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UPDATE ON THE QUALITY OF CARE PROJECT PRESENTATION OF THE RESULTS OF THE OPERATIONAL RESEARCH PHASE

This document provides an update of the operational research effort currently under way in Argentina and Peru to identify (1) gender-specific needs in the healthillnesscare process of men and women health services users, and (2) how these needs are being addressed by health care workers in primary health care settings. Two medical conditions were selected as examples through which these issues are examinedChypertension and diabetes type IICchronic illnesses that present themselves in men and women in similar fashion, thus permitting a comparative equity perspective. The research demonstrates that at any point in the healthillnesscare continuum major differences exist between systems of perceptions, conceptions, and values of the men and women interviewed in this study. At the same time, important differences emerged as a result of the perceived roles of clients and doctors, with specific implications for men and women, as well as negative stereotyping of users in relation to their social class. The document presents these differences, and concludes

with a description of
how to apply the findings to sensitize health workers to
gender-specific needs and to
facilitate their participation in the formulation of strategies
and actions to improve the
health care model currently offered by the service.

The Subcommittee is requested to review the advances made to
date and comment on
the findings in the light of their own countries' health
systems.

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1. Summary of the Project

During the last decade there has been a heightened interest on the part of countries in Latin America and the Caribbean to participate in the creation of new instruments to measure quality in the health services. At the same time, there has been an important commitment to focus on gender as a determinant of health and illness. The Pan American Health Organization is now intent on introducing a gender analysis into areas traditionally excluded from the field of "women's health," and this initiative bears testimony to that interest.

The project's objective is to explore and promote the socio-emotional dimension¹ of quality of care, giving special priority to the identification of socially constructed gender-specific needs, which may be exacerbated or simply unmet by health services.

The principal outcomes of the project are, in addition to furthering the documentation of gender equity in the distribution of care, the development of a new approach to the evaluation of quality of care that takes into account social and cultural dimensions, thus allowing the incorporation of a gender perspective, and in-service training workshops that seek to spark critical reflection and participatory problem-solving among health workers in relation to the problems identified in the first stage.

The project is currently under way in Argentina and Peru. It is composed of three phases:

- (1) The first phase consists of a qualitative study designed to explore the issue of gender and quality of ambulatory care for chronic illnesses in an area of extreme urban poverty. The result of the research will be a mapping of the principal problems as defined by contrasting male and female clients' and health workers' views and a data base of qualitative data that can be used in in-service training. (14 months)
- (2) The second component concentrates on the design and testing of a simple, low-cost, and rapid assessment protocol capable of measuring the problems defined in the first stage, that can be applied to validate in other sites the research carried out in Argentina and Peru. (9 months)
- (3) The final component builds on the first two and consists of the development and testing of in-service training guidelines for health care professionals that incorporate a gender perspective as a tool in analyzing both community needs and satisfaction, as well as issues relating to health workers themselves. These workshops will be based on the principles of total quality management, emphasizing such strategies as teamwork, utilization of information in decision-making, and, above all, the importance of health workers' and health users' satisfaction. (9 months)

The first phase will be completed in Argentina in June 1997 and in Peru in August 1997.

The second and third components will be carried out simultaneously during a period of 18 months, from June 1997 to December 1998.

2. The Research Component

The first phase of operations research began in Argentina in February 1996 and in Peru in June 1996. This component of the project has sought to respond to the following questions:

- What are the differences between men's and women's explanatory models of their illnesses, including perceived needs and expectations in regard to the ambulatory care they receive?
- How do health workers' views on this range of issues compare to the explanations provided by male clients, on the one hand, and female clients, on the other?

The differences or conflicts between the social discourse of health workers and either or both groups of clients will be understood to be indications of possible problems in the quality of care. Areas in which similarities are found will also be considered.

This is considered to be an equity study to the extent that it seeks to explore different standards of socially constructed needs as defined by men and women clients themselves and, subsequently, to analyze the health services responses to those gender-specific health needs.

Two medical conditions were selected as examples through which these issues would be examined: hypertension and diabetes type II. A requirement of the conditions selected was that they present themselves in men and women in a similar fashion, thus permitting a comparative equity perspective. Current knowledge about gender differences in relation to these diseases is, at best, restricted, as reflected in the comment of a leading diabetologist in Argentina who, while debating the lack of necessity of such a study, asserted that "hypertension and diabetes are genderless."

