

CHILD-CENTRED CARE IN AFRICAN HEALTH CARE SYSTEMS: WHY IS THERE SO LITTLE OF IT? AND WHAT CAN BE DONE?

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Introduction

Today, in many African countries the issue of quality of care at the level of modern First Line Health Services (FLHS) - public or private - is prominent. Huge efforts have been deployed in the eighties and nineties to 'revitalize' African primary health care systems. At the level of the first line, the focus has been on arrangements ensuring the provision of the necessary inputs (human, drugs, equipment, etc.) in the health care delivery process and, at the same time, on the rationalization of health care delivery in facilities staffed by auxiliary health workers (1). The sustainability of these policies benefited from the introduction of community financing schemes based on user fees, and on the management of these funds by local health committees. The Bamako Initiative (BI) launched in 1987 by the African Ministers of Health, the World Health Organization (WHO) and the United Nations Children Fund (UNICEF) has without doubt contributed to positive achievements in this domain (2). The operational integration in first line health services of preventive and promotional activities for mothers and children - the Expanded Immunization Programme (EPI), Antenatal Care (ANC) and Well Baby Clinic (WBC) including growth monitoring (GM) - was central in this strategy. Improvements were achieved in the accessibility of health care, in the range of services offered, and in the availability of essential drugs (3).

But today there is a standstill, sometimes even a frank decline, in utilization rates of modern FLHS. The coverage rates of preventive services remain low and the utilization rates of curative services hardly go beyond 0.3 contacts per year per inhabitant in many first line health services, even in 'revitalized' ones. Although there is no such thing as a golden standard when it comes to measure appropriate levels of utilization, these low levels indicate that there is a major problem in accessibility and acceptability of health care. The immunization rates increased sharply over 50%

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but the further increase required to achieve an epidemiological impact is much more difficult to obtain. In the Well Baby Clinic, the over-concentration on measurable targets, justified by a concern for efficiency, has sometimes led to poorly effective rituals. The number of health education sessions held, and thus the number of supposedly well-informed mothers has increased. So did the number of children undergoing regular weighing, at least until the age when they are fully immunized. But the outcome of these activities remains far below expectations (4). To add to this balancing view, there also is a growing concern for equity. There is increasing evidence that the poor have less access to essential services although they are the ones most in need.

A question therefore emerges: why is it that the population is increasingly ignoring these health services? What is happening? Why does the model of the “integrated health centre” not attract people? There is growing evidence pointing to problems in the human interaction between health workers and patients. The increase in the availability of primary health care services was not accompanied by an improvement in the quality of care offered. Evaluations and studies indicated that health services are often seen as hostile and aggressive vis-à-vis patients (5). If patients are given the opportunity to express their feelings, they say that they feel not listened to or heard. They feel that their views and opinions, their own explanations of what happened to them is not sufficiently taken into account (6). They claim that they are not seen as subjects, but rather as an object in a process that offers standardized responses to their complex individual problems. Sometimes, they even claim to have been the victim of aggression, insults and maltreatment. The question health services all over the world, both in the developing as in the industrialized world², need to address is what needs to be done to (re)situate the patient back at the very heart of the health services.

This paper presents an attempt to answer this question. We will concentrate on child health care and analyze the lack of child-centred care observed in African modern FLHS along three lines: i) the dimension of the clinical method that is practiced; ii) the dimension of the organization of health services and programmes; and iii) the dimension pertaining to the social and anthropological environment in which children, mothers and staff interact. In a first part we will introduce the concept of child-centred care. In a second part we will review the gaps between what is being practiced and

² The increasing success of alternative forms of health care witnessed in industrialised countries points to a lack of patient-centredness within the prevailing classical forms of health care delivery.

what would be a child-centred WBC. In a third part we will propose a comprehensive strategy to move towards a more child-centred approach.

What is going wrong? Lack of child centred-care

A lack of patient-centredness in child care is at the heart of the problem of quality of care

Patient satisfaction surveys indicate that public health services are often seen as delivering poor quality of care (7): a key element in that perception is the users' dissatisfaction with the quality of the interaction between health worker and patient –also in situations where medical doctors staff the first line (8). The clinical consultation is indeed often conducted as a mechanistic process in which the patient is hardly listened to, and where her/his problem is purposely reduced to one or more physical complaints leading the health worker in charge to standard decision-making. Alongside the call from WHO for more responsive health services, efforts are currently being deployed to improve the overall quality of the patient-health worker interaction (9). These efforts tend to focus on (important) aspects pertaining to communication skills and practices, to attitudes of kindness, respect, and compassion vis-à-vis the patient, as well as on more down-to-earth issues like cleanliness of buildings and offices. This is laudable indeed, but not sufficient. Quality of interpersonal care cannot be merely reduced to solely increased patient satisfaction through better communication. Concentrating only on these aspects would constitute a missed opportunity for needed profound changes in the process of clinical care itself. Indeed, the emergence of the problem represents a unique opportunity to integrate the patient-carer interaction within a genuine patient-centred clinical method. Good communication *per se* is not an end in itself, but should be seen as part of a larger methodological process of patient-centred care where the patient is considered in her/his wider psychological, social, cultural and economic environment.

