An assessment of the impact of Health Workers for Change in Avellaneda, Province of Buenos Aires, Argentina

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This paper describes the evaluation of the Health Workers for Change (HWFC) workshop series in a primary health care clinic in Avellaneda, Argentina. The study found that there was an important impact at the facility level 2 months after the intervention (T2). Health workers were motivated and willing to examine their own practices critically in an effort to improve quality of care. Informants from the community also perceived that patients were being treated more kindly. Eleven months later (T3), however, the impact at the facility level had receded significantly. At the system level the main benefit of the workshops was to focus attention on the health workers themselves, particularly their perception that there was little communication with the authorities. As a result, the number of system level supervisors increased and they were urged to spend more time in the clinics. Reasons for the limited impact at T3 are discussed and suggestions are made for improving the intervention.

Introduction

This paper evaluates the impact of the workshop series Health Workers for Change (HWFC), an intervention designed to improve quality of care, in a primary health care clinic in the city of Avellaneda, Argentina. The study formed part of a multi-country initiative that also included six other sites, all of which were located in Africa (Fonn and Xaba 1996, 2001).

The Pan American Health Organization (PAHO) became interested in HWFC in relation to two areas of its technical cooperation. First, the Women, Health and Development Program saw HWFC as a potentially useful strategy for sensitizing providers to clients’ gender specific needs and for improving quality of care through a process directed by the health workers themselves. In addition, HWFC was seen as a flexible vehicle for disseminating to providers research results emerging from another project on the gendered experience of quality of care.

In order to assure that HWFC was useful and applicable to a Latin American setting the methodology was tested and adapted accordingly. Two changes were introduced from the original series described in Onyango-Ouma et al. (2001). First, in response to a request by the city authorities, an additional session was added in which the role of the first level of care and the concept of quality of care were analyzed. Second, the session concerning women’s status in society was adapted in order to include an analysis of men’s gender needs as well as women’s.

The workshops took place between September and November 1996 at the Villa Lujan health facility (also known as Sanitary Unit No. 11) in Avellaneda. Avellaneda is a city of 300,000 inhabitants that forms part of the industrial belt that surrounds Buenos Aires, the country’s capital. The city runs 26 free municipal outpatient clinics, ten of which, including Villa Lujan, serve extremely impoverished communities.

The clinics operate on two six-hour shifts, from 7 a.m. to 7 p.m. In Villa Lujan there are ten professionals per shift covering the areas of paediatric care, dentistry, psychology, social work, general clinical care for adults and gynaecology/obstetrics. In addition, there is a director, a receptionist, a nurse and a janitor.

Since most health workers hold other jobs, it was impossible to include both the afternoon and morning shifts in the same workshops. The decision was made by the city to give priority in this instance to the morning group, which was slightly larger in size and included the director of the establishment. Fourteen health workers participated, 10 of whom were women (including the director) and four men.

In considering the impact of the workshops, it is important to describe the social and political context in the city at the time the intervention began. City authorities had just assumed their second term in office and had established as their primary goal in the area of health the transformation of the model of care from curative-based to preventive, based on the principles of primary health care (PHC). There was a lively debate among those responsible on just how this would be achieved. Officials explained that efforts to produce reform in the past had met with confusion and resistance from most of the health workers. This situation was evidenced on the first day of the HWFC workshops, when health workers immediately protested that the inclusion of preventive care would constitute an additional activity that would compete with demands for curative care.
Health workers at Lujan, as in many health services, expressed suspicion of the motives behind virtually all the new programmes and projects. This scepticism was grounded in the problem of working conditions. Suspicion of new programmes and projects designed to effect change is clearly not exclusive to Avellaneda, and it was fuelled by several additional factors at the time of the baseline study. The first and most obvious is the situation of the medical profession, which had deteriorated dramatically in the last 20 years. At the Lujan clinic, doctors attended to 20–30 patients during their shift, only to hurry on to their second and third jobs. As a result, doctors saw themselves as underpaid, overworked and socially unrecognized for their long years of training. They described their work environment as monotonous and devoid of creativity, and most importantly, they expressed a total lack of hope for improvements in their work situations.

