difference in how staff who participated in HWFC treated patients and worked as a team compared with those who did not. Staff who did not participate in HWFC and newcomers to the clinic did

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<td>(4) Inform and educate clients</td>
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<td>(5) Blaming clients when late</td>
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<td>(6) Reporting time on duty</td>
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<td>(7) Putting on correct uniform</td>
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<th>Table 3. Patient time in the clinic</th>
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not treat clients in a friendly way. Poor relations were neutralized during the intervention and this provided an opportunity for the staff to recognize the contribution of each and everyone among them towards their overall goal of service provision to clients. This was facilitated by participation in team building exercises. After the intervention staff relations had changed noticeably and a socially interactive atmosphere prevailed at the facility. For example, the trained cadre (mostly the female nurses) readily accepted to help the cleaners in doing the cleaning to avoid delays in service provision. At T1 the trained cadre waited for the few cleaners, who were short-staffed due to the civil service restructuring programme, to finish cleaning before they started offering services. After T3 only the non-HWFC participants and newcomers did not easily agree to perform such duties, which they felt were not part of their job designations.

### Improvement in service provision

Relations between providers and clients are also influenced by the perceived quality of services by clients, including structural aspects of quality such as the availability of drugs and equipment. Where clients perceive services as less than satisfactory they feel demoralized and dissatisfied. From the results it is clear that before the intervention clients perceived the quality of care offered at the facility as less than satisfactory. At T1 there were complaints regarding recurrent shortages of essential drugs for common ailments and equipment, including syringes, needles and reagents. For the clients the most important element of quality of care was availability of drugs. In fact, for some clients the health centre was considered as good as closed if there were no drugs, and in such circumstances clients preferred to go to private clinics. Thus, when drugs became available at T2 and T3, utilization rates increased and long queues were observed at the health centre.

Client perceptions and experiences presented below corroborate these observations. All clients interviewed at T2 (n = 4) and T3 (n = 25) received medication while at T1 (n = 6) only four received medication. One of the reasons clients disliked the health centre at T1 was shortage of drugs, while at T2 and T3 availability of drugs, in addition to the quality of care given, was a reason given for liking and using the health centre. Observations in the facility at T3 showed that patients’ clinic cards and laboratory request forms were available at the consultation room and the MCH clinic. Time schedules for the frequency of routine drug intake had also been introduced and were observed at the maternity ward.

To deal with the problem of shortages of syringes and needles the health providers set up a facility revolving fund from which they could buy the equipment to sell to clients at cheaper rates. The proceeds went to the facility and not to individual health workers. From this fund the facility could also replenish stocks of food and reagents before they received supplies from the system level. The practice was commended at the system level by the Medical Officer of Health and the nutritionist, who saw it as a good way of utilizing cost-sharing money. Although this system was meant to make equipment available at cheaper rates and to improve quality of care, clients felt otherwise. At T2 the single most important reason for disliking the clinic was the fee for services. Clients felt that the providers had turned the health centre into a business enterprise. This, plus the cost-sharing fee, made clients feel that the improved quality of care was at their cost, despite the fact that the providers sold the equipment only when there were no supplies.

Staff commitment was observed when the staff established a kitchen garden for growing vegetables to further solve the problem of inadequate food supplies. Also, by T3 the system level was convinced that facility staff had demonstrated an ability to use cost-sharing funds appropriately and improvise alternatives in case of delay in government food supplies to in-patients.

### Clients’ opinions of providers

Clients’ opinions of health providers changed during the study period to agree that not all providers were “bad, arrogant and disrespectful”. At T1 clients maintained that although some providers were good, most of them were negligent while on duty and often biased. Female providers were said to be rude and sometimes arrogant. However, at T3 clients remarked that some had changed and that it was normal to expect others to remain as before. Clients in one focus group agreed that “some are naturally looking bad but have no ill motives against patients; they just attend to people officially well”. Also at T3, clients reported that providers were giving women a chance to explain all their health problems. This increased understanding made clients feel more at ease when interacting with providers, consequently improving relationships. They no longer feared rebukes and quarrels, and advice was being given on how to take drugs that made patients feel happy.

Interestingly clients maintained throughout the study that male providers dealt with them better than females in that they were good, sympathetic and attentive to clients. As one focus group participant said: “In general the male health workers treat us better than the female health workers.” Female providers acknowledged that this was often true and that males were generally sympathetic, especially during deliveries. They reasoned that males had not experienced giving birth and were usually fearful and more cautious in attending clients than females.

### Discussion

These results show that some changes took place at the facility after the HWFC workshop intervention that contributed to an improvement in provider–client relationships. For the most part these changes can be attributed to the intervention itself. Although no attempt was made to control for other factors, conclusions drawn are based on data collected through the triangulation of methods (Hammersley and Atkinson 1983); they were also collected over three time periods, in some cases from the same respondents, and in others, from different ones. This strategy allowed for the exploration of the experiences and views of different people with respect to the intervention.
The reduction in the overall time clients spent at facilities during T2 was most likely due to the intervention. T2 was conducted 4 weeks after the intervention, where, among other things, providers discussed issues such as why they became health workers and possible solutions to their problems at work. From the intervention providers developed a renewed interest in their jobs and this made them report on time and attend to clients quickly. In addition, staff relations improved substantially by initiating teamwork, especially where higher-level staff helped the cleaners to finish their work in order to avoid delays in providing services. Nine months later (T3) the overall time was found to have reduced again, pointing to increased commitment. The posting of the new in-charge, who strictly enforced timely reporting and service delivery by the health providers, also contributed to improved quality in the health facility. The in-charge was also strict with regard to the delivery of services, which improved accordingly. The result was an efficient working facility, as evidenced by the reduction in the overall time clients spent there, even at T3.