Indeed, a clinical method centred on the patient is not only more humane and acceptable, but would at the same time yield better results and be more effective. First line health services would also benefit greatly from this approach because they are the place where the initial contact takes place between health services and population; between professionals and patients (or potential patients) and their health problems. Moreover, it has a universal dimension. It would be a mistake to think that this is a luxury reserved for private institutions accessible to the privileged, or for

rich countries. But what exactly is meant by a clinical “patient-centred” method?

Patient-centred care: a genuine clinical method

Patient-centred care and thus also child-centred care is a concept which brings five key dimensions at the heart of health care activities: 1) a bio-psychosocial perspective; 2) the patient as a person; 3) the doctor as a person; 4) sharing power and 5) responsibility and the therapeutic alliance (10).

What is a patient-centred clinical method?

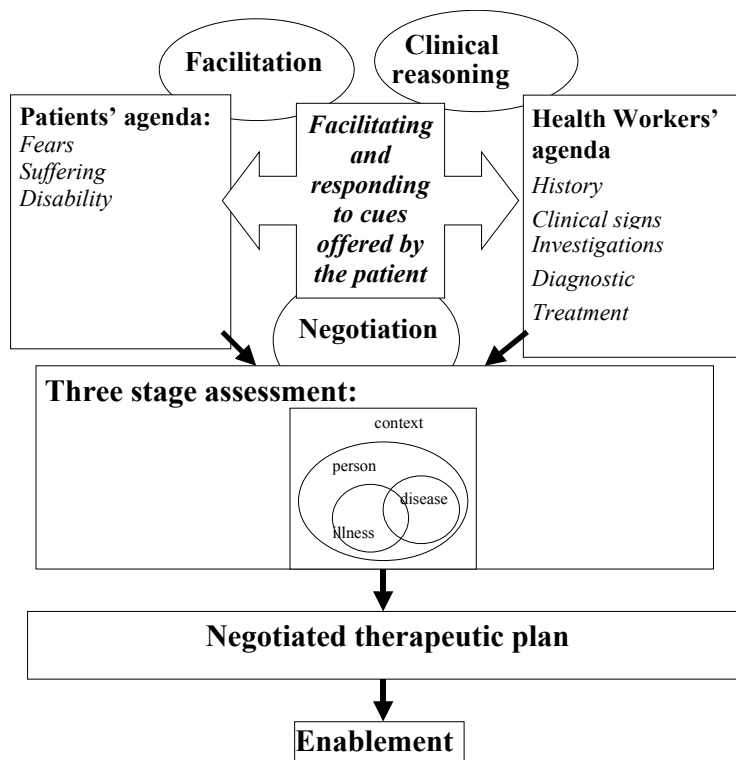
In the classical ‘biomedical’ approach, which is still the most prevalent approach in medical schools and teaching hospitals of industrialized countries, the task of the health worker consists in interpreting, decoding and translating symptoms and syndromes and to categorize the ‘crude’ complaints expressed by the patient under well-known nosological entities. Eventually, a course of action to be taken is proposed. The health professional thus follows a sort of sorting procedure leading to a diagnosis. He discards whatever is not relevant to his decision-making process. The dialogue, generally led by the health worker, consists of asking precise and generally closed questions in order to obtain further information which is not spontaneously given and which is necessary to his train of thought. He can then come to a diagnosis and propose a treatment. He even may conclude that there is an absence of pathology. In that case, the health worker can reassure his patient and explain him that there being no explanation for the pains, there is no need to worry. Of course, in spite of the sometimes ‘police questioning’ style this approach is not contradictory with a respect for the patient’s dignity, nor with a sense of compassion. Moreover, a kind and respectful attitude and a sense of communication on the part of the health worker contribute - this has been proven - to a better compliance. But a genuine patient-centred clinical method goes in fact a lot further than that.

In the domain of family medicine, Michael Balint first introduced the concept of a “patient-centred clinical method”. It was then further conceptualized by Mc Whinney (11,12) and also applied in a South African context to the postgraduate training of family practitioner specialists (13,14). The technique is based upon the health worker 's identification of *clues* offered by the patient during the history taking or the clinical examination. These clues are seen as opportunities for the patient to express all the dimensions (physical, psychological and social) of his problem. This is useful for

himself as well as for the provider who will integrate all this information in his clinical reasoning.

