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Bringing About a Behavioural Change in Providers to Meet the Reproductive Health Needs of Clients

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INTRODUCTION

The international conference on population and development held in Cairo in 1994 has became a historical turning point in the way population policies and programmes are perceived and sexual and reproductive health services are conceptualised and delivered.

Inherent in the ICPD plan of action is the concept of care that recommends providing a range of reproductive health services to both men and women, that are safe and effective, and that satisfy clients, needs and wants. Clients are far more likely to use services that are of high quality. Achieving quality care requires complying with high technical and ethical standards (such as freedom of choice, informed consent, and freedom from coercion and abuse) and providing services at costs that are affordable to both clients and health care system. The most common barriers to quality are negative provider attitudes or behaviours, poor interactions between clients and providers, a lack of essential drugs and supplies in facilities, and delays in referrals to other necessary services.

Pakistan has among the worst reproductive health indicators in the developing world. It has lagged behind many of its neighbours in terms of its social indicators. Access to health and educational facilities, especially in the rural areas has remained outstandingly weak. Maternal and infant mortality rates are unacceptably high at above 500 per 100,000 and 80 per 1000 births, respectively. Malnutrition, anaemia and reproductive tract infections are widely prevalent in women. Furthermore, the gap between contraceptive use and the desire to space or limit births at well above 33

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percent is amongst the world's highest. Due to excessive female mortality during childhood and childbearing, the sex ratio at 108 per 100 women is extremely unfavourable to women. Lack of access to reproductive Health services is one of the major reasons for this scenario. Obstacles to access can be attributed to both societal factors that include women's autonomy and status as well as the quality of care provided at care facilities. Both men and women visiting Centres providing Reproductive Health Services are exposed to a range of obstacles that prevent in fulfilling their reproductive health needs. The most important of these obstacles include the interaction that takes place between the provider and their clients.

This interaction is extremely important since its outcome essentially determines whether the needs of the client would be met to their satisfaction, and whether they would be able to address these needs. The outcome of the interaction depends upon the amount of time providers spend with the clients, their ability to ascertain and assess client needs and by the ability to suggest a solution that the clients would be able to implement. The client provider interaction is also influenced by the manner providers behave with their clients.

Most often provider behaviour acts as a major barrier that prevents clients to be able to fully discuss and describe their needs. The behaviour adopted by the providers is rooted in the training received by doctors and paramedics in most countries and especially Pakistan. Doctors, trained in medical institutions, receive no formal training in how to approach patients. Instead they tend to emulate their seniors whose dealings with their patients are based on an unequal footing. Even providers who have been taught in the art of counselling for provision of family planning services subscribe to the school of thought that holds clients to be ignorant, who have to be informed. Therefore the emphasis is on telling the clients what to do, rather on asking and assessing their situations.

In most instances providers adopt a supercilious manner, which is not conducive for ascertaining, and accordingly, advising poor illiterate male and female clients about sensitive issues related to their general or reproductive health needs. They indulge in laying blame on the clients for their conditions, pass judgemental remarks, and discourage asking questions or seeking clarifications. Similarly on such occasion's reassurance or sympathy are rarely extended. Based on a superficial examination a prescription is handed over, rarely is it enquired whether the client would be able to comply with the instructions, from where would the medicines be obtained and how would they be used, whether the client can afford the medicine or are alternatives to the prescribed treatment available. Providers usually maintain societal norms associated with gender discrimination and therefore behave differently with men and women who are treated and managed differently. This conventional interaction sustains the power equilibrium in favour of the providers who believe that by giving away or sharing information they would lose some of their own powers. Hence they remain reluctant to take on any queries raised by clients.

In community based settings providers visit the homes of the clients, although in some instances clients may occasionally visit the home of the community provider, in both settings, again the interaction is governed and influenced by almost similar conditions that are observed at the static facility level, as these workers are trained by doctors who are based in the static facilities and therefore the way they assess and address client needs tends to follow the traditional medical model. In addition within the client's home the interaction is also influenced by the presence of friends and family, the general lack of privacy and in general how family members perceive the provider.

Due to the weak autonomy of women in Pakistan they face greater obstacles than men in being able to address their general as well as specific reproductive health needs. Traditionally households invest less on females in terms of education, food, and provision of health care as compared to males. This discrimination manifests itself in early childhood and continues through out adult life. Owing to the low status accorded to women, they do not participate in most household decisions including those pertaining to their fertility preferences; they are financially dependent, face restrictions on mobility, which further hampers access to appropriate and timely health care.