These diseases were also particularly appropriate to the study because the same members of the medical community that have had difficulty in visualizing the importance of a gender perspective are currently extremely open to and in search of new models of health care delivery. Concern over issues of compliance and continuity of care are testimony to their view that current practices have been relatively unsuccessful in obtaining changes in lifestyle habits, particularly among the

urban poor. At the same time, epidemiologists in the Region have warned that the relative weight of these diseases is on the rise, particularly in countries like Argentina, where infectious diseases have been partially controlled.

In light of PAHO's mandate, the population selected for the study resides in areas of extreme poverty. Urban communities, where diabetes and hypertension are more prevalent, were chosen over rural areas. It was also considered important that the group be as homogeneous as possible, so as to avoid the interference of major confounding factors such as type of services utilized (public/private), social class, and ethnicity.

The methodology utilized in the study is the "semiotics of statements," a formal system of discourse analysis that draws upon principles of cognitive semiotics (Magariños: 1996). While tedious in its application, the method purports a greater degree of scientific rigor than most qualitative methods, in that it formalizes the analytical process and thus makes it possible to account for the journey from data to research results. In addition, the principles of cognitive semiotics, transformed into research method, help to bar the incorporation of the researchers' own categories or social discourse a priori. The methodology requires: (1) the application of a series of procedures that include the description of the material dimension of signs, and (2) only permits the interpretation of meaning through contrast with other possible forms of constructing meaning. These two seemingly abstract criteria allow the researchers to distance themselves from the data, organize it, and, above all, account for the analytical process undertaken.²

The two techniques applied in the collection of data were in-depth unstructured interviews that included in some cases a second visit interview, and focal groups, conducted with the same members of the community and health workers who had been interviewed. Interviews allowed the researchers to observe the internal logic of the cognitive process through narrative, while the focal groups served to spark dialogues that tended to reinforce areas of common discourse and to permit the expression of more critical comments than were manifested in the one-on-one interviews.

The criteria for defining the number of interviewees in the sample was established by "theoretical saturation," or the emergence of patterns that begin to repeat themselves in the texts being analyzed.

The research was carried out in Avellaneda, a city of 300,000 bordering the capital of Argentina, Buenos Aires. The population interviewed was exclusively urban poor. Fourteen women and 16 men between the ages of 30 and 60 suffering from either hypertension or diabetes type II, or both diseases, were interviewed. Eighteen health workers were interviewed: nine doctors, five nurses, and four receptionists/administrative clerks. The doctors were all general practitioners.

In order to obtain this number of practitioners it was necessary to include five different primary health care clinics. These clinics were all situated in areas of extreme poverty and were chosen because they were similar in size and type. Clients interviewed live in these five neighborhoods and attend the same clinics.

3. Principal Findings of the Research to Date

At present, the research data has been collected, processed

in a data bank, and organized, in accordance with the methodology, in sets of associations of semantic fields. Several stages of the analysis have yet to be completed, including: (1) charting each group's discourse formations in such a manner that contrasts can be easily identified; (2) interpreting these differences in light of the theoretical framework, in particular the concept of gender as a social category that could explain certain differences; (3) situating findings in the context of other research efforts; and (4) discussing the practical implications of the findings for several fields of public health in addition to quality of care, including human resources training, and health promotion activities.

Before presenting these preliminary findings, it is important to situate them in light of several elements specific to the field of qualitative research, and to the methodology that was utilized in this study:

- The results of qualitative research cannot be extrapolated to other places and periods in time; they are by definition locally grounded. As such, the study may be considered exploratory in nature.

- It is worth recalling in reading these preliminary results that one of the extremely strict criteria set forth by the method "semiotics of statements" is that the entire text recorded and subsequently transcribed be analyzed. Thus, the word searches carried out were based on all the data collected, and at the same time restricted to that data. Readers, in theory, may have access to that same data base and may carry out the same word searches.

- It is also important to cite two principles of the theory of semiotics. First, each association of material signs, or in this case association of terms and the resulting meaning, are ideas that derive from, and whose possibility of existence is determined, by systems of discourse or thought. Thus, the mere enunciation of an idea, even if it is expressed by only one or two interviewees, reflects the possibility of constructing meaning in that manner, and is scientifically valid. Second, semiotic theory assumes that there is plurality within and between social discourses, and that such contradictions are in fact more important from a research viewpoint than the repetitive patterns, since they are the markers of historical transformation. The implication of such an assertion for this study is that, while the nature of the research questions lead to identifying differences between three social groups, it should be clearly understood that there is plurality within each group, or what Magariños would term a range of ideas that are semiotically possible for members of each community.