During this process, the health worker tries to acknowledge and explore the different clues offered by the patient. He/she facilitates the discussion through open questions being as little directive as possible. In this way he/she can come to a more in-depth assessment of the problem. The aim of this interactive assessment is not to find a diagnosis but to come to a three stage assessment of the problem: i.e. a clinical level (the symptoms), a personal level (the patient's experience), and a contextual level (the interaction between the patient, his health problem, and his environment). This mutual assessment will eventually lead to a plan negotiated between the health worker and the patient. This plan often, but not necessarily, includes a therapeutic dimension (Figure 1).

Figure 1: The patient-centred consultation model (adapted from Fehrsen & Henbest 1993)(13)



Between the classical biomedical approach and the patient-centred clinical method there is an essential difference. In the biomedical approach, the doctor-patient relationship basically serves the purpose to obtain an optimal participation of the patient in the diagnostic (accuracy of information) as well as in the therapeutic process (compliance). Eventually, it aims to achieve a satisfactory result according to biomedical criteria: that is to restore the patient's good health - the latter being defined by the absence of any apparent disease. The patient-centred clinical method considers the health worker-patient interaction as a facilitating process aiming to improve the understanding of the problem by each of the two actors. A collective negotiation process about a mutually agreeable course of action then follows. These two processes, facilitation and negotiation, are such that they increase the patient's capacity of facing his problem. They put at the patient's disposal, if necessary, further information, skills and resources. This process relates to the concept of 'enablement' developed by Howie (15). Within this model the outcome of the consultation is no longer a diagnosis-treatment strategy, but a re-built capacity of the patient to face his health problem(s). The intended outcome is not cure *per se*, but rather an overall restoration of the patient's capacity to properly function in his environment according to criteria defined by the patient himself.

A child-centred clinical method: the most important feature for child care to be meaningful

We have highlighted that one of the core elements of a child-centred approach is the importance given to the facilitation of the expression of the mother's agenda. In his paper on routine growth monitoring, Garner states that there is insufficient reliable information to be confident that routine growth monitoring is of benefit to child health. In the same paper, commenting Garner, Davies suggests that an important spin-off of growth monitoring is the opportunity for mothers to ask questions about health issues (4). Bringing these three statements together, one can go on to say that if a well baby clinic, focusing on growth monitoring, is not child-centred, it may very well be irrelevant, if not harmful given the anxiety it may create. Introducing and developing the practice of a child-centred clinical method is thus pivotal if this kind of child-care activities have to remain meaningful.

Proposing an appropriate clinical method is not sufficient, the working environment must also change

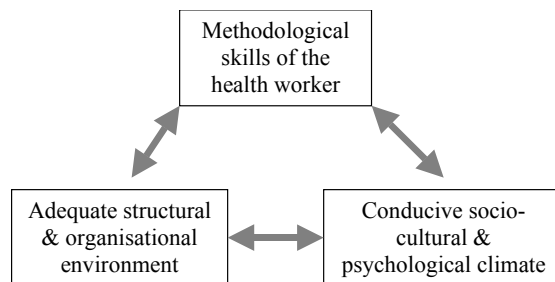
It would obviously make no sense to consider the clinical patient-health worker encounter in a perspective where abstraction

is made from the broader environment in which it takes place. Hence the need to take into account the social and cultural aspects of the environment in which patient and health worker interact, the structural features of the health facilities, and the organizational characteristics of the health care delivery process. It is therefore justified, even necessary, to take into account two other dimensions next to the methodological one: a social-anthropological dimension, and a health services' structural-organizational dimension.

The first of these two dimensions concentrates on the social and cultural variables that may limit the patient's demand for, and the health worker's supply of patient-centred care. A patient may indeed not wish the health worker to take into account elements other than strictly somatic ones. The health worker her/himself may also resist engaging in a patient-centred relationship for a variety of reasons. The other additional dimension looks into the structural and organizational environment in which patients and health workers interact. An organizational set-up of health care delivery where activities are disintegrated obviously is not ideal for the implementation of a patient-centred and empathic approach (9). An excessive workload resulting from a poor planning of activities does not facilitate an open attitude both from health worker and the patient. The rigid application of diagnostic and therapeutic instruction also does not open space for participatory negotiation of a shared therapeutic plan.

We believe that the introduction and the promotion of child-centred care is not only a matter of participatory interpersonal communication, but also of its articulation with the process of clinical reasoning in a genuine **child-centred clinical method**. The latter in turn requires an **appropriate organizational environment** and takes into account possible **social & anthropological factors** that hamper or to the contrary foster such child-centred care (Figure 2).

Figure 2: The tripod fostering patient-centred care



Why is it going wrong? Organizational, methodological and socio-anthropological problems in the delivery of child care

In this section we will briefly review some of the most important gaps between what is actually the practice of under-fives' care and what child-centred care really would need to be. We will analyze this considering the three above-mentioned perspectives.