Research within Pakistan as elsewhere has demonstrated that there is a link between women's autonomy decision-making and reproductive health outcomes. Casterline, *et al*. (2001); Mahmood and Ringheim (1997), have demonstrated the link between spousal communication and the ability of women to use contraception. Similar research documents the problems women face in making critical decisions about accessing maternal health care during the antenatal period and particularly emergency obstetric care during delivery [Jaffarey and Korejo (1995)].

MATERIAL AND METHOD

In order to meet the reproductive health needs of clients, the Population Council tested a quality of care project in Tehsil Bhalwal, District Sargodha that aimed at bringing a behaviour change in providers in the way they interact with their clients in order to assess and identify their needs and help them to negotiate a mutually agreeable solution that can be implemented. The intervention was based in district Sargodha since the district is fairly representative of all other districts in Punjab based on socio demographic considerations.

Tehsil Bhalwal was divided into four quadrants, two intervention sites and two control. This project was able to for the first time bring together and jointly train community based and static facility providers belonging to the discretely separate population welfare and health departments. In total, 180 providers underwent the training followed by a refresher course in ten months.

The Intervention: helping clients meet their reproductive health needs.

The concept of quality of care traditionally assess the services provided to the clients once they access a provider [Bruce (1990)]. The innovation here is to broaden the approach to incorporate elements of perceived quality or utility of services on the part of the clients, which prevents them from utilising services at all. Therefore, improving quality of services also requires addressing some surrounding elements such as gender relations and power structure in the household. Thus perceived needs and perceptions about availability and quality of services among clients are as important as among their families.

The training was designed to address the issue of making providers recognise the power structure existing within clients' households and to learn to confront it in order to address women's reproductive health needs. In short the objective was for providers to learn to empower their powerless clients through a change in their approach. The secondary challenge was to dismantle existing power relationships between providers and clients mainly through changing the nature of their interaction.

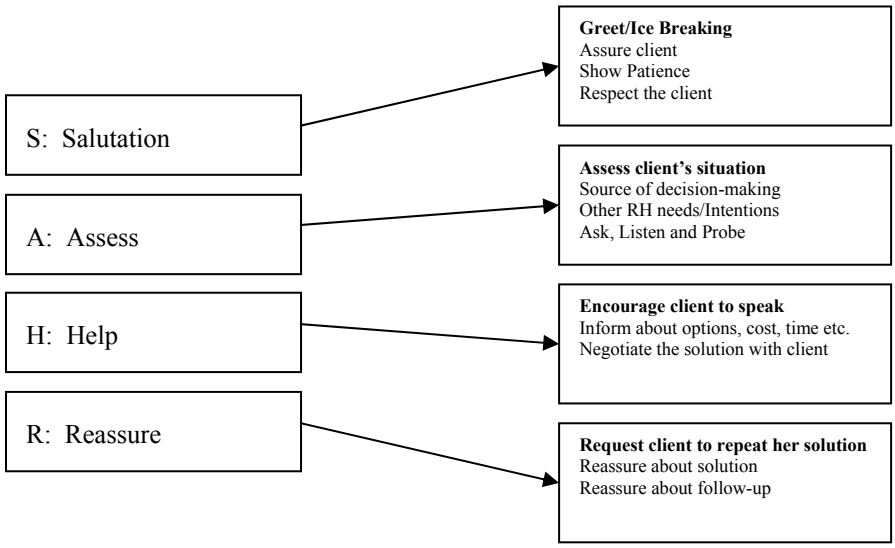
To address these the Council was able to design a training package that would achieve both the objectives. Behavioural change within the providers was brought about by utilising psychological principles that delve into concepts such as self-awareness and its relationship to self-development and extending it to the concept of overall societal development. The analysis of ones owns strengths and weakness helps in establishing a realistic self concept that helps in developing skills for achieving greater control over our behaviour and develops within us greater initiative and appreciation of our role in meeting our obligations to ourself, to our family and to society as a whole.

The whole concept revolves around the simple principles that our actions are congruent with our thoughts and feelings. Providers learn how behaviours can be moulded and altered; through role-plays they learn the impact of behaviour in developing and fostering relationships, how others view them because of certain stereotyped behaviours and the dividends that can be accrued by becoming more assertive and positive. This component also sensitises providers about the influence of society in creating gender roles and how gender discrimination in turn has detrimental affects on women's health. Providers also appreciate the importance of sharing or transferring their power through information sharing, interacting with their clients in an atmosphere of equality, to gain the trust and confidence of the providers. Above all the training helps in developing a sense of gender sensitisation within the providers who are now able to appreciate the special needs of women.