3.1 Differences between Men's and Women's Explanatory Models of Their Illnesses

The research has demonstrated that at virtually any point on what could be considered a health/illness/care continuum major differences exist between systems of perceptions, conceptions, and values of the men and women interviewed in this study. It is also true that there are many similarities, obviously determined by the fact that they suffer from chronic illness, share a social class, and of course by the multiple specificities of the places and times in which they reside. Some of the major differences found in the study were the following (findings considered most interesting appear in bold type):

3.1.1 Experiences of Being Chronically Ill

(1) When men and women perceived that their illness is chronic:

- Women expressed feelings of anguish and lack of hope.
- Men explicitly expressed denial of such feelings, although they sometimes mentioned that they are "less masculine" or compared themselves to children in describing their condition.

(2) When they expressed the idea that their own health is not important and is therefore unworthy of the effort or sacrifice to alter lifestyle habits:

- Women associated "being selfish" with caring for their own health and referred frequently to the demands of their role as mother, defined as caretaker of others' health. At the same time, they lamented not enjoying the status of a sick person, by virtue of their family's refusal to recognize them as such. They recalled periods of pregnancy as the one time they felt "protected" in health services, and in some cases within the home. It would appear that a prerequisite for caring for their own health would be that others recognize them as ill.

- Men rejected the idea of caring for their health in conjunction with the rejection of the "sick person" identity; they frequently stated that they were "not interested" in illness.

(3) When, on the contrary, men and women expressed concern for their own health:

- Women explicitly stated they do so because they fear their young children will not survive without them. When they referred to the idea of caring for themselves when their children are older, the idea appeared as a distant possibility rather than a current practice.

- Men said that they care for their health because they fear dying.

(4) When they described physical sensations:

- Women used rhetorical expressions that rely on substitution of terms.

- Men described symptoms in a direct fashion.

3.1.2 *Determinants of Illness*

(5) **When men and women provided organic explanations of their illness:**

- **Women's explanations included reference to their source of information, always a medical doctor. That information was uncritically repeated.**

- **Men also sometimes referred to the medical doctors as their source of information on why they have become ill. However, much more frequently, that information was tempered by comments on whether the doctor's remarks were pertinent in light of their or others' personal experiences.**

(6) Both men's and women's principal explanations of their illness related to social and emotional factors in their lives that cause stress (poverty, neighborhood violence and drugs, family strife, etc.):

- Women, however, did so in a manner in which they identified the cause and the symptom simultaneously, i.e., anxiety due to children's hunger-illness.

- Men sometimes did the same, but more often referred to intermediary emotions in a causation model, i.e., conflict-anger-impossibility of expressing anger-illness.

(7) When economic strife was identified as a determinant of illness:

- Women spoke of their inability to respond to children's needs.

- Men spoke directly of unemployment.

(8) Both men and women referred to the neighborhoods in which they reside as distant from themselves and a cause of illness. However:

- Women emphasized street violence, drugs, and the breakdown of community ties that once "helped" them.

- Men emphasized a lifestyle that is different than in their home provinces and that involves women, drinking, and staying up late at night.

(9) When men and women referred to domestic life as a source of illness:

- Women spoke of worrying about children, domestic violence, and husband's alcoholism.

- Men spoke of feeling angry and irritated when they are forced to be at home because they are without work, and directly link "being at home" to becoming ill.

(10) When they cited past traumas as having caused their illness:

- Women spoke of recent family conflicts and deaths.

- Men spoke of family problems when they were children. Traumas suffered as adult men were either street fights or conflicts in jobs.

(11) Only men spoke of "abuses," "bad habits," and/or "excesses" as a cause of illness, in reference to alcohol, women, staying up late, and overworking.

(12) When men and women described the situation in which their diseases were diagnosed, it was frequently during a health crisis; however, in addition:

- Some women related having been diagnosed during pregnancy.

- One man related having been diagnosed during a routine check-up required by his job.

3.1.3 *Treatments*

(13) When men and women described treatments, they referred to their knowledge of how their bodies function in different ways:

- Women referred to knowledge of their bodies with insecurity and doubt.

- Men referred to their bodies with great certainty of the accurateness of their knowledge.

(14) When they spoke of medication as part of a regime, both men and women described the difficulties of purchasing medicine:

- Women expressed extreme dependency on drugs, to the extent of proclaiming that they could not live without them.

