# Do health care institutions support health workers to achieve role as healthy role model? : An exploratory study

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## Abstract

The Primary Health Centers (PHCs) and the Professional Health Organizations (PHOs) should support health workers to perform their profession in accordance with specific ethical codes. This study used descriptive-exploratory qualitative methods and involved heads of PHCs (3), clinical practitioners (6), PHOs (3) and informants from communities (3) in Pontianak**.** Responsibility, awareness and commitment towards themselves, community, and colleagues are the reasons for health workers to perform as healthy role models. Although, the community never reprimanded behavior of health workers directly, yet the demands towards healthy lifestyle still exist because of their health science background. Health care institutions provide rules to perform daily physical activity, healthy diet and establish no-smoking areas but there are many constraints in reality to execute these policies. The code of ethics should be a robust rule in setting the standards for the behavior of health workers so they may perform healthy lifestyle behavior as healthy role models.

**Keywords:** *health care, health workers, healthy lifestyle, role model, code of ethics*

## Introductions

Role model is defined as a process of imitating behavior from someone and an unwritten contract between patient and health worker as part of the professional action and working commitment.1,2 Being a role model of healthy lifestyle behavior is an action of professional matter for health worker, which eventually will effect on patients’ beliefs towards medical actions given by health workers, patients’ obedience on following treatments, and their satisfaction towards health services.3-6 Furthermore, it is stated that the role as a role model of healthy lifestyle behavior will affect the confidence of health workers while giving therapy for patient.7,8 Doctors with normal Body Mass Index (BMI) have more confidence to deliver diet consultation (*p*=0.002) and physical activities counseling to patient (*p*=0.001).9 Other researches stated that physical activities behaviors performed by health workers will influence the frequency of delivering health counseling with the odds ratio between 1.4 and 5.7 (*p*<0.05). This result is because of the strong desire to be viewed as more powerful role models of performing healthy lifestyle behaviors and providing better counseling and motivation healthy lifestyle to their patient.10,11 In spite of that, the level of patient trust towards doctor is still high regardless of their BMI condition.12

In Indonesia, in accordance with Law Number 36 Year 2004 Chapter 1 Article 1 Verse 1, it is stated that a health worker is every person who devotes themselves in the health field and obtains knowledge and/or skills through education in the health field which for certain kinds need authority to perform health services and are arranged in the professional ethic codes.13 Subsequently, based on review of the Ethic Codes of the health profession in Indonesia, it is explicitly stated in the ethics codes of doctors, nutritionists, and nurses to serve as role models and maintain a healthy life style.14-16

Moreover, in Indonesia, based on specific instructions of the President, to reduce the number of non-communicable diseases by changing to a healthy lifestyle has been set into policy and called as The Healthy Community Movement or GERMAS (*Gerakan Masyarakat Sehat*). Germas is initially performed in the community by performing physical activities 30 minutes per day, consuming vegetables and fruits, and checking health condition routinely. This activity should be consciously done and accompanied by high desire of all person, families, and communities.17 In order to support GERMAS, the Indonesian Ministry of Health performs one of planned activities is stretching gymnastics aimed for all civil servant staffs (blue-collar) with the purpose of reducing tension and training muscles so that exhaustion from working could be reduced, moreover to train workers to perform physical activities in between working hours. This approach is in accordance with the law number 36 year 2009 chapter XII article 164 verse 1 about occupational health in which it obligates every workplace to hold health services so all health workers may perform with a healthy lifestyle and be free from any health disorders mainly influenced by occupation and not cause any diseases for themselves and the community.18

Primary health service institutions are expected to be the spearhead of Germas by applying healthy lifestyles in health institutions’ environment and to all health workers, staffs, and communities. This activity should also be supported by health profession organizations as advisors of all health workers in Indonesia. This expectation is in accordance with has been listed in the professional code of ethics, to create health workers as role models of healthy lifestyle behavior in the community. However, as far as the knowledge of the researcher, there has not been any research to assess the perceptions of the heads of Primary Health Centers (PHC), Professional Health Organization (PHO), health practitioners and community about the application of healthy lifestyle programs and the role of health workers as healthy role models. Therefore, this study aimed to describe the kind of supports which have been given by PHCs and PHOs in Indonesia to perform healthy lifestyle behavior and to address the perceptions of executor units towards this issue.