It was assumed that once providers are sufficiently convinced about the importance of bringing about a behavioural change in their attitudes to earn the trust and confidence of their clients, they would be able to communicate with their clients more effectively. Through behaviour modification the providers were trained in how

they should interact with their clients and *what* are the steps that can be followed for indentifying and meeting needs. The strategy for bringing behavioural change within providers was achieved by questioning existing beliefs and values in light of the existing Reproductive Health situation obtaining in Pakistan, and through a process of self awareness and information exchange replacing older beliefs and values with a new set of ideas that influence attitudes. The client provider interaction was conceptualised into a framework and called SAHR. SAHR is an abbreviation for Salutation, Assessment/Ask, Help, and Reassurance. Three main areas of reproductive health that were selected for imparting training in the SAHR approach included family planning, infant health and maternal health.

SAHR



S: The SAHR approach entails first of all establishing rapport with the client. This comprises the Salutation stage and includes greeting the client in a polite and friendly manner; it includes ensuring privacy, confidentiality, and respecting client sensibilities. By using appropriate communication skills the client is made comfortable and at ease to develop confidence in the provider.

A: The next step deals with assessing and understanding client needs through a process of obtaining all necessary information that is in one way or the other related to the occurrence of the problem and can be helpful in understanding their background, attitude, prior experiences, preferences, past history current state of reproductive health and personal needs. An assessment is also carried out to find out the domestic environment and power dynamics that influence decision-making within the household.

H: Based on the assessment the next stage deals with helping the clients. During this process a wide range of options are provided to the clients and through a process of negotiation or information sharing, the client is encouraged to select a solution appropriate to her needs, with which she feels satisfied and can implement given the exigency of the situation as well as her financial and domestic conditions and constraints. This step includes empowerment of the client with sufficient and appropriate information that would encourage the client to take charge and be able to address her needs. It also includes equipping the clients with the necessary negotiation skills that can be applied within her home settings in discussing the solution with other family members, as well as assuring the client that if the need arises the providers would be willing to discuss the negotiated solution with family members who may stand in the way of its implementation. The term solution has been used to express a wider connotation that could include prescription of medicines instructions for their use, dosage, side effects, contraindications, and information as to where they can be obtained, approximate costs, and alternatives. It could also include general advice, carrying out procedures, or providing information on referral facilities, how to access these and why is it important to go there.

R: The next step is reassurance and includes reassuring the client of the support that can be expected from the provider in future regarding advice, provision of supplies, handling emergencies and complications, as well as exploring alternate solutions in case the one that was originally identified is not suitable. The client knows that she could visit the provider any time she feels the need for doing so.

How SAHR Meets Challenges of Genders, Power, and the Health System?

From the provider's perspective the SAHR approach provides an opportunity for the providers to become more self-aware, to modify their behaviours to become more client centred, and to move away from the traditional approach used for assessing client needs. It helps in shifting the balance of power from the provider to the clients in an atmosphere of equality so as to reduce the distance that exists between providers and clients and to avoid one way lecturing and instead adopting the process of negotiation or mutual discussion, while more widely assessing the client's situation going beyond her present condition to include assessing decision-making sources within the household and working with other family members to ensure that the needs of the client are met.

RESULTS AND DISCUSSIONS

Evidence of Post-training Behavioural Change

After the completion of the training, teams comprising the original trainers carried out a number of process studies to observe client provider interactions and obtain in-depth qualitative data on the perceptions of the providers regarding the training and its implementation.

Our analysis and field reports indicate that there are differences between static clinic staff and community based workers. This observation is also supplemented by the empirical findings that we report here with contextual information that was gathered during the course of implementing the project. Field reports by research team indicated that community workers were probably better able to imbibe the spirit of the client-centred approach than static clinic personnel. We believe that this is more related to the nature of their work. Community workers are long term residents of the communities where they work and are hence well acquainted with their clients and the particular familial circumstances of each one of them. In fact the 'social distance' between them and the clients is less as compared to other providers. It has also been borne that the community workers who felt shy or hesitant visiting client homes as a result of the training have become more confident and assertive, as one community worker put it *"My clients thought I was young, I felt shy, I could not talk openly, but now (after the training) I speak with confidence and clients open up and tell me everything"*.

The process studies that were carried out after the completion of the training provided an opportunity to observe and gather valuable qualitative data that shed light on how the provider's have incorporated the training in their work and what impact it has created on them personally. The following quotes provide an illustration of this.