- Men spoke of self-regulation of consumption, and the capacity to simply decide to halt medication.

(15) When they spoke of secondary effects of medications:

- Women expressed concern that it could make them gain weight.

- Men expressed concern that medication could make them have less energy.

(16) When men and women referred to the special diets that were indicated by doctors as part of their treatment regime:

- Women often said that doctors "ordered" them to alter their diets and did not question this. The doctor's principal motive of indicating a diet was understood by the women to be weight loss.

- Men often referred to the doctors' indications as "prohibiting," which in turn was considered fair (given the cause of the illness). The principal motive of the diet was understood by the men to be caring for themselves.

(17) When they spoke of the obstacles for complying with diets, they both referred to the diet as (1) an artificial form of living; (2) eating differently than the rest of the family, which was impossible; and (3) costly.

- Women also spoke of prioritizing the use of resources in favor of their children's needs.

- Men also spoke of the difficulty of complying during social gatherings.

(18) When men and women questioned the efficacy of diets:

- Women said that it did not make them lose weight.

- Men said that the doctors were to blame in that they prescribed the same diet for all people regardless of weight differences.

(19) Both men and women identified participation in groups as improving health:

- Women expressed the view that groups helped in that they permitted them to speak about their illnesses, and provided activity outside the home.

- Men attributed the importance of groups to the possibility of coming to an agreement and elevating suggestions for improving health care to authorities. The idea of a group fulfilling a need for more social life was not present; one man even said that he refuses to see his friends because he feels less manly now that he is sick.

3.1.4 Access

(20) When describing the decision to seek care, both sexes attend health services when worrisome or painful symptoms appear. However:

- Women described the need to concur with great urgency.

- Men described the decision as a personal matter over which they had entire control.

(21) Men and women stated that the decision not to return to a health service is often linked to having been mistreated, or to the costs involved:

- Women also spoke of prioritizing resources for their children as an impediment to seeking care.

- Men spoke of their resistance to learning about their condition.

(22) When selecting a health service, both men and women considered the first level of care to be advantageous in that there is greater familiarity with the health workers and less distance.

- In addition, women mentioned that the length of time with the provider was longer, and that there was thus more time to tell the doctor their personal stories.

3.1.5 *General Images of Services*

(23) In describing negative images of health services (not explicitly linked to the choice of services), both sexes mentioned waiting time, lack of health professionals, and lack of hygiene.

- Women also complained of "feeling like nobody" in the health services.

- Men described health centers as being "for babies."

(24) When they referred to having been rejected by health services:

- Women expressed hurt, especially when doctors were unable to identify an organic ailment.

- Men expressed anger, especially when they have been made to wait and then are told that they will not be attended.

3.1.6 *Roles of Doctors, Nurses, and Administrative Personnel*

(25) When nurses and administrators were described by men and women:

- Women were harsher with this group than they are with medical doctors.

(26) When the role of a doctor was described, both sexes emphasized the importance of self-sacrifice and rejected the current tendency to equate care with economic retribution.

3.1.7 *Communication in the Medical Visit*

(27) When men and women referred to "social talk" in the visit:

- Women often spoke of the need to be listened to, given that in their families this did not occur. They also complained of those doctors who only give orders and do not participate in other forms of interchange.

- Men utilized the term "listen" only to refer to the action of listening to the doctor, activity which was also described as "chatting" and "conversing," and thus implies bilateral exchange.

(28) When men and women referred to instrumental talk, based on the exchange of information for diagnosis and treatment:

- Women valued receiving a full explanation from the doctor. At the same time they said that they often do not understand these explanations.

- Men demanded information and directly linked the need for information to their intention of making their own decisions with regard to treatments.

(29) When they described asking the doctor questions, both sexes considered it important and necessary:

- Women in some cases, however, also expressed fear that such an attitude could anger the doctor.

(30) Only women described the situation of receiving advice from doctors, which they value positively.

3.1.8 *Actions in the Medical Visit*

(31) Both men and women emphasized the importance of being physically examined by doctors:

- Some women also explicitly cited the importance of being touched by the doctor.

- Men valued the examination insofar as it was evidence of the technical competence of the doctor.

(32) Both sexes identified as central to the visit the act of prescribing medication; however, they also criticized those doctors who do nothing but prescribe during the visit.

