HEALTH PROMOTION PRACTICE OF RURAL HEALTH WORKERS IN BOLIVIA - A QUALITATIVE EXPLORATION -

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Introduction

The child health card or the growth chart as promoted by and UNICEF since the sixties, has been criticized since many years and at different occasions *(1-4)*. One major objective, that has been put forward in programmes advocating the use of the card, is that it should assist health personnel and community workers in health education and communication about child health *(5)*. Or in other words that it should help them in their child health promotion practice. The card is then proposed as the main or central tool around which this practice should be organized. Few are the recommendations on how health education and communication should or could be practiced. A concept or framework on how the communication should be practiced is clearly lacking. The consequence is that it is difficult to evaluate the quality of the education and communication that takes place. In this paper we briefly present a framework for consultation - called the patient centered approach developed by family medicine *(6)*- in which the modes of communication between practitioner and patient are better outlined. The explicit aim of this approach is to assist health personnel in their role of promoting the self-caring capacity of patients.

The aim of the paper is to explore in how far health personnel are practicing a patient-centered approach without been explicitly thought. The underlying hypothesis being that if elements of this approach can be found in the current practice of the health workers, then these could be used to build upon when designing specific interventions for enhancing a more empathic and responsive or patient-centered health promotion practice.

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Methodology

Transcripts from semi-structured interviews on the concepts and practices on promotion of health, growth and development of children under five of health personnel were re-analyzed. A question also probed on how the health card assisted them in health promotion. Two auxiliary nurses (AN1&2: *references in citations*), one licensed nurse (HN) and two doctors (GP & DIR) working at a rural health centre in Chapare district (Cochabamba province - Bolivia) and one auxiliary nurse (AN3) working at the health post depending of the centre, were interviewed.

The framework on patient-centredness as proposed by Mead & Bower, was used for coding and for organizing the results *(7)*. These authors discern five dimensions of this approach: the bio-psycho-social perspective, the 'patient-as-person', the sharing of power and responsibility, the therapeutic alliance and the 'doctor-as-person'. Citations were coded under the "bio-psycho-social perspective" when personnel talked about the definition or determinants of child health, growth and development. The code "patient-as-person" was attributed to citations where health personnel talked about their own versus the parents' explanatory models of child health and when they indicated their attitudes towards those of the parents. The dimension of "sharing power and responsibility" was investigated by reviewing all the examples given of their daily health promotion practice. Elements of listening and responding to questions with or without the help of the health card were considered as more patient-centered. The "therapeutic dimension" was elicited by checking on how appointments were made and follow-up visits planned. And elements of the "doctor-as-person" dimension were found in citations where personnel commented on the feasibility of integrating health promotion into their daily practice.

Results

The bio-psychosocial dimension

Conceptually child health is understood by all the health personnel interviewed as having biological and psychosocial dimensions. Still as good nutrition, absence of disease and good growth are presented as basic conditions for ultimately a normal development, it seems that most see a hierarchical relation between health, growth and development. In practical terms, growth is equated with measurements of weight and height and development

with the assessment of milestones. The importance of constitution, environmental factors - esp. the family environment - and economical factors in child health are all well understood.

Ok, health, growth and development of a child, well, I think that those three go together, no? Because when a child is sick, when he has no full health, that child cannot grow and he cannot develop as well, no? To me, health goes together with growth and development. [AN3, 51]

And health will have an influence on both, because when health is good, growth is equally good and if this is good, development of the functions will also be good. [GP, 72]

As for the 'social' we can speak of those that do not have a relation with other children and … but that could also be because their mothers forbid them to eat what they want, because there is no money. Meaning that they do not have sufficient revenue for being able to eat what any other child can eat. [AN3, 33]

To me, child health means that the child is in good health, protected against disease, that all his rights and needs are well respected, because child health that does not only mean to have everything at home, money. Health means also affection and protection. [AN1, 68-69]

Listening to their conceptual framework, one would believe that they really have a global view, but listening to how these concepts are translated into daily work, their biomedical orientation becomes clear. Most of the activities they report are related to prevention of disease via vaccinations or informing about diarrhoea or to promotion of good nutrition [citations see under C- Sharing power & responsibility].

These observations did not differ as per educational level of the interviewees. The only difference being that the higher educated - doctors and head nurse - gave more detailed accounts of their thoughts and concepts.

The 'patient-as-person' dimension

The health personnel did not show a highly understanding attitude towards the child rearing practices of the parents. One bluntly said parents are ignorant while another more politely commented that they do not have a conceptual base on child health needs.

No as for growth and development, they do understand. This is a problem that should be resolved! [DIR, 61]

I do not think they have a conceptual base for the fact that development is something psychological or intellectual [HN, 178]

But when asked whether they ever discussed these with the parents, none answered directly except one who exclaimed with surprise, "ooh, I never asked..." [AN1, 280]. None indicated much understanding of the parents' difficult life conditions either. As the fact that parents mainly use the health centre when the child is seriously ill and that they do not attend regularly to the healthy baby clinics was interpreted as a lack of understanding and concern and less as a lack of time or resources.

Most often times they bring their children when they are seriously ill, and in the end, they are not concerned about the health of their children. In any case, a number of mothers ... [AN2, 109]

The 'sharing of power and responsibility' dimension

Health promotion is understood primarily as transmitting messages that have to be captured by the mothers. The responsibility of the health personnel goes no further then making sure that the message can be repeated. Health personnel clearly expect the parents to closely follow even 'comply with' their advice, which in their opinion is rarely the case.