Exacerbating the resentment health workers felt were the structural adjustment programmes underway in Argentina. Plans to reduce public sector expenditures constituted a permanent threat of job loss that further deepened mistrust of political authorities. This concern was explicit in the pre-workshop meeting in Lujan, when participants voiced the fear that expressing their complaints honestly would lead to layoffs. By contrast, the authorities felt that the reason changes were difficult to introduce at the level of health services related to the fact that the education received by doctors in medical school over-valued specialized care and sophisticated technological interventions. These very different standpoints meant that dialogue between authorities and health workers at the time the intervention began was at best fragmented.

It was in this context that city health authorities proposed and carried out an 8-week seminar on PHC, which the 200 municipal health workers were required to attend. Simultaneously, they welcomed the proposal to test HWFC as an alternative or complementary strategy to be evaluated.

Methodology

The protocol broadly conformed to the HWFC impact study design described in this issue (Fonn et al. 2001), although several modifications were introduced. The time periods were respected: baseline data was collected during the month before the intervention (T1), the first post-test was applied 2 months after the completion of the workshop series (T2), and a second post-test – at the system level only – was applied 11 months after completion (T3). Changes were explored at all three levels (facility, community and system) only at T1 and T2. At T3 only system level changes were measured according to the original protocol, and in the facility a group interview (as opposed to focus groups) was undertaken.

Four of the original six instruments were applied: the questionnaire at the facility level, interviews and focus groups at the community level, and key informant interviews at system level. In addition, a group interview at the facility level was included. Reflecting the objectives of the PAHO project mentioned above, all of the instruments applied sought to focus on changes in the interpretation of the situation by the major actors, rather than changes in the quality of care itself.

An additional difference with the other studies was the inclusion of a control case. The workshop series on PHC mentioned above coincided in its period of application with the HWFC workshops, and thus constituted a significant confounding factor for this study. As such, we considered it necessary to include a clinic of similar characteristics, Unidad Sanitaria No. 7, situated next to the shanty town Nueva Ana, also in Avellaneda. The facility has approximately the same number of services and personnel, and attends a population with similar socio-economic status. Both the Lujan and the Nueva Ana facilities received the PHC seminar intervention. Only Lujan received the HWFC workshops. Most of the instruments were applied in the same way in the control group.

Table 1 lists the instruments and times of application in both the experimental case (Villa Lujan) and control case (Nueva Ana). The questionnaire at the facility level was self-administered in both facilities. It was not included at T3 because the time involved in filling it out was perceived to be an imposition by health workers. However, an additional instrument not in the original protocol was applied in the experimental case only – a group interview with the health workers designed to capture their perceptions and interpretations of the workshops and their usefulness, as follows:

- T1: the purpose of the intervention was explained and health workers responded with ideas about their situations and the expected impact such an initiative would have.

<table>
<thead>
<tr>
<th>Level</th>
<th>Instruments</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
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<tbody>
<tr>
<td>System</td>
<td>Key informant interviews</td>
<td>2</td>
<td>2</td>
<td>2</td>
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<tr>
<td>Facility</td>
<td>Questionnaires</td>
<td>9</td>
<td>8</td>
<td>0</td>
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<tr>
<td>Community</td>
<td>Group interviews</td>
<td>14</td>
<td>14</td>
<td>11</td>
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<td></td>
<td>Questionnaires</td>
<td>8</td>
<td>6</td>
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<td></td>
<td>Focus groups</td>
<td>9</td>
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<td>(7 adult control)</td>
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Table 1. Data sources, instruments and number of interviewees at three time periods
• T2: the work plan developed by the health workers in the last workshop of the series, and their own evaluation of the experience, including both a plenary discussion and an open-ended questionnaire.

• T3: a follow-up group discussion was held with the same workers to discuss the value of the experience and its possible areas of impact, including whether they had applied any of the proposed actions.

The community level interviews were arranged by asking clients at the time of leaving the facility whether they would agree to be interviewed. If they responded positively, a time was set up in which they would be interviewed at home. The same women were interviewed before and after the intervention. Eight women were interviewed at T1 and six at T2 in Lujan. Seven were interviewed at T1 and T2 in Nueva Ana.