> "*Previously we used to motivate clients which meant we educated them and perhaps pressurised them. Then the word counselling was introduced, which meant giving complete information. Now we have learnt about negotiation which means to sit in front of each other and discuss options in an atmosphere of equality"*.
>
> *"Previously we talked in front of everybody, now we judge who has the power of decision making in the household and then first talk with them. Then with the client…those women who cannot talk to their husbands, we try to help them by empowering them with information"*.
>
> *"We have learnt a very good lesson …we learnt about equality. We did not know how to visit in the field and talk to clients … now we seek an appropriate time, use simple language and maintain equality. First they talk and then listen to us"*.

Apart from the qualitative information obtained through focus group discussions and interviews the observation of client provider interactions in the field setting showed that the training had been largely internalised and the SAHR approach was being used routinely for assessing and helping clients meet their reproductive health needs. This was assessed through some key items of behaviour central to SAHR, which were observed in provider—client interactions and provider interviews in the intervention and control areas.

Overall, the training was largely successful because improvements were discernable in the intervention area relative to the control. Using a standard questionnaire

attitudinal differences were measured in the interventional and control sites. For example, in case of static providers there are notable differences between the intervention and control groups during the stage of rapport building or Salutation. Admittedly, some of the measures are based on cultural norms such as greeting the clients but the interesting point to note is that there are significant differences even in such normative measures (62 percent in intervention versus 39 percent in control). Furthermore, even in the salutation stage, providers in the intervention group are beginning to refer to the family of the client rather than concentrating on her alone as evidence by their responses on enquiring about family health. Similar findings are seen in the Assessment and Help and Reassurance stages as well. For example, while there is a tendency on the part of providers to follow the standard medical model of providing services by enquiring about how her current illness or need started, or about the status of pregnancy as in the case of pregnant women, there is a discernible shift towards enquiring about more diffused issues of access and gender which may provide insight into the client's current situation; for example, providers are beginning to enquire about what treatment the client had pursued for post natal concerns in the past (49 percent in intervention and 31 percent in control), who the main decision-maker is in the family (60 percent in intervention and 49 percent in control), and if the client can persuade other household members to assist in solving her reproductive health needs (19 percent in intervention and 3 percent in control). Other interesting findings include the efforts that providers report taking in helping the client to make a choice appropriate to her situation and reassuring her in the process. Providers in the intervention group were more likely to explain more than one option as a solution and encouraged clients to speak (as expanding choices) enquiring if they understood the instructions and if they could repeat them (for reassurance that good communication had taken place).

Similarly important markers for community workers were: asking about the family's well being (50 percent in intervention and 34 percent in control), asking who makes major decisions in the household (69 percent versus 55 percent), whether client can persuade that person (27 percent versus 14 percent), seeking permission for examination (76 percent versus 16 percent). Other measures include asking if instructions should be repeated and whether client could visit or call her any time (important because the community worker lives in the same community). These responses cover the spectrum of objectives of the training such as identifying client needs, respecting them and meeting those needs and reassuring them and ensuring that they would be able to negotiate solutions within households.

In general, providers from the intervention and control areas are very similar in terms of a number of socio-demographic and professional characteristics. The first research question posed was whether the training had the intended effect on changing the attitude of providers in the intervention areas. As the characteristics of workers are similar in both intervention and control groups prior to the intervention, we rely on data from the second round of the situation analysis providers' interviews. The items in Tables 1 and 2 are grouped by the particular theme connoted by each

Table 1

Provider Responses to SAHR-related Questions

	Intervention	Control	Total
Salutation			
Provider would develop rapport by:			
• Greeting the client	62*	39*	49
• Shaking hands w/client	12	5	8
• Asking/taking client's name	39	32	35
• Meeting w/a smile	30	17	23
• Asking about client's health	75	63	69
• Asking about health of children	35	35	35
• Asking about the family's well-being	28	14	20
• Asking about client's activities	14	12	13
Assessment			
Provider would assess general health and Safe Motherhood problems/ treatment by asking:			
• About purpose of client's arrival	91	97	94
• About duration of current problem	74	66	70
• About the symptoms of current problems	63	66	65
• How the current problem started	39	35	37
• Ask about previous pregnancy/ post natal concerns	49*	31*	39
Provider would assess Antenatal/ Natal and Postnatal care needs by asking:			
• About status of pregnancy	88	79	83
• About Antenatal/ Postnatal check up	35	28	31
• About whether client had TT shots	44*	25*	34
• About previous pregnancy/postnatal concerns	17**	22**	34
• Where client intends to go in case of danger signs/ complications	14	14	14
Provider would assess situation regarding infant [0-12 months] care by asking about:			
• Infant immunisation status	56	42	48
• Growth monitoring	42	48	45
• If client was giving milk to child other than her own	83	75	79
• Breastfeeding	74	74	74
Provider would assess intentions about next child and FP use by asking:			
• If the client wanted to have next child and when	67	51	58
• Husband's/ family member's intention about next child	39	23	30
• Intentions about FP use	63	52	58
Provider would explore the hindrances in client's family to seek health care by asking:			
• If client has support in HH for seeking RH care	42	48	45
• Who makes the major decisions about health care	60	49	54
• If client can go alone if there is veil system in her house	51*	31*	40
• If client can persuade/convince other family members/ decision maker about her RH care needs.	19**	3**	11
• Who could persuade the decision-maker	28	22	25