## Materials and Methods

This research applied descriptive-exploratory qualitative methods and was conducted to investigate the performed activities of PHCs or PHOs about giving supports for the health workers on performing healthy lifestyle behavior and becoming healthy role models in the community. Then the gained opinions were compared with the views of health practitioners and the community. This study was conducted since May 2017 with 3 months period of data collection and had received ethical approval from the Medical and Health Research Ethics Committee Faculty of Medicine, Public Health and Nursing Universitas Gadjah Mada number KE/FK/0528/EC/2017.

This study involved three units of health stakeholders consisting of 3 heads of PHCs in the region of Pontianak City, West Kalimantan, 6 informants from clinical practitioners with different professions comprised of 2 from each profession of doctor, nurse, and nutritionist profession working in different PHCs. Lastly, there were 3 informant from Indonesian PHOs at the provincial level, each consisting of 1 informant from Indonesian Medical Association (IDI), nurse profession (PPNI), and nutritionist profession (PERSAGI). Other involved informants were 3 people from the community in which 2 people were from health cadres, because they could give the perceptions from the community perspective to provide assessment about health workers’ behavior and performance of being health role models.

Informant’s selection utilized sampling criterion method, in order to ensure that selected informants were appropriate with the aim of study. Informants willing to be involved in this study after getting approached interpersonally were contacted via text message or telephone to receive introduction explanation. After arrangement of the meeting schedule, a meeting was held to explain the aims of the study and study procedures, which resulted eventually in an agreement of time and place for the interview. Most of the agreed places for the study were informants’ work places with an agreed time which would not interfere with the working hours. Informants and interviewer had never before met each other and had no previous relations so the initial introduction was performed to build interpersonal relationship and develop a more relaxed situation in order to create a better interview process.

Confidentiality of informants was protected in this study, by giving each informant a specific code, where the heads of the PHCs received code (H1-H3), clinical practitioners (C1-C6), PHOs (O1-O3), and community (P1-P3). Five semi-structured questions were delivered to guide the discussion in which the average time was 60 minutes. Sampel survey questionnaire is provided below in Table 1.

Tabel 1. Interview Questions Guide

|  |  |  |
| --- | --- | --- |
| No | Question | Probing |
| 1 | In your opinion, do health workers need to be role models of healthy lifestyle behavior? Why? | What is definition of healthy role model? |
| 2 | As far as of your knowledge, are there any demands or special hopes from the community or organization that health workers are responsible to be the role model of healthy lifestyle behavior? | Is there any compulsion from society to healthy workers to do a healthy lifestyle? |
| 3 | In your opinion, has professional organizations or your working place supported you to perform healthy lifestyle behavior? | What kind of support that given by PHC’s or PHO’s?  What might be a boundaries to do healthy life style in work place?  Does society get the benefits if health workers doing healthy lifetyle? |
| 4 | In your opinion, does the recent performance of health workers reflect good role model behavior? | What/who motivate health workers to do a healthy lifestyle?  What barrier to do healthy lifestyle in health workers? |
| 5 | If performance of healthy lifestyle behavior is written in the code of ethics of health profession, what is your opinion? | It have been stated in health profession code of ethics that health workers should do a healthy lifestyle. what do you think about it and what should be done to stabilized it? |