Participants for the focus groups were recruited by the director of a neighborhood day care centre, and women were divided into age groups 15–20 and 20–40 years. The community level was not revisited at T3 because it was felt that the multiple confounding factors that had interceded in the course of 11 months would make it difficult to attribute any observed changes to the intervention.

It was agreed that the system level would be invited to participate in the final part of the last HWFC workshop in order to hear the group’s conclusions, including the plan of action. They were also kept abreast of the process with weekly summary reports of what had occurred in each workshop, respecting the participants’ anonymity. These reports emphasized the successes and failures of each session. Key informant interviews were held in the three time periods with the top-level health official and his immediate subordinate (here referred to as the mid-level official).

In terms of the impact study, the T1 interview was held in the context of discussions on how best to adapt and apply the series in Avellaneda. The second interview took place after both officials had read the report written on the intervention experience, and the mid-level official had attended the final workshop session in which the health workers presented the action plan. The final interview took place 11 months following the intervention, in the context of a formal meeting in which they were asked to comment upon the strengths and limitations of the workshop series.

The health workers’ plan of action

Because the possible areas of impact of HWFC depend upon the particular context in which the workshops are applied, the plan of action agreed upon by the health workers in the last workshop is a useful point of reference for the assessment. The main areas where proposals for improvements were made in Lujan were the following:

• Internal functioning: increase communication, promote sharing of new ideas, more interdisciplinary approach to treatment of patients, weekly staff meetings, mechanisms for integrating afternoon shift.

• Relationship with city officials: increase dialogue, inform them of personnel and infrastructure requirements, present proposals that could be executed together, suggest methods for providing incentives.

• Relationship with the community: establish contact with schools in the area, meet with community leaders, identify existing social networks, organize health education workshops in the community, carry out research on risk groups in the areas of cancer, Chagas’ disease, bronchial and parasitic illnesses.

• Relationship with clients: greet them warmly, avoid underestimating them, improve interview with patients by asking more questions about social and family situation, include address, National Identification Number and information on domestic violence in clinical histories.

An analysis of the short and long term impact of HWFC requires differentiating between the impact of the workshops and the multiple external factors that conditioned the impact. The main intervening factors that occurred over the course of the study included the PHC seminar organized by the city government, renovation of the facility, and an unsupportive facility director. These influences will be discussed in more detail in the Discussion below.

Results

The impact of HWFC is examined at each level – facility, system and community – by comparing data collected at T1, T2 and T3.

Facility level

At the facility level, the impact of the workshop series was observed in six areas:

• desire and ability to effect change in quality of care;
• perception of a need to improve attitudes towards clients;
• perception of the relevance of a gender perspective in understanding clients’ needs;
• quality of interpersonal relations among health workers;
• attitudes toward authorities;
• existence of staff meetings.

Desire and ability to effect change

The situation prior to the intervention (as evidenced by the group interviews) was one of institutional stagnation, and a sense among health workers of being victims of an unjust situation. Staff described their situations as suffocating, having too many patients to attend to, and a sense of feeling used. At T2 the health workers perceived that the situation had changed as a result of the workshops. Health workers commented, for example: “We began to rise above the mediocrity of the context”; “It made us less passive and lazy”; “We feel that there is some hope in producing change”; and “We had been working with low morale. By generating proposals, we felt energized, happier”. The written evaluation included such statements as: “The workshops increased the desire and strength of our daily commitment”; and “It improved the group spirit and made us see ourselves in a positive way”.

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problem in the first place, and that any client dissatisfaction maintained that attitudes towards clients had never been a maximum age) had an important impact on the group, since health workers looked to her for leadership. At T3, she a new competition for her post because she exceeded the explained by the fact that she had just been eliminated from workshop situation. Her views (which may in part have been included: “I think the post-workshop situation was the same as the pre-workshop situation. They expressed the view that the workshops helped them “see the community in a different way” and made them want to modify their attitudes towards the users.