(33) Both men and women assumed that doctors should provide medication and did not consider the difference between drugs supplied by the government and those that laboratories have distributed to doctors on an individual level, and that may or may not be offered to clients.

(34) Men and women often spoke of doctors referring them to another health service:

- Women interpreted such referrals as either as a sign that no solution had been provided to their problem, or as being rejected by the doctor.

- Men sometimes valued referral as a sign that they merited the attention of a specialist. Complaints were voiced in reference only to the bureaucratic obstacles involved, such as waiting time for a new appointment.

3.1.9 *Doctors' Attitudes*

(35) When evaluating doctors' attitudes:

- Women constantly repeated the idea that they want to be taken into account "as a person."

- Men did not express this idea. The most linguistically similar statement was that they expected their illness to be taken into account by the doctor.

(36) When men and women used adjectives to describe the positive attitudes:

- Women utilized such terms as "loving" and "affectionate."

- Men utilized such terms as "friendly."

(37) Only men referred to the technical competence of doctors and the capacity to resolve the problem that had motivated the visit as highly valued traits.

(38) When men and women spoke explicitly of being mistreated in health services:

- Women referred to their own experiences.

- Men referred to the problem in general and in relation to the rights of others.

(39) Elements that were linked to the idea of ill treatment were:

Treated in a rapid impersonal manner:

- Women used the image of a checkout counter in a grocery store.

- Men used the image of cards being dealt.

Blamed:

- Women described being blamed for different situations in the visit and feeling hurt by the situation.

- Men described being blamed by doctors and feeling that they were right to do so.

Scolded:

- Both sexes saw scolding as a positive action in some cases and negative in others.

- In the context of scolding seen as negative, women spoke of the doctor becoming angry.

Threatened:

- Women described being threatened that if they did not comply they (the client) would (1) end up in a wheel chair, (2) become fat as a cow, (3) provoke their husbands into leaving them, or they (the doctor) would (4) prescribe insulin injections, (5) refuse to attend them in the future.

- Men described being threatened that if they did not comply they would die.

Treated in a dry, cold manner:

- Women complained of being treated in a distant, dry manner.

Made fun of:

- Men described situations in which they felt they were being made fun of, in particular when made to wait for long periods.

Inside contacts:

- Men complained that some clients are given special treatment due to political or family contacts.

(40) When men and women described the possibility of protesting when mistreated in the health services:

- All of the experiences recounted by women in which they had protested were in reference to their children whom they were bringing in for care.

- Men often expressed the idea that it is natural and obvious that they should defend their rights when mistreated.

(41) When they described the impossibility of complaining about

the quality of care:

- Among women, in recounting the experiences in which they were unhappy with the care they sought for themselves, the possibility of voicing dissatisfaction was not considered.
- Among men, past experiences of police repression and the possibility of police or guards being called if they protested was directly associated with not being able to protest.

3.2 Differences between Health Workers and Male and Female Clients

The social discourse manifested by health workers coincided to a large degree with that of the clients, and several of these points of convergence merit reflection. The strongest similarities reside in the explication of the determinants of illness (health workers also placed great emphasis on the socio-emotional factors) as well as the curative factors. What emerges, in this regard, is a picture in which all three groups conceive of the social environment as the principal cause of disease, have little faith in the possibilities of complying with medication and diets, and in essence perceive the contact health services have with the population with chronic illnesses as having little or no impact. This perception, however, does not lead to a process of reflection on how to modify their practice. Blame is instead placed on the clients themselves or, in general terms, on "the system."

At the same time, significant differences emerged as a result of the perceived roles of clients and doctors, with specific implications for men and women, as well as negative stereotyping of clients in relation to their social class.

3.2.1 General Images

(1) When health workers described their clients, a series of negative attributes were repeated: they are different from us, they are marginalized, they have no culture, they are lazy, they have no spiritual superior system of beliefs, in their communities anything and everything is permitted, they are violent, promiscuous, alcoholic, and addicted to drugs. No positive characteristics of the community were expressed. While clients also mentioned many of these same issues as problems in their community, only in the case of men were some of these attributes (alcoholism and promiscuity) ones in which they reported having been personally engaged and which had resulted in ill health. Women, and in some cases men, tended to see these problems as external and beyond their control.

3.2.2 *Determinants of Illness*

(2) When describing determinants of chronic illnesses, health workers, just as clients, had two groupings: the bio-medical and the socio-emotional explanations. In the second category, health workers coincided with clients in identifying the current economic situation in the country, the kinds of neighborhoods in which they reside, and conflicts within the family. The only factors identified by health workers and ignored by clients were environmental, such as pollution of streams.