Organizational obstacles to child-centred care

The structural environment of the child/mother - health worker interaction is often user-unfriendly

At the core of our definition of child-centred care is the capacity to integrate the "patients' agenda" in its full right in the clinical reasoning of the health worker. The way childcare services are organized in most instances does not foster such an approach. For example: growth-monitoring sessions are often sliced into pieces. One health worker is dealing with registration, another one with weighing, and yet another one with health education, etc. There is a chain-like division of the tasks to be performed for each single clinical case. A health worker, whose main required qualification is to be able to read and write, first registers the baby. Once the baby is weighed, it is taken for the control of its immunization status. Finally a short discussion is held, usually with the nurse in charge of the activity, to enquire about nutrition habits, potential risk factors and possibly prevailing acute disease. Eventually the child is discharged with an appointment for the next visit. It is not exceptional that a problem noticed at one stage of the chain will remain unnoticed at the stage where it should actually be dealt with. Too often, the mother is left with the challenge to make the necessary synthesis and to decide what the appropriate action is to be. It is obvious that this situation is not conducive to facilitate the mother to express her own (and her child's) agenda even if such a task division may appear more efficient in terms of productivity (number of children seen per unit of time).

Another problem that is often raised by patients is the lack of privacy. Most of the WBC activities are carried out with a group of mothers like in the case of education and immunization sessions, again with the rationale of improving speed and efficiency.

There also is a problem of service availability and permanence. Preventive activities like immunization or growth monitoring can readily be organized on a periodical basis. This improves an efficient utilization of staff time and allows maximizing

the use of vaccines. This is probably not a problem for populations living close to the health centre as long as information is clearly displayed and communicated but not so for scattered and remote populations. For example: a mother walking many kilometres to attend a curative consultation for herself may simply be requested to come again another day for the immunization of the child she carries on her back. Conversely, a woman coming for the immunization of her child and requesting family planning may be told after waiting a whole day to come again at the next family planning session. Such incidents are unfortunately not rare. They not only constitute a wealth of missed opportunities to improve the efficiency and effectiveness of the health care delivery but they also are missed chances to improve the health services' responsiveness to people's demands and to increase the acceptability of the system as a whole.

There is not only a problem of permanent availability of the service, but also one of stability of staff. High staff turn-over between facilities, but also poor stability of staff in the different activities performed in one single facility (a given person performing immunizations on day 1, but running the curative consultation on day 2) is not conducive for the mothers and health workers to engage in a long term relationship. A mother will refrain from sharing with the health worker a delicate part of her own history if she anticipates having to disclose such sensitive information to different staff members at the occasion of subsequent visits. This represents once more an obstacle for the mother to express her own agenda.

One of the main reasons raised to justify the lack of patient-centredness is the lack of time due to the high workload. It is indeed very common to see long queues in front of health centres, sometimes very early in the morning even long before the doors open. The issue for many people is to arrive early enough to be first in the queue. Yet it is not uncommon to see empty facilities in the early afternoon and evening. There is clearly room to reorganize the intake of patients in order to spread the workload over a full day. Some simple rules to decide whom to see first, the introduction of appointment systems, and more clearly signalled pathways in the facilities could greatly improve the situation. Sometimes apparently disorganized activities may hide well organized systems of bribery (16). In such cases, attempts to reduce waiting times and to rationalize patients' flow within the facility may interfere with staff's own personal interests. Unveiling these "coping strategies" and negotiating acceptable alternative strategies with the staff is crucial if the introduction of change is to be effective (17).

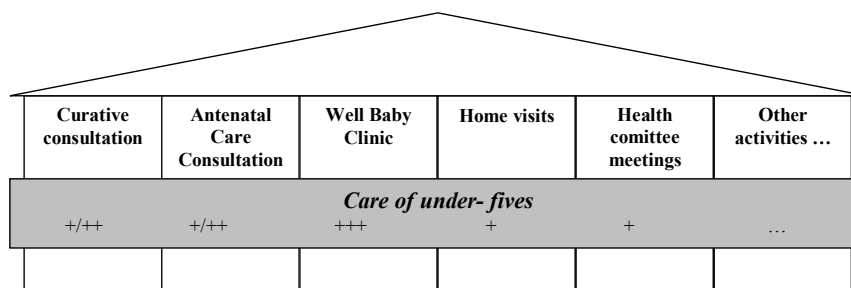
In many countries, the development of health services puts a very strong emphasis on managerial issues. Supervision tends to focus too exclusively on (albeit important) administrative and logistical aspects like the quality of record keeping, the accuracy of the financial accounts or the effectiveness of drug stock control systems. It is common to plan field visits of supervisory teams during the least busy moments of the day so as to avoid “disturbances” by patients. The message that is thereby conveyed to the supervised is that administrative management is more valued than actually interacting with patients. This will certainly not foster the construction of the role model of a supervisor promoting and valuing patient-centred care.