At T3, half of the participants in the group interview said that they had in fact improved the way they treated clients as a result of the experience of the workshops. Comments included: “It was like a voice of conscience for me. When I start out happy and by the end (of the day) I feel aggressive. It’s hard to get beyond this. In the beginning we were stimulated because we thought we could change things. I’d like to go out and do preventive care. But how can we implement this? But it’s also true that while the renovation of the building was going on, we could have organized activities in the community, for example, and we didn’t.”

Perceived need to improve relations with clients

At T1 health workers maintained that clients were satisfied with the care they received. At T2, this idealization of the situation had changed. Health workers now saw a need to improve their relationship with clients. One of the items that was included in the action plan was to obtain “changes in the attitude towards the clients”, which in turn they defined as being more cheerful, “not underestimating the intelligence of clients” and “establishing closer relationships”. They expressed the view that the workshops helped them “see the community in a different way” and made them want to modify their attitudes towards the users.

At T3, the situation had changed. Health workers at Lujan expressed frustration over having increased their hope only to encounter multiple difficulties for implementing the Plan of Action. Explanations offered by the health workers included: “The monotony of the work makes us go back to old habits. It all ended up being nothing”; “There are no incentives, no recognition for our efforts”; “We can’t produce change by ourselves. The authorities have not created the minimum conditions necessary, like appropriate physical space, for us to be able to carry out our work plan.”

However, in contrast with the T1 situation, at least some members of the group continued to reflect on their own responsibility: “Perhaps we are partly to blame. Sometimes I ask myself, as a doctor, what am I doing? I see 20 patients. I start out happy and by the end (of the day) I feel aggressive. It’s hard to get beyond this. In the beginning we were stimulated because we thought we could change things. I’d like to go out and do preventive care. But how can we implement this? But it’s also true that while the renovation of the building was going on, we could have organized activities in the community, for example, and we didn’t.”

Usefulness of a gender perspective

As mentioned above, a module was developed to clarify the concept of a “gender perspective”. This module included definitions of gender roles, relations and identities, and a subsequent exercise using testimonies of women in the community. In the questionnaire applied at T1 and T2, the issue of whether a gender perspective was useful in detecting and understanding clients’ needs elicited a more positive response following the intervention. As a result of the workshops, more participants understood and answered the question and more believed that a gender perspective was useful.

In the written evaluation, the gender session was evaluated as “positive” and “interesting” by 10 out of the 11 respondents. Health workers also said that it would be “important to take into account gender in our future actions in prevention and education”. At T3 two issues relating to gender that had emerged in the workshops were mentioned. The first was the idea that men perceived the health facility to be a place for women and children, a point that had been discussed during the gender workshop. Three members of the group insisted that men attended the clinic now as a result of providers being more welcoming towards them. The second issue referred to domestic violence. Health workers reported being more aware of the problem and better able to respond to patients who were victims of violence as a result of the discussions during the workshops.

Despite health workers’ perceptions that HWFC had increased their sensitivity to gender issues, during the group interview at T3 there were signs that the change was still superficial. For example, one doctor described at length how she thought mothers were taking advantage of health workers because they came at the end of the morning in order to avoid long queues, the implication being that if women came earlier in the morning, doctors could finish and leave early. This kind of comment would appear to be an indication that serious issues remain in regard to awareness of clients’ needs, particularly those of women.

Relations among health workers

A central issue for the health workers was the quality of interpersonal relations among them. At T1, there was a shared perception expressed that all problems were caused by ‘others’, that they were a very close-knit group, and that there were no problems in interpersonal relations. In the Action Plan developed at the end of T1 their views seemed to have changed. They included as an objective working towards a more inter-disciplinary approach to care. In the evaluation of the workshops at T2, one of the positive elements cited was improvement in interpersonal relations: “We became more integrated as a team”; “The group was consolidated”; “We got to know each other in a more personal way”. One participant wrote that the workshops had “made people less arrogant in their relationships”. Another

A second source of data complementing the group interviews was the questionnaire applied at T1 and T2 in both the experimental and control communities. Whereas in Lujan health workers at T2 expressed a desire to “meet community needs” and improve interdisciplinary approaches”, in Nueva Ana no changes had occurred.