Verbal transcription results were read twice by the first and co-author to ensure no skipped data and clarity of data. All analysis was performed manually utilizing a computer to record and report, while data analysis utilized inductive content analysis method. Steps taken included sorting out data into its specific type of answer (positive/negative) and giving highlight to interesting sentences or words. Subsequently, codes were given to each key sentence and the categories were arranged accordingly. This process was performed twice by the research team and been was rechecked by an expert in qualitative research to ensure no missed appearance of codes and personal biased. Furthermore, to gain a deeper understanding and naturalistic result in this research, data were descriptively analyzed as quoted words recorded in a sentence line.19

## Results

We selected participants who have extensive experiences in their related fields, for which informants from the heads of PHCs had leadership experience more than 3 years in the recent work place with previous work as head of PHC in more than one PHC. This also applied for informants from PHOs with more than 3 years working experience in the organization, where they also held positions in organization structures as secretary, head of research division, and organization advisor due to previous experience as chairman in 2 consecutive periods. Furthermore, besides holding positions as organization administrators, they were also clinical practitioners in hospitals or educational institutions with more than 10 years working period. These clinical practitioners also had working experiences in PHC for more than 5 years and one of the informants on behalf of the community served as head of the health cadres with working experience more than 4 years.

### Health workers as the role models of healthy lifestyle behavior: responsibility, awareness, and commitment

All informants stated that health workers as role models are viewed as a person who is able to give an example and role model for the community, mainly about healthy behavior because the function of health workers is as agent of change and channel of health information in the community. One of the informants stated that “role model meant person to follow” (O3), and they are assessed as the centre of examples in the community. The most attention from both the informants from health workers and the community agreed was that the most viewed part of the health workers was their performance beside owning good looks. Health workers considered to have good performance are the ones who act energetic, vibrant and rarely sick accompanied with appropriate physical body.

Based on the role as someone who can be imitated by the community, health workers felt responsible to perform healthy lifestyle behavior in the community, and share health information in accordance with what they performed. Also, the health workers’ actions should also correspond with what they said to the community. Being responsible as role models was a part of the consciousness as health workers since they received health education, they should understand the effect of health toward themselves, and it is a part of the function of health workesr to give health promotion to community. Moreover, the responsibility of health workers as role models was to give examples and to remind each other as colleagues about the importance of performing healthy lifestyle behavior.

These valid expectations were also confirmed by the community that “example came from the ones who knew more about health” (P2), so that health workers should demonstrate the commitment to give examples of appropriate behaviors in accordance with the knowledge they have. According to one of the clinical practitioners, unhealthy behavior performed by health workers will cause a pessimistic attitude from the community, so they will see the health promotional program as useless and will be harder to educate since it was considered as irresponsible information. Eventually, the community becomes skeptical towards health worker’s behavior and will feel lazy to follow health advices.

### Community demands performance from health workers as healthy role model

According to several clinical practitioners, the community was considered to not yet demand health workers to be a role models of healthy lifestyle behavior, rated from the number of complaints conveyed to health workers that had inappropriate healthy behavior or performance, This leniency was because the community only sees health workers behavior in the working place and are not able to see what they did at home. Besides, health workers felt that for being role models of healthy lifestyle behavior needs time because of short meeting time between community and health workers in the working place, thus to judge and imitate health worker behavior cannot immediately happen. Moreover, it was stated that clinical practitioners still doubt the existence of themselves as a role model because they never received reprimands from the community and saw the influence of their action towards community.

However, this opinion was opposed by other clinical practitioners and every head of the PHCs, who stated, “it was not rare that (demands) more often they (the community) wanted it (health workers to perform healthy lifestyle behavior)” (H2). This opinion was strengthened by the answers from the community, even though the people did not reprimand directly, yet they were very concerned about health workers’ behavior and most of the practitioner informants felt that way. The reason for the demands from the community was due to the opinion from the community that health workers are models of healthy behavior, and they were considered as credible people who had obtained more knowledge about health. The health education background of health workers demands health workers to perform appropriate behavior in accordance with health science.