Well, when I explain something to them, they understand me as they say "yes, I understood, you said so and so". So, they repeat, meaning that they say what I said them, then I know for myself that these mothers have well understood. [AN3, 123]

There are a few indications that health personnel respond to questions of the mothers. Doctors seem to have a relative advantage over nurses, as within the cabinet they seem to dispose of a bit more time and privacy. Nurses have fewer opportunities of these one-to-one contacts.

So, they themselves open up mentally, and they say things, they suggest others, so you have to accommodate. You feel it when there is interaction with the mother. [GP, 210]

Well, I tell them this in relation with the problem they came for. When they came for diarrhoea, I tell them to wash their hands, ... I tell them that in relation with the pathology for which they consulted and then I try to orient them. [GP, 307]

Two nurses indicate that on a few occasions they were able to listen and respond to questions of mothers.

… In two communities we have organized meetings with the mothers. So, they told us that their children could probably have diarrhoea. So, they told us that sometimes this is because of the dirty water…. So, we gave them an orientation saying that they should first let sediment the water. Then, to boil the water without the deposits. … All this, so that they could use it and not to drink directly from the river. That is what we told them concerning the diarrhoea, that the water of the river is not good because we know that troubled waters are bad. [AN3, 71]

While I am weighing and measuring the patient, I discuss with the mother. … I ask her questions on health, whether they told her about vaccinations, growth and development of her child. If she was told already, she explains to me what she knows and I argument bit by bit and I complete what she does not know. [HN, 257-264]

So time availability, opportunity and willingness of the personnel seem to determine whether a certain amount of power and responsibility is shared. The health card does not seem to aid in creating opportunities for listening and responding, rather on the contrary its use more oftentimes leads to transmitting health messages without asking any questions.

So, I show the mother that the weight is going down and I tell her: "the weight of your child is decreasing, that is not good, you do not nourish him well, you should improve on that". [AN1, 190]

The 'therapeutic alliance' dimension

All health personnel interviewed complained about the lack of cooperation by the parents in the follow-up of treatment or the lack of adherence to the vaccination or weight control schedule. It seems that in the perception of the health personnel, the parents do not keep their part of the agreement.

They only come to the health centre when their child is very ill. I mean, they do not come in time for their controls. When the child is healthy and does not become ill, they never set a foot on the doorstep of the centre. They are more regular when their child is frequently ill. Rare are the mothers that come for the controls of their child and I think that they rather come because they feel obliged to … [GP; 162-163]

The 'doctor-as-person' dimension

As already indicated, time availability is reported as a constraint to proper child health promotion. All complain about it, and in most examples cited where a certain amount of patient-centredness was present, time was less restrained.

Ok, when we went down there, we had conversations with the mothers because we were two nurses to do the job, so we have discussed. In two communities we have organized meetings with the mothers … [AN3, 71]

Where some indicated a need for more training on the subject of child health, none indicated a need for training on better understanding the parents' perspective or on communication skills.

Discussion and conclusions

The three first dimensions of the framework on patient-centredness were fully covered by the interview script that was used during the interviews. Both remaining dimensions were not that well covered. This definitely leads to a partial picture on the level of patient-centredness of the health personnel interviewed and interpretation on these dimensions should be done with caution. However, from the analysis, the discrepancy between theory and practice of promotion of child health, growth and development is striking. Although their conception of child health is very comprehensive, the practice the health personnel reports is on the one hand clearly disease oriented and on the other hand strongly paternalistic in nature. This discrepancy is not surprising as medical education and socialization is known to stimulate these characteristics *(8,9)*. Although far from being systematically practiced, four of the six persons interviewed clearly indicated strong examples of patient-centered practice. This means that to a certain degree an inclination or willingness is present and that with appropriate support this could be further developed into a more systematic practice.

There exists no literature specific to our subject of concern, but our results concur very well with the critique upon which the patient-centered approach was developed *(10)*. Namely, that a clinical method is needed in order to incorporate more systematically non-biomedical concerns into the doctor-patient encounter and into medical decision making. This would mean that our observations are far from context specific and that it seems that we documented a problem that is rather linked to our scientific -

rational or reductionist - way of practicing medicine. Encouraging is that the more comprehensive or 'holistic' concept of child health, growth and development is well known to the personnel interviewed. And that there is not much difference in understanding this between the higher and the lesser trained. What lacks is the integration of this concept into daily practice. As such the concept of patient-centredness could be introduced in medical and nursing schools and in continued education programmes for professionals.

Three topics seem in need of further elaboration and attention in these education and training programmes: a better understanding of the mediating role of the parents in child health, openness to the perspective of the parents and practical training on what advise to give on child development. The socio-economic determinants of child health are well understood but health personnel need to appreciate more the central and mediating role of the parents. In other words, they need to better understand the difficulties of parents in coping with these factors while trying to preserve the health of their children. This understanding will be facilitated when health personnel during their different training programmes also learn to see child health from the parents' perspective. Courses on different explanatory models and practical exercises on communication skills are some of the methods that can be used to sharpen their empathic abilities and lessen their paternalistic attitude.

The third topic that should be better covered in these programmes is on how to translate the concepts of child development into practical advice. As for nutrition, advice on how to stimulate psychomotor and social development needs to be adapted to the opportunities and possibilities of the local reality. Local medical and nursing schools should take a leading role here.

A final remarks is that all this training and reorientation will not be successful if the conditions of daily practice are not made more conducive for meeting and discussing with parents. As indicated by the interviewees, time availability is an important factor, but a reorientation in the assessment of health worker performance is probably a more important precondition. Measurements of performance should then use fewer indicators of coverage and more of patient satisfaction.

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