At the time of the last group interview, T3, the situation had changed. Health workers at Lujan expressed frustration over whether a gender perspective was useful in detecting and understanding clients’ needs elicited a more positive response following the intervention. As a result of the workshops, more participants understood and answered the question and more believed that a gender perspective was useful.

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wrote, “It made us recognize our own errors and negative attitudes”.

The questionnaire, applied at T1 and T2, included five items on interpersonal relations among the health workers: enjoyment in working together, support provided to each other, freedom to express feelings, use of conflict (from repressing them, on the low side of the scale, to finding them valuable, at the high side) and sensitivity in the group to feelings of other co-workers. Interestingly, in all of these a decline was observed in satisfaction with interpersonal relations between T1 and T2 in the intervention area (Lujan), whereas in the control case (Nueva Ana) there were no changes.

In the group interview at T3, 11 months later, health workers reported an increase in group tensions, and they cited these as one of the reasons they had not moved ahead with the Plan of Action: “The workshops made us see that we could no longer blame the authorities and the community, but at the same time that meant we needed to blame someone else, and so problems between us emerged”; “Issues that had always been there jumped out at us”; “It became apparent how little solidarity there was among us”; and “The relationship that we had broke down”.

The issue of implementing staff meetings followed the same pattern. At T1, despite the group’s self-image as “united”, there had never been a staff meeting. Social interaction, as well as informal information exchanges on policy modifications, occurred in the kitchen over refreshments. In the Plan of Action, the group requested the permission of authorities to continue using the same time that had been used for HWFC for staff meetings, which entailed keeping the facility closed to the public for 2 hours in the morning once a week. The city health official who attended the final session agreed to their request. At T3, however, the group reported that the staff meetings had lasted just 4 weeks. They were dropped, they said, because of poor relations within the group, and lack of recognition of their efforts by authorities.

**Attitudes towards authorities**

The pre-intervention situation was characterized by anger toward the authorities, on whom they blamed virtually all problems in the clinic. Typical comments included: “There is no one above us with whom we can talk about our problems”; “We are isolated”; “At the higher levels they never think about everything we do”; “The authorities come to give orders”; “They told me that they were going to change the services to improve overall community health outcomes. At T3 the situation had partially returned to its T1 state. Part of the group blamed the authorities for the lack of change, although there continued to be greater sympathy for the authorities than before the intervention: “Our relationship with the health secretariat is good. I don’t want to boycott. But we don’t have the necessary elements (to produce change)”; “We need to receive more recognition from above”; “They still evaluate us based on how many patients we see. For them, the good doctors are those that see 30 or 40 in one day”; “If they don’t provide incentives, things begin to disintegrate”.

The basis of these complaints included lack of space, the need for more staff to accompany the high level of demand from the community and, more generally, the sense that their efforts to improve the quality of care had not been recognized. As previously mentioned, 4 months before T3 work had begun on renovating the facility and at T3 it was still ongoing. During this period the staff functioned in half their normal space, which they saw as one of the reasons for tensions in the group. Authorities were blamed for inefficiency in taking so long to complete the renovation.

Another frustration at T3 concerned the proposal on adolescent pregnancy. Health workers complained that, almost a year after presenting this proposal, no feedback from the city authorities had been received, and that promises of further on-site support, which had been planned as a second stage after the seminar, had not materialized. From discussions with city authorities, we knew that there had been a delay in obtaining the necessary funding from the province. However, this information had not been communicated to the health workers. The result was that the health workers at Lujan felt deceived, and in turn this was cited by the Lujan group as one of the reasons that they had not followed through on the Plan of Actions developed in the workshops.

**System level**

Two health officials – the first and second level city officials – were interviewed at T1, T2 and T3 in order to discern changes in their perceptions of problems at the facility level, as well as on the strengths and weaknesses of HWFC.

At T1 the officials voiced two problems: the community was not happy with the services provided and the failure of the services to improve overall community health outcomes.