Continued—

Table 1—(*Continued*)

Provider would apply the following manners to assess client's problems:			
• Maintaining eye to eye contact	39*	20*	28
• Showing sympathy/ talking politely	61	66	64
• Using understandable language	58	46	52
• Using appropriate body language	9	2	5
• Listening to the client carefully	32	31	31
Provider would do the following before/ during examination:			
• Seeks permission before examination	51**	20**	34
• Explain why examination is done	33*	14*	23
• Inform about results of examination	54*	32*	43
Help			
Provider would help the client negotiate a solution to problem by:			
• Explaining more than one option	77	69	73
• Asking why client not taking medicine/hurdles from family for health	47	34	40
• Encouraging client to find out more and more about solution	21	11	16
• Encouraging client to choose the solution on own.	28	23	25
Provider would provide the following information about the problem/illness:			
• How/why problem started	54*	34*	43
• Encouragement to seek health care	54	60	57
• How/how long to use the treatment/medicine	70	64	67
• Possible side effects of medicine/ FP methods	23	18	20
• danger signs	37	39	37
• what to do and where to go in case of danger signs/ complications	23	20	21
• IEC materials	2	6	5
• How to prevent problem in the future	39	54	47
Provider would help the client to discuss her family's situation and hindrances to carry out the solution:			
• Asking about occupation of client's husband	88	83	85
• Ask about problem in gaining access to referral facility	21	22	21
• Ask about HH activities which may cause a delay in seeking health care	25	22	23
• Identify decision-maker in family	46	32	39
• Asking if client brought husband/family member with her	46	40	43
Reassurance			
Before client is about to leave, provider would:			
• Ask the client is she has understood the given instructions	33	19	25
• Ask the client to repeat the instructions	33*	17*	25
• Mention when to return/ contact for follow-up	93**	75**	84
• Invite the client to visit/ call any time	35	26	30
Total Providers	**n=57**	**n=65**	**n=122**

Data Source: Provider interviews in static clinics, round 2.
Chi2 test * $p<0.05$ ** $p<0.01$.

Table 2

Provider Responses to SAHR-related Questions

	Intervention	Control	Total
Salutation			
Provider would develop rapport with by:			
• Greeting the client	79	89	84
• Shaking hands	7	11	9
• Asking/taking client's name	2	2	2
• Meeting with a smile	10	11	10
• Asking about client's health	62	73	67
• Asking about health of children	69	64	66
• Asking about family's well-being	50	34	42
• Asking about client's activities	43	30	36
Assessment			
Provider would assess general health/safe motherhood problems/ treatment by asking:			
• About duration of current problem	45	55	50
• About symptoms of current problems	38	45	42
• How current problem started	31	39	35
• About past treatment of current problem/illness	50	59	55
Provider would assess Antenatal/ Natal and Postnatal care needs by asking:			
• About status of pregnancy/ postnatal concerns	83	84	84
• About Antenatal/ Postnatal check up	52	32	42
• About whether client had TT shots	55	45	50
• About client's intentions about where and by whom to deliver	52	41	47
• Where client intend to go in case of danger signs/ complications	33*	11*	22
Provider would assess the situation regarding infant (0–12 months) care by asking about:			
• Infant immunisation status	64	58	61
• Growth monitoring	50	42	46
• Diet and nutrition	88	80	84
• Breastfeeding	90	75	83
Provider would assess intentions about next child and FP use by asking:			
• If the client wanted to have next child and when	76	64	70
• Husband's/family member's intention about next child	34	23	28
• Intentions about FP use	76	91	84
Provider would explore the hindrances in client's family to seek health care by asking:			
• If client has support in HH for seeking RH care	57	57	57
• Who make major decisions about health care	69	55	62
• Client can make decisions about seeking health care on her own	54	50	52
• Client can persuade decision maker about her RH care needs	27	14	20