(3) When referring to special situations that determine illness in men and women, health workers pointed to unemployment in men and domestic violence in women. Violence against women, however, was represented as a problem of social class and not gender-based. Women were also perceived to be "instinctively" more nervous, which they linked with illness, as well as sicker due to biological factors (hormonal changes).

3.2.3 *Treatments*

(4) Health workers did not believe that clients comply with either medication treatments or with prescribed diets. Their explanation for this was two-fold: on the one hand economic limitations inhibit compliance; on the other, clients do not understand the idea that their illness is chronic and, as a result, when they feel better they abandon treatment. Clients agreed with the first point. In terms of explanations, they also shared the identification of costs as a barrier. However, both sexes referred to their illness as chronic. Men expressed the idea that they could voluntarily abandon treatment.

(5) Health workers did not mention the recommendation of exercise as part of their treatment regimes, while men particularly saw walking as curative.

(6) Health workers did mention the possibility of using groups as part of a treatment strategy, while women clearly identified the importance of groups in this regard.

(7) Health workers constantly referred to the need for clients to make more effort in promoting their health. Effort, as a personal attribute similar to discipline, was not present in the clients' discourse.

3.2.4 *Access*

(8) Health workers coincided with clients in identifying as

motives for seeking care: (1) a health crisis; (2) pain and other symptoms: (3) interest in obtaining free medication and prescriptions: and (4) interest in having blood pressure taken. The difference with clients lay in the legitimacy attributed to these motives, as revealed in a ranking of good and bad clients: the best clients were described as those who come in regularly for check-ups and have no symptoms, while those disdained are clientsCusually womenCwho (1) come in too often (ironically, the same metaphor used by women to describe ill treatment, a grocery store, was by health workers), and (2) come in when they are extremely ill.

(9) Health workers identify the need for affection as a motive for seeking care among female clients. While women spoke of this need in regard to the kind of care valued, it was not mentioned as a motive for deciding to seek care.

(10) Nurses and receptionists referred to women seeking care for their children simply as a way of obtaining dried milk distributed by the city government to mothers of undernourished children. This motive was not considered legitimate. Women also referred to this motive but considered it valid.

(11) Health workers expressed disdain for certain ailments that they termed "trivial." No such ranking of health needs was present among clients.

(12) Health workers did not identify clients' perceptions of having been mistreated as a motive for postponing or avoiding visits. However, they did express the view that clients return when they feel they are well treated. Both men and women clients referred to ill treatment as a major reason for avoiding health services.

3.2.5 *The Practitioner's Role*

(13) The confusion over the definition of primary health care, as well as the general belief that prevention is impossible so long as the demand for curative medicine dominates their daily practice, is an issue that was not mentioned by clients.

(14) The limits health workers said they need to establish in their relationships with clients, including the fear that friendship with clients reduces what is considered by them to be a necessary position of authority. This idea is in sharp contrast with the images expressed by both men and women, although it may be true that the conflict is even greater with men, in that they spoke frequently of friendship, while women represented a relationship in which they are requesting advice and protection.

(15) The concept that "patients should wait," and that this is a natural part of the doctor-client relationship, is in clear conflict with the idea, expressed with particular vehemence by men, that they should not be made to wait.

(16) Health workers cite as a source of dissatisfaction in their daily practice the impossibility of "resolving" the social factors that determine the diseases present in their clients. This is not a problem manifested by clients (although implicitly, as pointed out above, there is agreement in the view that health services are not affecting the principal causes of illness).

(17) Health workers expressed a sense of having been abandoned and misunderstood by local city authorities. This is not an issue mentioned by clients.

3.2.6 *Communication in the Medical Visit*

(18) **Social talk (including listening to clients) was seen by health workers as necessary in that it leads to greater compliance. Women clients, in particular, see social talk in the visit as an end in and of itself.**

(19) Health workers did not emphasize the importance of specific actions included in social talk, such as the initial greeting ceremony, to the same extent as women did.

(20) **Instrumental talk was described by health workers as a one-way transference of information, while men saw themselves as active participants in an interchange.**

(21) Health workers mentioned posters and health education sessions as strategies that are possible, but that are not used. Women did not mention these kinds of activities. Men mentioned and valued positively such educational efforts.

(22) Health workers referred to a limit on the types of questions they considered appropriate to ask clients. No such limit was mentioned by clients.