At T2, the second level official, who attended the last workshop of HWFC, mentioned his surprise at learning that the health workers perceived a lack of communication with the authorities. As a result of discovering this, he said, he had instructed the three directors of areas and the supervisor to visit the facilities more often. His comments indicated that he had given considerable thought to the matter: “The workshops made us see the need to listen more [to the health workers]. This, in turn, will enable them to listen more to the community.”

At T3 the health officials still recognized the need to strengthen communication between the system and facility...
levels. Both authorities mentioned this as the primary benefit of HWFC. Two changes had been implemented between T2 and T3 in this area: an increase in the number of supervisors in the city from one to three, and a change in the system of drug allocation from predetermination at the central level to allocation according to the demands of the health facilities. Authorities said that these changes had been introduced in part as a result of what they had learned from the HWFC experience. At T3 the authorities also expressed interest in continuing to work with participatory workshop methodologies in other areas of in-service training. One example was the organization of a training module on tuberculosis.

The shortcomings of the workshops, as seen by the top official, were firstly, the small number of beneficiaries and secondly, their failure to bring about a transformation from a curative to a preventive model of care. The top health official concluded: “It’s very difficult for the doctors to change. I now believe that the way to go is to train new human resources, nurses and community agents, who can implement preventive programs.” Thus, over the course of the eleven months between T1 and T3, the workshops affected policy only modestly.

Community level

In order to explore whether any short term changes, especially in attitudes towards clients, had been perceived by users of the health services, semi-structured interviews and focus groups were applied at T1 and T2 in both the experimental and control cases. As mentioned above, T3 was not measured because it was considered that the multiple intervening processes in the community in the course of 11 months would make any observed changes impossible to attribute to HWFC.

In the interviews with female clients (the same informants in T1 and T2), changes were noted only in Lujan. The first change concerned perceptions of the quality of care. At T1 one of the eight interviewees expressed negative views concerning the manner in which patients were received by the health workers. At T2, all responses were positive. A second question regarding the kinds of reforms that the interviewees believed to be necessary at the facility also reflected a shift. At T1 three of the eight informants cited the manner in which clients were treated as the primary area in which reforms were needed. At T2 only one respondent still spoke of this problem. Instead, several respondents concentrated their complaints on one health professional in particular with whom they were unhappy.

In the focus groups too, changes were also observed only in Lujan. The issues that emerged were similar to those observed in the interview. In both age groups, at T2 the view was expressed that the manner in which care was delivered had improved. Complaints also focused on the same health professional mentioned in the interviews, and on a new issue, criteria for distributing milk for pregnant mothers and small children, which participants considered unfair. There were no major differences between the two age groups interviewed.

The small samples and the impossibility of controlling for confounding factors make it difficult to attribute the small improvements perceived by clients to HWFC. However, the fact that the same changes were seen in the results of both interviews and focus groups (triangulation), changes that were not observed in the control case, strengthens the possibility that real changes resulted from HWFC.

Discussion

At the facility level, the most important outcome of the workshops was a shift in health workers’ perceptions of the possibilities for change. They progressed from a situation in which they saw no hope for change to one in which they recognized that their own attitudes and actions could affect both the quality of care they delivered and their own levels of satisfaction. They became motivated, which, as the literature on Total Quality Management indicates, is a prerequisite for improving the quality of services.

This shift occurred in relation to new ways of viewing themselves in the context of a triangular relationship with the community and the authorities. They no longer saw themselves as passive victims of these relationships; they proposed actions to improve communications with authorities, with the community and within the group itself. While the dynamics were different in each case, there was an overall curve, from low motivation at T1 to high motivation at T2, and again to low, although not as low, motivation at T3.

Improvements in relationships with clients, the pivotal objective of HWFC, were noted both by health workers and their clients. Health workers reflected critically on their own practices at T2, and they were able to identify gender specific needs of their clients. Clients also perceived changes in how they were treated, while there were no changes in the control case. However, at T3 only half of the providers in Lujan still thought their attitudes towards clients had improved as a result of the workshops; some even reverted to the pre-intervention stance that there had never been a problem in this area in the first place.