Integrated care is an ill-understood and ill-implemented concept

Integrated care is an important characteristic shaping the quality of the health care delivered at the level of the first line. It has indeed the potential to make health services more user friendly and health care more effective and efficient. But the concept is often ill-understood and/or ill-implemented. A major misconception is that integrated care would be automatically achieved when different types of care (curative care, antenatal care, family planning, care for under-fives, etc...) are offered in one single facility. It is as if the mere existence of different types of care under one single roof would be a sufficient condition for care to be integrated – which is not the case. Integrated care, in fact, is an active approach where the health worker selects the type(s) of care that is (are) best for the patient. The health worker can either offer that care himself when possible, or he may refer to a colleague in his team who offers it, or he refers to a service availed outside his own facility.

Integrated care is an approach ‘cutting through’ all the different activities taking place at the first line (Figure 3). Integrated child care, for instance, refers to an approach whereby every single opportunity of contact between a health service and a child / patient / household / community is used in an optimal way so as to provide the under-fives with the care they need.

Figure 3: Integrated care: a 'cross-cutting' approach



Some health care activities for under-fives may be structured within vertical programmes. This may have disruptive effects on the functioning of first line health services. Immunization programmes for instance, although they often claim to be entirely integrated, are usually piloted from a centralized administration and further channelled downwards. Vertical programmes are guided by a different logic compared to the one of primary health care services. They tend to focus on a limited range of quantifiable and thus measurable results. The priorities of the programme manager, the health worker and the family may be conflicting. A vertical programme manager tends to see his activities as having absolute priority and will strive to maximize impact. The manager of the versatile health care delivery system is confronted with the relative priority character of each single activity. He therefore tries to optimize care through the offer of a balanced packet of services. The offer of child-centred care also means that the child's, the mother's, and the household's perspective need to be considered. This may entail an even more relative order of priority. Families, and more in particular poor ones, consider health as a relative priority to be balanced with other priorities like housing, schooling, clothing, etc. The order of priority that people establish will obviously vary over time and from one person to the other.

The necessary articulation between vertical programmes and primary health care services often is a difficult process. In many instances an *operational* integration of the activities has been achieved but without *administrative* integration. The routinely offered health care in a first line health service combines interventions and activities related to different programmes. But quite often the tools for monitoring and reporting remain specific to each single programme. Resources for some activities, like outreach immunizations for instance, are often earmarked and conveyed through specific channels. The health workers' common sense, and his search for efficiency, will motivate him to take advantage of the

resources available for one particular activity to operate other activities not part of that programme. For instance some of the fuel available for Community-Based Growth Monitoring (CBGM) may be used for family planning outreaches, despite the fact that the programme of CBGM may forbid this. Hence, if a specific programme's resource dry up for a reason internal to one programme, then other activities at the level of the first line may be jeopardized.

The setting of targets to be achieved often takes place under pressure of the managers of the different programmes. Annual plans then look like a juxtaposition of different programmes whereas they should be the balanced result of a comprehensive and participatory analysis of needs and a balanced package of activities. The incentives (financial and others) attached to the achievement of the specific targets of a specific programme of course influence the focus of the staff of the first line. It may imbalance the basic package of activities and decrease the overall acceptability of the first line health service while trying to increase staff's responsiveness to some specific needs.

What is there to be done?

A variety of organizational changes can be proposed to change the way services are offered. The objective should be to arrive at a genuine integration of all activities relevant to decentralized versatile first line health services. It is beyond our scope here to review in detail what could be done; we will limit ourselves to a few examples. The patients' flow may be reviewed, a more appropriate system of appointments may be useful to reduce waiting time during peak hours, the distribution of tasks may be altered with different job descriptions, etc.

A good example of such an approach has been reported by Bossyns (9) in Niger with Family Planning services. In a set of First Line Health Services, the experiment introduced a package of new operational instructions to actively propose family planning, integrated within curative and under-fives consultations, and coupled with measures to increase the health centres' responsiveness to their clients. Patients procedures were made more flexible. Family planning services were integrated and special family clinics were abolished. Health staff was asked to systematically propose family planning to all eligible women presenting to the health centre and to engage in a respectful dialogue. Although earmarked family planning consultations disappeared, the number of new family planning acceptors and

other outcome indicators remarkably increased as a result of these simple measures.

We discussed in the preceding section that the delivery of integrated care goes beyond the grouping of activities under one single roof. It is a matter of both rational organization of the service and of an appropriate attitude from the health worker. In reality this may lead to a variety of practical arrangements. When different tasks are distributed among different staff in one team, then regular communication between team members will always remain essential. If different but related activities are spread among different structures, then co-ordination and efficient information systems are required. Last but not least, there will always be the need for an open and empathic attitude from the health worker allowing him to seize all opportunities for needed care.