Continued—

Table 2—(*Continued*)

Provider would apply following manners to assess client's problem:			
• Maintaining eye to eye contact	34	20	27
• Using appropriate tone of voice	67	59	63
• Using understandable language	57	41	49
• Using appropriate body language	17*	2*	9
• Listening to the client carefully	27	27	27
Provider would do the following before/during examination:			
• Seeks permission before examination	76**	16**	45
• Explain why examination is done	21*	2*	12
• Inform about results of examination	43	25	34
Help			
Provider would help the client negotiate a solution to problem by:			
• Explaining more than one option	81	89	85
• Encouraging client to speak more about her problem	38*	18*	28
• Encouraging client to find more and more about solution	33	16	24
• Encouraging client to choose the solution on own	29	18	24
Provider would provide the following information about the problem/ illness:			
• How/ why problem started	31	20	26
• Encouragement to seek health care	67	66	66
• How/ how long to use the treatment/ medicine	45	52	49
• Possible side effects of medicine/ FP methods	38	32	35
• Danger signs	12	27	20
• What to do/ where to go in case of danger signs/ complications	38	20	29
• IEC materials	2		1
• How to prevent problem in the future	14	25	20
Provider would help the client to discuss her family's situation and hindrances to carry out the solution			
• Asking about economic concerns of client's family	73	64	68
• Ask about problem in gaining access to referral facility	52*	27*	40
• Ask about HH activities which may cause delay to seeking health care	38	27	33
• To identify decision maker in family	48	30	38
• discuss how to persuade decision maker/ HH members about health care	48	36	42
Reassurance			
Before client is about to leave Provider would:			
• Ask the client is she has understood the given instructions	22	26	24
• Ask the client to repeat the instructions	36	19	27
• Mention when to return/ contact for follow-up	45	40	42
• Inform client that she could visit/ call her any time	63	51	57
Total Providers	**n=42**	**n=44**	**n=86**

Data Source: Community Provider interviews, round 2.

Chi2 test * $p<0.05$ ** $p<0.01$.

letter of SAHR. Overall, the training appears to be successful because we see improvements in the intervention area relative to the control.

Other interesting findings include the efforts that providers report taking in helping the client to make a choice appropriate to her situation and reassuring her in the process. Providers in the intervention group were more likely to explaining more than one option and encouraging clients to speak (as expanding choices) and asking clients if they understood the instruction and if they could repeat them (for reassurance that good communication had taken place).

In order to analyse if these differences across the intervention and control areas persist after controlling for possible confounders, we ran multivariate models.

Results are presented in Tables 3 and 4 for static clinics staff and for community providers, respectively. The coefficient for intervention area in almost all the logistic regressions for the SAHR related measures is statistically significant.

The training appears to have impacted on the very attitudes it was meant to change such as assuring equality, searching for decision-makers in the household, and getting clients involved in the interaction. There are areas of weakness such as the assessment of intentions, encouraging clients to find their own solutions and to persuade decision-makers in the family.

In order to further demonstrate whether providers' behaviour has changed we carried out observations of client provider interaction.

The observations indicate the superiority of providers in the client centred approach in the intervention areas. A key indicator with respect to community based workers is the average duration of their visit. This has risen from an average of 6 to 10 minutes in the intervention area as compared to rising from 5 to 8 minutes in the control area.

CONCLUSIONS

The key result from these analyses indicate that it is possible to alter beliefs and values of providers from both departments in the public sector and influence their attitudes so as to adopt a more positive behaviour in the way providers interest with their client. This is the very essence of the Cairo agenda and its call for a client-centred approach.

In summary, there is evidence that the training was able to change some core elements of providers' attitudes and behaviour and we believe that these changes would not have occurred without an intervention. The most striking and encouraging finding from these analyses is that providers in the public sector can be trained to recognise that gender, power relations, and existing social norms may intervene in accessing health care.