With regard to the relationship with the authorities, an area critical to obtaining health workers’ support for any policy or programme, substantial improvements occurred as a result of the workshops, as observed in the Plan of Action and the health workers’ evaluations. While at T3 there was a partial return to blaming the government for problems, the situation was still better than at T1, when authorities were viewed with distrust and blamed for all the facility’s ills.

Lastly, the relationship among the health workers themselves was affected by the workshops. This is another area cited in the Total Quality Management literature as a prerequisite in the process of continual improvements in clinical outcomes as well as administrative efficiency. Immediately following the interventions, participants reported that they had begun to know each other better and that they wanted to work more closely as a team. By T3, the situation had changed radically: health workers perceived that the level of conflict among them was unmanageable and that it prevented them from following through with their work plan, including the holding of staff meetings.

In attempting to understand why positive changes seen at T2
were only partially sustained at T3, lack of follow-up by authorities certainly ranks high among possible explanations. In this regard, it would appear that the ongoing political debate over how to transform the health care from a curative to a preventive model overshadowed the experience, constituting unrealistically high expectations of change for a modest instrument such as HWFC. Next to such an enticing impact, the impact of the workshops seemed small in the eyes of the authorities. This, in turn, reduced the health workers’ enthusiasm and incentive to initiate change.

A second factor that may have diluted the impact of the workshops at the system level (and consequently at the facility level) was the fact that the intervention was applied in only one of the 26 clinics in the city. Had its application been extended to all the clinics, there would certainly have been more momentum from the health services, as well as interest at the system level in creating mechanisms to support and follow up on the respective Plans of Action.

A third factor, entirely unforeseen, was the negative role played by the facility director. Her anger over being excluded from the competition extinguished any desire she may have had to improve the quality of care. She continued to claim that the authorities were responsible for all problems, and the leadership she exercised in the group inhibited others from voicing more positive expectations.

The increased tensions among health workers at T3 can be partially attributed to the transformation model that HWFC exemplifies. Increases in conflict in any group learning to work together and to change existing relationships are normal and even inevitable. However, in this case, the group was not forewarned of these dynamics, and it lacked the necessary skills, experience and support to work through the conflicts that emerged.

Conclusion

The fact that the initial enthusiasm among health workers was not sustained reaffirms a key tenet of the methodology: that HWFC is only one element in a process which cannot, on its own, be expected to produce long-term positive changes in workers’ attitudes and behaviour. The workshops lay the groundwork for a participatory process of planning and action, but they are useful only in situations where the authorities are both eager to implement change and willing to let the health workers themselves direct the process. When either of these elements is lacking,HWFC may actually increase the frustration experienced by health workers.

As a result of the experience in this case study, it may be advisable to apply the workshops widely within a district. This would permit cross-fertilization and mutual strengthening of initiatives between health services, and as a result, increase the likelihood that local governments focus on the Plans of Action as a first step in promoting a more participatory management style. Apropos the content of HWFC, health workers should be alerted to the inevitability of conflict, and provided support, such as expert guidance or written guidelines, on how conflict can be handled.

Lastly, HWFC is not a ‘magic bullet’ that permanently solves problems of providers’ insensitivity towards clients; improvements were only temporary in this study. As a result, follow-up workshops that reinforce positive changes, perhaps focusing on clients’ needs in relation to specific health conditions or social situations, could be useful. For example, accompanying modules on topics such as domestic violence could be developed, as was done in the area of substance abuse (TDR and UNDCP 1997). Once health workers have enough confidence in the workshop process to critically analyze their own practices, they themselves should be able to determine when such reinforcement would be useful.

In conclusion, the evaluation of the impact of HWFC in one clinic in Avellaneda revealed both limits and strengths in the model. Many of the weaknesses discovered in this experience serve as lessons, which, if anticipated, could be overcome. As a result, we suggest that HWFC is an extremely useful tool for launching a process of participatory improvement in quality of care, that it is particularly well-suited to helping health workers become more sensitive to their clients’ needs, and that it is rapid and flexible and, as such, can be quickly adapted to different contexts and problems. Nevertheless, it is evident that these benefits are only applicable in situations in which local authorities have already decided to adopt a policy that places the health workers themselves at the centre of the process of quality improvement.

References


Biographies

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