Methodological problems in the consultation process

The extreme standardization of clinical processes leaves little room for facilitation or negotiation

Still today most of the first line health services in sub-Saharan Africa, but also in other parts of the developing world, are not run by medical doctors but by less qualified health workers to whom clinical and managerial responsibilities are delegated. The leading criterion for doing so is the possibility to standardize the task at hand. Indeed, if well designed, the clinical-therapeutic decision making process can be standardized to an acceptable level to reduce uncertainty and to allow health personnel with low qualification to address many complex clinical situations and to cover most of the health care needs (18). Care for under-fives, be it in the curative consultation or during preventive activities, is practiced in most first line health services within the boundaries of standardized instructions, flow charts and protocols.

The core of the practice of patient-centred care is the facilitation and negotiation process. The encounter between health worker and patient is expected to lead to a common assessment of the patient's situation with regard to his health. If there is agreement about the existence of a problem, a plan of action is negotiated and agreed with the full participation of the patient (or his spokesman). It is clear that this model is conflicting with the expectation that staff should comply to a complete and precise set of instructions, guidelines and flow charts which link a given clinical observation to a given decision.

The initial experiences in African primary care services of standardization of procedures using flowcharts, beyond the

possibility to delegate complex clinical tasks, pursued two objectives. Firstly, the use of flowcharts was supposed to free the mind of the health worker from clinical reasoning which was hazardous as his competencies were limited, and to free consultation time so as to concentrate on the quality of the relationship with the patient. Indeed less qualified staff was expected to be in a better position to engage in an empathic relationship, being socially closer to his rural patient than would be a medical doctor. Secondly, the delegation of complex tasks to staff with limited qualification was considered as a means of human promotion. Delegation of tasks was seen as a motivation factor for staff (19). Regular supervision visits, training oriented, and carried out by senior practicing health professionals who were primarily responsible for the activities delegated and who had been closely involved in the design of the standardization of the procedures, was essential for the flexible use of flowcharts. The relationship between supervisor and the supervisee was characterized by the willingness of the former to take account of the difficulties met by the staff in applying rigid standards and by the openness and authority to adjust the procedures accordingly. In that perspective, it was expected that such a promotion of auxiliary personnel would gradually, and in the long run, upgrade them to a more professional status. Professional is here understood in the sense of a worker able to make independent decisions, based on his knowledge, and taken in the patients' interests. Such expectations only materialized when all the above-mentioned conditions and enabling factors were present. Scaled up at large level, the approach has shown to lead to a range of perverse effects: all too often it has reduced the clinical encounter to a mechanistic ritual (20).

The challenge: articulating patient-centred care with compliance to clinical and health programme standards

The tension between patient-centredness and standardization needs to be resolved. Moving the swinging of the pendulum from extreme standardization to an attitude of *laissez-faire* in a context where professionalism is still lacking in many instances would lead to the loss of all the benefits of policies of standardization and delegation of tasks. The challenge is to arrive at an optimal articulation of the facilitation-negotiation process with the need for conformity to given professional standards. We should not throw the baby away with the bathwater. In Europe professionalism has been the sole quality assurance mechanism for centuries. Today the guideline industry is flooding health professionals with potentially useful, but hardly manageable, evidence-based information at the

point of health care delivery. In developing countries, guideline-based clinical management has been a safeguard in a system where professionalism was weak.

Technical considerations and recommendations should be brought in during the facilitation process as part of the doctor's agenda, and then be considered as an element of the therapeutic planning negotiation. In Australia, a patient-centred model has been developed that suggests best practice occurs when there is a fusion of knowledge derived from the best available evidence, clinical experience and knowledge of the patient's lifestyle and preferences and then consideration of the remote rural context (21). This model is probably also relevant to less resourceful health services. The presentation by Isabelle François during this conference, and which is reported in this book³, of an experiment with an interactive model of care shows that it is indeed possible to give more flexibility of decision making to nurse-practitioners. In this interactive model of under-fives care, the health centre nurse was free to choose what type of investigation and what type of management was appropriate for each child situation. The nurse had access to a set of guidelines to apply, according to his/her own assessment. In addition, the nurse was requested to systematically ask the mother two open questions on how she perceived her child's health and her child's growth. The results clearly indicated that the interactive model of care increases staff satisfaction and accountability, and that it improves the outcome of child health care.

Nevertheless, we should not be naive. A child-centred clinical method has definitely the potential to make health care more appropriate and more effective. It also has the potential to be recognized and valued by the staff practicing it. But it cannot be achieved overnight. The move from a biomedical to a biopsychosocial approach may also encounter strong resistance by the health personnel who may feel threatened and destabilized.