Hence sometimes it is important to be a role model, they are in our room, they see what we are doing, we forbid them to eat fried food, yet there are fried food in our table... eventually it becomes reprimands for us, if we cannot give them examples, our education messages will not be accepted by them since they have seen that we do not do it ourselves (C2)

Furthermore, the community assessed that daily performance of health workers has been healthy already so that the community does not explicitly reprimand unhealthy behavior of health workers or reprimands them in the form of jokes. Interestingly, the first informant from the community chose to close his/her eyes when seeing inappropriate health behavior from health workers and acted to understand those behaviors, and moreover he/she also contended that health workers are not only seen from their behaviors but also their abilities:

Yes... (health workers as role models of healthy lifestyle) but it’s not very urgent ... what is more urgent is their service (P1)

Reprimands from the community towards health workers usually happened because of having close relation with health workers and said in the form of satire jokes so it will be less offensive, however it gives extraordinary impact towards the attitude change of the health workers. Some changes happened in health workers’ behaviors such as not smoking in public areas so the community will not see them and providing fruits in every community meeting.

### Support from institutions to health workers to achieve the function as role model of healthy lifestyle behavior

The practice of healthy lifestyle in PHCs was performed through increasing physical activities, consuming fruits and vegetables, and forbidding smoking activity. Every health service place prohibits smoking assertively in the PHC environment, applying zero tolerance for anyone who still smokes in PHCs by not providing either ashtray nor smoking rooms, and more assertively by obligating to not smoke purposively for patients, PHC visitors, and mainly the health workers either working as health professionals or not.

Furthermore, one of the PHCs in this study has initiated activities on distributing fruits every Friday for every staff, visitor, and all people around PHCs, while other places released mandatory policy to provide vegetables and fruits in every meeting at PHCs. Meanwhile, in order to increase physical activity, gymnastic activity was performed every Friday and Saturday starting from 7 a.m. with additional stretching exercise. Stretching was performed between service hours, every 10:00 a.m. (Monday-Saturday) for 10-15 minutes, while, in other PHCs stretching was also performed at 2 p.m. and this activity had been done for almost 5 months.

All these activities were considered by the informants as indirect examples of healthy lifestyle to the community, by watching health workers doing physical activity, eating healthy food, and not smoking. One of the heads of a PHC hoped that “PHC is centre of community health education” (H2), furthermore implementing healthy lifestyle would have an impact on the PHC staffs themselves. According to the head of the PHC, routine medical check-ups (blood pressure, blood glucose, and cholesterol levels) were already prepared free on every Saturday after morning exercise, and thereafter they will get staff medical check-up results, and if there was some medical problem they will also get consultation and treatment.

Although all the activities have been facilitated for PHC staff to do a healthy lifestyle, a healthy canteen still was not facilitated in the PHCs’ area yet. Recently there was no special food provision for staff so they have to buy lunch meals outside the PHC. Consumption of high fat and low fibre food was still a favourite, because the nearest available food shop to PHC have limitations (menu and food flavour), and not ideal for choosing healthy food.

Other factors that were limiting was short rest time given, which is only for 1 hour, and they had to divide their time for prayer and lunch, so some of informants chose to bring their meal from home or wait until the time to go home. According to one of the heads of a PHC, it was not possible to provide a healthy canteen in PHC because there were no rules and no clarity about financing and income system in all community health care centres.

The experience of clinical practitioners at the PHCs was also perceived by the board of professions, where the supports of institutions for the fulfilment of nutritional needs were still lacking. Funding limitations were the main reasons given so that the workforce was asked to provide their own food even though other facilities have been provided such as sports facility and no-smoking banners in various places. Policy makers and management systems in the workplace were considered to play an important role to provide health facilities for their staff, but as to date they were still in the form of recommendations and demands on the awareness of each individual to apply healthy lifestyle behavior.