Furthermore, the trained providers have understood these concepts and are able to express them. This in itself a signal of change. These are the areas assessing

Table 3

Regression Analysis of Providers' Responses to SAHR, By Their Characteristics, Ministry Affiliation and Area (Intervention and Control) as Explanatory Factors

Logistic Estimates	Prob>chi2	# Obs	Pseudo R2	Area=I	MoPW
Provider would develop rapport by greeting client	0.00	105	0.18	1.20	3.4
				(0.01)	(0.00)
Provider would assess general health and Safe Motherhood problems/treatment by asking about past treatment of current problem illness	0.06	105	0.10	1.17	0.46
				(0.01)	(0.51)
Provider would assess Antenatal/Natal and Postnatal care needs by asking by asking whether client had TT shots	0.60	105	0.04	0.79	–0.65
				(0.06)	(0.37)
Provider would assess Antenatal/Natal and Postnatal care needs by asking by asking about previous pregnancy/post natal concerns	0.11	105	0.09	1.37	0.21
				(0.00)	(0.63)
Provider would explore the hindrances in client's family to seek health care by asking if client can go alone if there is veil system in her house	0.33	105	0.06	0.86	0.50
				(0.04)	(0.45)
Provider would explore the hindrances in client's family to seek health care by asking if client can persuade/convince other family member/decision-maker about her RH care needs	0.00	105	0.37	3.45	1.75
				(0.00)	(0.24)
Provider would apply the following manners to assess clients' problems maintaining eye to eye contact	0.05	105	0.11	1.48	1.50
				(0.00)	(0.04)
Provider would do the following before/during examination: seeks permission before examination	0.00	105	0.18	1.69	0.15
				(0.00)	(0.85)
Provider would do the following before/during examination: explain why examination is done	0.05	105	0.12	1.17	0.38
				(0.02)	(0.64)
Provider would do the following before/during examination: inform about results of examination	0.02	105	0.11	1.30	–0.24
				(0.00)	(0.74)
Provider would provide the following information about the problem/illness how/why problem started	0.01	105	0.13	0.99	-0.41
				(0.03)	(0.56)
Before client is about to leave, provider would: ask the client to repeat the instructions	0.09	105	0.10	0.94	-0.67
				(0.06)	(0.43)
Before client is about to leave, provider would: mention when to return/contact for follow-up	0.14	105	0.12	1.48	1.13
				(0.02)	(0.22)
Linear Regression Estimates	Prob>F	# Obs	R-squared	Area=I	MoPW
Salutation Index	0.00	107	0.27	0.12	0.14
				(0.00)	(0.02)
Assess Index	0.00	107	0.24	0.12	0.02
				(0.00)	(0.76)
Help Index	0.03	107	0.17	0.04	0.05
				(0.12)	(0.26)
Reassure Index	0.01	107	0.20	0.16	0.11
				(0.00)	(0.12)
SAHR Index	0.00	107	0.27	0.44	0.31
				(0.00)	(0.05)

Data Source: Static Clinic Interview Round 2 only.

* Other variables controlled for: age, number of children, marital status, higher education, language.

* Probabilities in parenthesis.

Table 4

Regression Analysis of Providers' Responses to SAHR, By Their Characteristics, Ministry Affiliation and Area (Intervention and Control) as Explanatory Factors

Logistic Estimates	Pseudo R2	# Obs	Prob>chi2	Area	MoPW
Provider greet the client	0.0844	86	0.4880	.4176605	.6053125
				(0.176)	(0.510)
Provider ask about past treatment of current problem/ illness	0.0669	86	0.3389	.5940444	36744763
				(0.263)	(0.472)
Provider ask about whether client had T.T. shots	0.0514	86	0.5252	1.50156	.6676723
				(0.372)	(0.479)
Provider ask about previous pregnancy/ postnatal concerns	0.1206	86	0.0456	1.664496	.2100113
				(0.289)	(0.006)
Provider ask where client intends to go in case of danger signs/ complications	0.2454	86	0.0023	5.304489	.0980413
				(0.012)	(0.007)
Provider ask if client could make decisions about seeking health care on her own	0.0833	86	0.1933	1.173062	.3093653
				(0.732)	(0.035)
Provider ask if client can persuade/ convince other family members/ decision-makers about RH care needs	0.0575	85	0.6732	2.520117	.6809029
				(0.112)	(0.565)
Provider maintained eye to eye contact	0.1291	86	0.0686	2.857759	.531002
				(0.054)	(0.321)
Provider used appropriate body language	0.1887	85	0.1881	11.60606	1.154137
				(0.031)	(0.890)
Provider seek permission before examination	0.3838	86	0.000	28.43889	.3116213
				(0.000)	(0.115)
Provider explain why examination is done	0.2176	86	0.618	16.63538	1.555089
				(0.014)	(0.645)
Provider inform about results of examination	0.0579	86	0.4974	2.399869	.6021897
				(0.072)	(0.373)
Provider inform how/ why problem started	0.0647	86	0.5019	1.674762	.5695418
				(0.324)	(0.342)
Provider encouraged to seek health care	0.1720	86	0.0059	4.809449	1.990678
				(0.004)	(0.260)
Provider ask the client to repeat the instructions	0.0569	85	0.5818	2.518588	.5624385
				(0.007)	(0.334)
Provider mention when to return/contact for follow-up	0.0483	85	0.5872	1.216061	1.394523
				(0.671)	(0.542)
Salutation Index	0.0756	86	0.1477	.0051314	.0372842
				(0.886)	(0.382)
Linear Regression Estimates	**Prob>F**	**# Obs**	**R-squared**	**Area=I**	**MoPW**
Asses Index	0.000	86	0.3803	.0950845	–.216325
				(0.000)	(0.000)
Help Index	0.0258	86	0.1796	.0753108	–.0417245
				(0.002)	(0.140)
Reassurance Index	0.2768	85	0.1034	.0823029	–.1147098
				(0.136)	(0.079)
SAHR Index	0.0059	85	0.2212	.251978	–.2366131
				(0.008)	(0.032)