Social and cultural problems the health worker faces.

The existing role model of the health worker-patient interaction: more harm than good

The undergraduate training of medical personnel in most developing countries still focuses much on biomedical aspects. Hardly any post-graduate training programmes exist in the field of

³ François, I, Tonglet R *et al.* A randomised trial for the evaluation of a new model of routine child health care in Ouagadougou, Burkina Faso: the effects of changing practices and attitudes of the health staff.

family medicine. For most junior doctors, ill-prepared to take responsibilities at the peripheral levels of the health system, high technology hospitals are perceived as the privileged working place, and a hospital specialist career consequently is the profile most valued.

At the best, the patient-health worker interaction model follows a paternalistic approach. This is even more pronounced when dealing with rural populations. Yet the interaction model most practiced is probably the authoritarian model. In the health care profession, the socialization of personnel by peers is a very strong mode of role modelling. Therefore it is not surprising that a patient-centred approach is not common if an authoritarian model is prevailing. It is further passed on from health worker to health worker.

The way supervision is usually being conducted also conveys a message and fosters role models that do not contribute to child-centredness. To the question "How do you make a nurse care for his patients?", a South African family medicine professor answered "You care for him!". Ideally a supervision of health centre personnel should be supportive. It should address in an empathic way the various problems the team encounters in its daily work. It is striking how similar are the process of a patient-centred consultation and the process of a supportive supervision. Both are about facilitating the elicitation of clinical and managerial problems; both put the issues in a health policy perspective (evidence based medicine, programmes instructions and standards); both try to arrive at a common assessment of the problem and an agreement on the course of action to be taken. But in most instances supervision follows an authoritative style drawing on hierarchical relationships and conformity to procedures.

In many countries, the bulk of health services, especially preventive services and mother and child services are provided in the frame of public services. On the one hand, the identity of civil servants is more associated with the control of the population's general hygiene than with the supply of a service to the public. On the other hand, their identity as health worker is probably associated with a compassionate model of caring. There appears to be a conflict between the social identity as a civil servant exercising control by the state and the professional identity as a health care worker. It is not clear why the former seems so often to overrule the latter.

A variety of socio-cultural elements interfere in the consultation process: a complex and contextual web

There may be good reasons for a health worker not to engage in a child-centred relationship. In a traditional hierarchical society a health worker may feel he does not have the legitimacy to discuss family related problems. A growth problem with an illegitimate child in an HIV high prevalence area would require a good understanding of the family context. Yet it would not be surprising to see a young unmarried nurse very reluctant in such a context to engage in an empathic relationship and to enquire into the family complex.

The boundaries of the therapeutic alliance are not necessarily easy to delineate. Especially when empathy in health care is not part of the usual behaviour of health workers. A nurse-practitioner may fear to get entangled in endless social obligations if he starts to be involved in the social dimensions of health problems. In Conakry, a local NGO (*Fraternité Médicale Guinée*) developed health centres with a strong social mission statement. At one stage, children consulted for long-standing physical disability. The health centre contacted an existing orthopaedic centre and children were provided with appropriate prostheses. Parents, children and staff did not stop at this stage though the clinical rehabilitation was achieved. The new emerging felt need for these children was one of social rehabilitation. An education project supported by the medical NGO was then created. This was possible because of strong social identity of the facility and because it had developed a network of partners supporting their initiatives. But this is an exceptional situation. In most instances, in the absence of support from a network of social services, it is not surprising to see health workers reluctant to open the "black box" of social problems. It is then (understandably) easier to stick to pure biomedical answers.

One of the comparative advantages of having nurses instead of medical doctors staffing first line health services was seen in the social proximity of nurses with their patients. But this does not automatically imply a more open attitude in the work situation. A career in the public service may be a means for the nurse-practitioner precisely to mark a social difference with the community he emerges from. In addition, there often exists a problem of ethnic differentiation because in some countries it is customary to post civil servants far from their community of origin in order to prevent attitudes of patronage. Moreover, as we mentioned above, we cannot take for granted that the dominant professional identity of the nurse is one of caring.

Health services in many countries are plagued with corruption. Health workers, like other civil servants, have developed

a variety of coping strategies to improve their living, taking advantage of their position. First attempts to describe and analyze this behaviour have taken place (20). They show that different forms of petty corruption are generalized. To some extent, the involvement in such coping strategies is part of the socialization process for the health workers and is justified by the low salaries they are paid. Some of these coping strategies remain rather neutral in terms of patient-health worker interaction: this is the case, for example, of the (ab)use health workers may make of the many opportunities for training workshops (17). But others strategies are clear forms of racketeering and are obviously conflicting with a patient-centred attitude. It will be useless to attempt any change in patient-health worker interaction, unless such behaviour is being addressed.