3.2.7 *Actions in the Medical Visit*

(23) Health workers mentioned the physical exam as part of their

activity. However, it was not emphasized to the same degree as it was among clients. The contrast with women was greatest since they linked the exam with physical contact and affection.

(24) Health workers did not focus on prescribing as an activity, and certainly did not see themselves as being prescription providers only, as they were sometimes described among both male and female clients.

(25) Health workers made a point of differentiating between medication provided by the city government and that which they obtained through laboratories. This distinction was not made by clients.

(26) Referral was mentioned by health workers as (1) commonly practiced; (2) necessary due to the lack of specialists at the health centers; and (3) carried out with concern for the clients. Female clients, however, sometimes saw referral as being expelled from the health services.

3.2.8 *Practitioner's Attitudes in the Visit*

(27) The manner in which care is delivered was considered by health workers to be part of a two-fold strategy to assure compliance. "Being nice" and "being mean" are attitudes they choose to adopt in accordance with the type of client being attended. For clients, however, these attitudes are evaluated independently from the impact they may or may not have on their compliance with medical indications, and are, as seen above, motives for returning or not returning for a medical visit. The contrast is greatest with women, since women are seeking recognition "as a person," affection, etc., in the consultation.

(28) Health workers frequently mentioned the idea of being protective of the clients. This concept is in conflict with male clients, who neither solicit affection nor advice.

(29) Health workers referred to a form of client participation they call "pacts." Doctors agree to allow clients to eat certain foods in certain situations if they comply with some other indication. Other decisions are described as beyond the scope of client participation. Among male clients, the view expressed was that they alone would make decisions with regard to compliance. Female clients did not mention any situations in which they participated in decision-making.

(30) Health workers, in referring to their strategy of "being mean," described becoming angry and threatening clients. Clients usually shunned such attitudes as ill treatment (although

there is the idea that if merited, scolding is appropriate). The threat one practitioner said he employed with women that do not comply is to say, "You no longer exist. You died. Don't come back." This threat is the mirror image of women's plea to be recognized "as a person."

(31) Health workers refer to their efforts to maintain distance from clients by addressing them in a cold and abrupt manner. As seen above, neither men nor women recognized the need to establish limits in their relationship with the practitioner, and women specifically rejected doctors' attitudes of speaking "too seriously."

In addition to the contrasts established above, the study gathered valuable information on a series of issues specific to health workers that are important to take into account when planning training interventions. These include: (1) images of the differences between men and women clients; (2) sources of satisfaction and dissatisfaction in their jobs; and (3) their reactions and strategies when faced with a client who has been beaten by her husband.

4. Adaptation and Evaluation of the Workshop Series, "Health Workers for Change"

An ongoing activity within the context of this project has been the adaptation and evaluation of the workshop series, "Health Workers for Change." This series was originally developed by Sharon Fonn in South Africa, under the auspices of the Special Program for Research and Training in Tropical Diseases of the World Health Organization. Because the objectives of the workshops coincided to a large extent with the objectives of the third component of this initiative, the decision was made to coordinate the two initiatives, so as to take advantage of the experience accumulated by the WHO team. In effect, this has meant that preparation for the third stage (training) of the PAHO project began while the first stage (research) was ongoing.

During the months of March and April 1996, the Program on Women, Health, and Development (HDW) tested *Health Workers for Change* in one of the health centers in Avellaneda in which the research project was being carried out (Villa Corina (U.S.1)). The objectives of the workshops were to sensitize the health workers to gender-specific health needs and to facilitate their participation in the formulation of strategies and actions to improve the health care model currently offered by the center.

Despite the identification of the limits inherent in such a brief intervention that has no follow-up measures, the pilot experience was considered to have been enormously valuable insofar as it opened the door to further participatory efforts to improve care in the clinic, by modifying health workers' view that "no change is possible" or that "change will worsen our working conditions."

Following this experience, the Division of Health Systems and Services Development (HSP) of PAHO offered support in continuing to develop the series in an effort to make it compatible with the problem-solving workshops HSP has developed: "Análisis de desempeño" ["Performance Analysis"]. Several criteria were agreed upon as the underpinnings of this interprogrammatic effort:

- The workshops should be based on the principles of total quality management, emphasizing such strategies as teamwork, utilization of information in decision-making, and, above all, the importance of health workers' and users' satisfaction.
- The workshops should take as a point of departure the principles of primary health care, in particular, the importance of prevention and promotion, the role of the first level of care in reference to other parts of the system, and community participation.
- The workshops should incorporate a gender perspective as a tool in analyzing both community needs and satisfaction, as well as issues relating to health workers themselves.
- Attention should be drawn to the socio-emotional dimension of care, although to the extent that other types of problems emerge in the participatory process of the workshops, they will also be addressed.