Data Source: Community Providers Interview Round 2 only.

* Other variables controlled for: age, number of children, marital status, higher education, language.

* Probabilities in parenthesis.

of power dynamics, of decision-making in the household, applying negotiation skills, and respecting client's rights and dignity. We believe that the small changes that we were able to measure empirically mark the beginning of a process of a paradigm shift; there is more work to be done to change other aspects of provider attitudes and behaviour as well, however a beginning has been made.

In conclusion, we would like to indicate that changing provider behaviour is feasible. The results of adopting such an approach are encouraging but time consuming. It is necessary to allot sufficient time to see big and significant changes in well-entrenched public sector systems. We have been heartened to note that as a result of the intervention clients are being empowered by the providers who have themselves undergone a marked behavioural change.

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Comments

The interaction between health service providers and clients and the providers' attitude and behaviour are important means to facilitate the process of service delivery and influence the quality of care the clients need and receive. In this context, the authors present the results of an operational research project in Tehsil Bhalwal, District Sargodha—an intervention made to bring about a behavioural change in providers' attitudes and behaviour to meet the reproductive health needs of their clients.

The study is based on quasi-experimental design and tests the differences in providers' responses to a number questions related to family planning, infant and maternal health to assess the impact of services offered. Using SAHR (Salutation, Assessment, Help and Reassurance) approach, data were collected from service providers in communities with intervention and without intervention at the site selected, (case-control design) to measure the difference in outcome between the two communities. The results are useful and informative but leave many information gaps and question unanswered.

First, there are questions about the study design such as (i) the rationale for selecting Tehsil Bhalwal in Sargodha; (ii) different characteristics of control and study areas; (iii) differences in the levels of skills and background of the trainees selected for behavioural change training; (iv) no information on the duration of training; and (v) small sample size of trainees—57 from static clinics and 42 from the cadre of community health workers. It is observed that a large majority of clients visit government health facilities in static clinics compared to community health workers to seek services. It would be more appropriate to assess pre-training and post-training situation for both types of service providers to minimise the biases inherent in case-control design studies. All these questions need to be elaborated and explained in the study.

Second, the approach used to measure the impact of the intervention has its limitations. The questions asked through SAHR framework reflect the responses and perceptions of service providers only which were basically a part of their training. At the same time, clients' perceptions about the attitudinal and behavioural change of service providers is completely missed out who could give a more candid view of the behavioural aspect of providers and the quality of services received.

Third, the results and the outcome of the intervention are explained in terms of improved attitudes and behaviour of service providers, especially the community

health workers (CHW) who attended to the needs of the clients more effectively after the training. However, results from an earlier study show that less than 1 percent of sick persons seek services from CHWs compared with 26 percent visiting static clinics in government health facilities. It would be more meaningful if the impact of the intervention, especially training of service providers, is measured in terms of selected indicators, e.g. increase in contraceptive use in the intervention site, rise in the number of clients, improved RH indicators, type of health needs of clients met, etc. In this regard, indicators of the client satisfaction or perceptions would be useful addition to see the beneficiary impact.

In the end, I would like to reiterate that the study undertaken is a step towards enhancing the quality of service provision through improved attitudes and behaviour of service providers towards clients in need of RH services. The results yielded give a clear message of making such interventions in other areas to make service provision more effective and relevant to meet the health needs of the clients.

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