Create a social climate that is favourable to child-centred care: fostering professional identity, raising accountability, deterring coping strategies and supporting staff

Unless the many social and anthropological barriers to child-centred care are being addressed, one may expect resistance to change from staff. A comprehensive package of interventions of different kinds must be considered. First, a professional identity focusing on caring should be promoted. Second, alternatives to coping strategies that conflict with an harmonious patient-health worker interaction should be looked for. These alternatives should permit the staff to have a decent income and to restore morale. Third, strategies to increase accountability of health personnel towards the public must be proposed. Fourth, innovative approaches should be developed to create or to strengthen networks of social services to which the health worker can refer for further support. Fifth, support must be provided to the health workers to help them reflect on the difficulties they will undoubtedly encounter when they start engaging in more empathic and committed relationships. This could take the form of discussion groups of professionals. 'Balint groups' represent an interesting example of such discussion groups usually set up to provide psychological support to medical doctors. Experiments of discussion groups involving patients and health workers have shown effectiveness for structuring the social support to psychiatric patients in Guinea (22). These discussion groups gathering health workers could be structured as a forum where health workers can share their fears, their practical difficulties or successes, while at the same time building a culture of commitment and proactive behaviour in addressing their patients' demands.

Where lie the priorities? A research agenda

We propose to answer this question by raising three other ones. Firstly, where is the problem? Secondly, what are the determinants of the problem? And thirdly, what can be done to tackle the problem? What works and what doesn't work?

Where is the problem? A general consensus on the lack of child-centredness probably exists

Descriptive surveys in many developing countries repeatedly pointed to the fact that today there is a major problem in terms of acceptability of health care delivery in modern health services, especially when the relational aspects are concerned. The past twenty years there has been a strong focus on the managerial aspects in the development of local health systems. This probably contributed to underestimate the importance of the interpersonal relationships in the provision of health care in general. Yet interpersonal relationships are known to be major determinants of quality in health care. In 1979 already Donabedian made the distinction between technical care and interpersonal relationship in the management of an episode of illness (23). This is even more relevant in situations where the relationship is not a binomial colloquium but where it consists of a triad 'mother-child-health worker'. Little space, so far, has been given to participation and empowerment in health care programmes that target under-fives and older children. Empirical observations converge to the need to put child and mother's perception, feelings and opinions at the very centre of the entire child-care process. This is consistent with the perceived lack of client-centredness and accountability towards the public in many public services in Africa. Further research to demonstrate this need is no longer a priority. It is now time to move forward.

What are the determinants of the lack of PCC? Need to investigate the complexity of this multidimensional problem

What is, however, still largely lacking is a thorough understanding of the precise determinants of this lack of patient-centredness. The mere training of staff in communication skills will not solve poor communication. As we pointed out earlier, child-centredness goes far beyond a mere technical issue. There is a need for an inventory, specific to each setting, of the various structural and organizational obstacles to the provision of child-centred care. The reasons for the rude staff behaviour vis-à-vis patients must be understood, unveiled, sociologically decoded and openly discussed

in a non-judgmental way. Staff's underlying coping strategies should be identified, addressed and possible alternatives explored. Eventually, more research is needed to develop a more appropriate (i.e. child-centred) clinical method, suitable in situations where there is no qualified medical professional, and which appropriately balances the need for conformity to professional standards with the need for responsiveness to the individual situation of each single child. This new development of the clinical method in African child-care must contribute to the promotion of more professionalism among the health workers.

What strategies work and what strategies do not work? Need to test multidisciplinary interventions aiming to promote child-centred care

We urgently need field trials and demonstration projects to test what works and what does not work. Innovative research programmes must be conducted to identify the most appropriate strategies to boost a more child-centred approach to child health. This research should build on multidisciplinary approaches. Acting solely on communication patterns or on managerial issues or on clinical techniques will not be sufficient. We should encourage a research framework that combines managerial, clinical and socio-anthropological approaches and that gathers field practitioners, public health experts, family medicine specialists and socio-anthropologists.

Positivist research approaches are unlikely to be appropriate for the investigation of the problem and for the identification and testing of possible solutions. Quality improvement techniques often follow a linear reasoning in search of a single root cause to tackle. This would mean considering the clinical interaction as a simple linear process. But the problem is clearly multicausal and relates to several domains and disciplines (biomedical, sociological, anthropological and managerial). The reasons for the lack of patient-centredness are as complex as the possible strategies to address it. We need to move away from naïve positivism and adopt a research and intervention methodology able to deal with complexity. Action research is one of the methodologies that have the potential to deal with complex systemic problems. But innovative approaches are most welcome in an area that is likely to become a major topic for health systems research in the years to come. Perhaps the principal challenge, since Alma Ata, in the promotion of appropriate child health care is to increase the responsiveness of child-care programmes and services through the implementation of more child-centred health care delivery systems.

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