To a large extent, the posting of the new in-charge can be seen to have occurred because of the intervention. During the workshop series providers noted that they needed more trained personnel in order to meet client demands for specialized services. Hence, in their monthly reports they made requests for additional staff, to which the system level agreed. By T3 five additional staff, including the new in-charge, had been posted to the facility. Although the system level argued that the postings were not as a result of the requests from the facility, insisting that postings are based on administrative units and not requests, it was clear that facility reports were used in the planning of health services in the district. This implies that the requests had some bearing on the new postings. The HWFC workshop series assisted health providers to openly re-evaluate themselves and their work focusing on what they could do on their own and what they needed outside help to do, thus identifying deficiencies in skills and relevant infrastructure such as equipment and physical facilities. These are important elements in planning health services with regard to training, distribution of personnel and supplies, and the range of services that can be offered in a facility.

Data from three different sources (client interviews, provider interviews and objective observations) attributed the improved communication between providers and clients to the intervention. Before the workshop there were complaints regarding interpersonal skills, especially provider’s negative attitudes and behaviour. Clients were not compliant with the prescriptions of the service because of distrust resulting from poor communication styles. The HWFC workshops were conducted in a participatory and inclusive manner, involving role plays depicting problems of communication between the providers and female clients. In the process, providers realized that some of the problems portrayed were actually their own and together they identified how they could adopt better approaches. These included providing clients with needed information, diagnostic practice and attitudes, such as listening to the patient (Gilson et al. 1994), improved to the satisfaction of clients as shown by client perceptions and experiences. Throughout the project duration none of the facility staff attended any other in-service course on communication skills that could account for this improved provider–client communication.

Changes in providers’ attitudes towards clients also resulted from HWFC. From the workshops providers came to realize that some of the problems that female clients brought to the facility were not of their own making but the result of larger societal issues. At T1 providers complained that their clients did not follow instructions, did not carry a *kanga* for MCH and came to the clinic with shaggy hair and untidy babies. But after HWFC they developed a critical awareness of the living conditions of their female clients, which enabled them to transcend the ‘blame the victim syndrome’ and to develop a positive attitude towards them.

It is difficult to attribute with any certainty the changes in structural quality of care, including availability of drugs, clinic cards and laboratory request forms, to the intervention. These elements were mostly beyond the control of the providers; their role was limited mainly to making requests for new supplies. Honouring the requests at the system level depended on availability of enough stocks for distribution. Indeed the facility staff made requests after the intervention just as they had been doing previously. The fact that more drugs for the treatment of common ailments were available at T2 and T3 could have been due partly to increased supplies at the system level. This situation might have been reinforced by the fact that, as a result of HWFC, providers were more committed to, and disciplined in, their work, thus reducing misuse of drugs. Staff commitment was also reflected in the way the problem of food shortage was solved by improvising alternatives. Perhaps some changes were enhanced because the system management had been briefed by the researchers about the workshops and the fact that they were sponsored by WHO.

In general, the HWFC workshops had an impact that led to an improvement in the provision of services by changing health providers’ interpersonal communication skills and making them more committed to their work. The end result was that health workers developed team spirit, understood the problems of their female clients better, and the public and health system regained confidence in the staff and services rendered. Lack of good interpersonal skills and commitment accounts for poor services offered in many public health delivery points in Kenya. Improvements in these two areas are likely to lead to client satisfaction, compliance with services offered and, to some extent, improved curative services.

Drawing on wider experiences from Kenya, the following recommendations are suggested with respect to increasing the impact of the HWFC workshop series.

(1) To sustain the changes initiated health workers should undergo the workshops more than once, ideally once every year. The health workers expressed the desire to have the workshops run more than once, providing an opportunity to build on the changes realized. Changes that can be sustained this way are those that health workers are able to initiate without external help, such as...
interpersonal communication skills, commitment to duty, behaviour and attitudes. The importance of in-service training, mentioned by providers as a constraint on quality of care, needs to be emphasized because it boosts staff morale, improves communication skills and, to some extent, may also improve their income.

(2) In order for the impact of the HWFC workshops to be felt effectively at all levels the health system should be involved from the inception. One way of involving district level managers is to encourage them to be the implementers of the workshops, with technical assistance from researchers and facilitators. In this regard the workshops can become part of routine district plans and health workers are likely to view positive changes as coming from the system rather than an external source. Supervisory visits by the district managers can be a good way to evaluate impacts in the short and long term.

(3) The HWFC methodology works very well. However, a functioning system that is open and committed to change is needed for the workshops to be effective. As researchers we found that health workers were willing and managed to effect changes that were within their control. But there was a slow response to, or unwillingness to undertake, changes that required external assistance and this frustrated health workers’ efforts to implement changes, even those within their reach. Health workers need such external support for their initiatives because they are already working under stressful conditions and facing numerous problems, ranging from lack of equipment to low salaries. Support such as the workshop series acts as a catalyst to rekindle a positive spirit in the face of hopelessness and even desperation. This is why this methodology is most suited for an open system – one that listens and responds to initiatives from the lower levels even if it does not have the resources to fully implement the demands.

References

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