Following further modifications, and in the context of a quasi-experimental impact study designed in conjunction with the Tropical Disease Research Program (TDR) and five African research teams, the series was tested in Villa Lujan, Avellaneda. While the model being tested in Argentina has been altered, it will, nevertheless, form part of the larger multicentered study organized by TDR to evaluate the impact of the original series. This will permit a mega-analysis of the data, useful to both the Argentine and the African teams. In addition, of course, the study will produce critical information that will nourish the ongoing process in PAHO to develop the in-service training for the third stage of this project.

The impact study is ongoing. The team has collected pre-

test and post-test (two months after the termination of the intervention) qualitative data from both the experimental site (Villa Lujan) and a control clinic. Instruments were based on key informant interviews with authorities, observation of medical visits, focus group and in-depth unstructured interviews with female users, and a checklist of supplies in the clinics. A second post-test will be applied in June, in order to observe longer-term results of the intervention.

Meanwhile, HDW has begun work to introduce new modifications, based on the team's immediate evaluation of the strengths and shortcomings of that experience, as well as subsequent conversations with HSP. In synthesis, it was agreed that the series seems to contribute to a motivational change among the participants and to improve institutional communication at three levels: between health workers themselves, with the city authorities, and with the community leaders. Changes that will be introduced include breaking the series into two blocks of four sessions each, separated by a month. The first section will concentrate on the role of the first level of care and obstacles in the providers' working conditions. The second section will focus on clients' needs and the importance of a gender perspective. Two issues will be highlighted in the second module: how gender roles affect the healthillness process and the problem of health workers' response to gender-based violence.

Lastly, as planned, in upcoming months the preliminary results of the research phase will be incorporated into the series. The empirical data on differences between male and female users, as well as the differences in the views of these two groups and those of health workers, will be spread throughout the modules and will serve to spark discussions and critical reflection by health workers of their practice.

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¹ The term *socio-emotional dimension* of care is utilized in this project to encompass those elements of care that Donabedian termed “inter-personal.” This same author has attributed the importance of this dimension to be “of approximately equal importance” as the so-called “technical dimension” of care, insofar as it increases the efficacy of the technical intervention. The approach usually applied to measure this dimension, however, has been reduced to closed-ended client satisfaction questionnaires. The methodology employed in this project seeks to go beyond such instruments in that: (1) it situates both health workers’ and users’ views on quality of care as part of larger social discourses present in the communities to which they belong, as such “opinion” and “behavior” are not considered individual problems to be corrected, but rather part of an ongoing social and historical process; (2) it examines the internal logic of social discourses, rather than assuming that interview responses are indicators of the quality of care in and of themselves; and (3) it requires the comparison of two different forms of attributing meaning (in this case to quality of care) in order to interpret significance, and thus demands going beyond either “expert” views (normative approaches) or “user” views (satisfaction), measured in separate instruments. While theoretically this approach could be applied to an analysis of the “technical” side of care as well, it is not the purpose of this project to do so.

² These two stages are defined by Magariños as the stages of *attribution* and *substitution*, respectively. For the attribution stage, the methodology requires, first, the processing of simplified texts, through their syntactic rather than semantic standardization, their segmentation into basic syntactic units, and their processing as “contextual definitions.” Contextual definitions, which separate the noun of interest in a segment from the rest of the utterance, are processed in a database, together with the sociodemographic data of the person interviewed. For the purposes of this study, contextual definitions served simply as a resource to facilitate greater distancing in the reading. (In other studies, they are used in the preparation of semantic dictionaries.) In preparation for the substitution stage, axes are constructed. These are identified as clusters of associations among terms, or sets of terms, to form a semantic field and

are used in conducting word searches in the database. When contrasting men and women, the same searches were conducted in the corpus of one as in the corpus of the other. These clusters, or axes, are subsequently correlated in a type of logical tree that makes it possible to deepen the level of the description of "opinions" and discover *how* and *why* women, men, and health workers construct meaning with regard to the health/disease/care process in a particular way. This latter phase of the analysis is currently in process.