If we look closer, profession organizations support for implementing healthy lifestyle was not as much as PHC. Until now, the profession organizations had only been giving suggestions to change behavior and do healthy lifestyle, but the implementation was not done yet. They more emphasized about prohibition of smoking and consuming drugs for the health workers. One of the informants explained that healthy food menu was not implemented yet in organization meetings. Buffet food menu still did not list its nutritional content and it was often serving high protein and fattening food, so health workers need to be self-aware for choosing healthy food according to their nutritional needs. Sadly, these behaviors are seen by catering or hotel staffs, so they judged health workers’ behavior was the same with common people.

### “This is my right, my own money”, Obstacles in implementing health lifestyle for health workers”

Not all the health workers were doing healthy lifestyle even when the health facility had been facilitating. From observations by the informants toward health workers’ behavior in the work place, it was observed there still was a smoking place even though there was prohibition for smoking, furthermore smoking was considered as something common and secretly done. Smoking behavior was difficult to change because it is already done since a while, whatever goes situation, and individual right. Health workers’ responsibility as a healthy lifestyle role model was considered to not exist anymore while not wearing health attire and outside the PHC area, but meanwhile this smoking behavior still biased their status as health workers.

There is no law that prohibit smoking, so that it is right for each person, they will say ‘this is my rights, my own money’ ... ‘many people that smoke but did not die’ as health workers, he/she already knows the effect of smoking but he/she feels it’s their rights (C3)

The following obstacles were felt by health workers to do physical activity, where daily stretching exercise in working hours was considered troublesome because they had to stop their work suddenly, stand up and do stretching, while morning exercises in Friday and Saturday mornings were constrained by time. Early time for exercise was not ideal for women, since as a housewife, they have to prepare breakfast and escort their children to school so they come in time with the working hour. Moreover, there was intersection between exercise at 7:00 a.m. and start of working hours at 7:30 a.m., so that more of the staffs were not coming. “Only one quarter of 20 staffs that come for exercise” (C3), and this was confirmed by the head of PHC (H1).

Another reason for this reaction was the high work load, so they had no time for doing physical activity. The main activity as clinician in a hospital and PHC consumed most of the time and additional community service activity in the field was energy consuming. Therefore, they assumed that this reason can be accepted by the community, which commented “health workers were too busy so they cannot do physical activity” (P1). Another opinion by the community was health workers were doing physical activity according to their habit, and this was also said by one informant that acted as exercise activist in a PHC that health workers were not doing morning exercise because it was not their hobby, even though there was obligation to do exercise without force by the head of the PHC.

One consequence of high work load was forcing health workers to work overtime, with lots of meeting. Furthermore, food was served in every meeting, in the form of snack or main meal without adjusting for balanced nutritional principle, so in the end this will cause health problems in health workers as stated by one of clinician informant “when there were so many meetings ... it will cause ‘tingling’ (blood glucose rise) when I went home ...” (C2). Another obstacle was taste, even with high education about healthy food, the health workers selected their food based on taste and flavour without looking for the nutritional content and the effect for health, so they were easy tempted for doing unhealthy lifestyle. In the end, it was stated that “we already know the theory but for implementing that was difficult” (C2), “reality was not the same as that what we say” (C3), so to become a role model of healthy lifestyle was considered as a burden for health workers for him/herself and the community.

### Ethical code as binding rule not just a word

As a professional in health, they are expected to not break the social norms and moral principles that are stated in the medical Ethics Code. According to some informants, the ethics code is defined as standard rules that control behavior, so clearly makes provision to state ethical code for health workers as role models in healthy lifestyle. Furthermore, it was explained that the ethical code will motivate health workers to implement healthy lifestyle, and indirectly it will form a culture of healthy lifestyle. One clinician in a PHCs hoped that the Ethics Code was not just important words but needed to be a strong doctrine with clear punishment for those rules, and this statement was similar with other informants’ opinions:

When healthy lifestyle was obligated, it would motivate health workers to really apply what he/she mastered to become good and healthy for his/her daily life... when its motivation was strong and the consequences were serious, it would rightfully change his/her behavior (C6)

The above opinion was rejected by one PHOs informant, explaining that implementing a role model of healthy lifestyle was supposed to be personal. The Ethical Code was a written rule and not all the implementers agree with its content and want to implement it. It was further explained that if the purpose of stating a role model of healthy lifestyle as part of developing lifestyle behavior was considered not incriminating even then there was a consequence. In fact, the community was questioning health workers’ ability to maintain a healthy lifestyle perfectly although it was stated in the Ethics Code, because they are just human and not perfect people as indicated by one informant who said the following: “healthy lifestyle in ethics code was heavy for them” (P1).

## Discussions

Based on our study, the community saw the health workers as a figure who had a role as agent of change and center of health information and this was voluntary as understood by them as their responsibility to the community. Health workers are supposed to have self-ability and perform as a role model, and maintaining self-performance was one of non-verbal communication and professional attitudes to the patient.20 Others explained that most communities view health workers as health educators who have knowledge, skills, and works professionally in the health field. Therefore, as mentors and role models, they are obligated to show appropriate performance towards health to develop community trust, mainly by adopting a healthy lifestyle, because inappropriate behaviors will influence community’s view towards the health workers.21,22

“Practice what they preach” was a responsibility of health workers,23-25 and they were judged as a credible source’ so they should practice what they said in both formal conditions at academic places and informally at restaurants.23,26 Character as a role model of healthy lifestyle behaviors is affected by several factors such as credibility, responsibility, impact of health behaviors, professional duty and social norms; hence, these should be part of the responsibility held by professional organizations and the medical education system.27

These performances were indirectly linked with attractive physical appearance, which was similar with study results that showed health workers’ performance was the first aspect seen by the community. In addition, attractiveness and beauty from physical appearance had an ability to influence self-confidence and other people’s judgment about someone’s ability in doing work and social life.20,28,29 Many studies showed positive relationship between healthy behaviors that were performed by health workers, not only building patients’ trust, empathy, and closeness but also increasing intensity, ability to give healthy lifestyle counseling and willingness to give health promotion.11,26,30-34 One study in Greece found that 79.1% nurses agreed they showed their selves as a role model in a healthy lifestyle and three-quarters of them agreed that physical appearance would affect perception of their profession. In addition, the community would adopt knowledge that was received from health workers who had already implemented those behavior themselves.30 Hence, there must be a balance between behavior and physical appearance in health workers because the community would always compare it with an ideal role model.26

As a person who had already finished health education and considered to have more knowledge of health, health workers should implement proper behavior based on their knowledge. This expectation is because they would be judged by the community as a comparison between knowledge and self-willingness to implement healthy lifestyle, based on social norms in the community that are their vision, hope, and demand for health workers’ healthy behavior.23 Although our results showed the community is actually not pushing health workers to become role models of healthy lifestyle, but it was best for them to show proper behavior based on their knowledge, supported by their ability in service. Other behavior such as having a clean and neat appearance, decent and healthy working place, and having excellent professional behavior were more important than BMI or smoking behavior.35

However, an unhealthy lifestyle performed by health workers would ruin their image as credible persons in the community, so some of informants said that improper behavior of health workers should be performed behind the patients’ backs and unknown by the community. As mentioned in one study that smoking behavior should not be done while wearing nurses’ uniform (68.6%) and it is better if they had ideal body weight (60.7%).30 Factors that inhibited doing healthy lifestyle were overloaded work, improper work schedule and shift work, which are considered as job problems.36-38 Others explained, lack of time, lack of motivation, lack of facilities and feeling too tired are personal barriers to do physical activity and implement healthy food pattern.39,40

Moreover, a stock of healthy food in the working place was also lacking especially at night and the most interesting was the habit of unhealthy food consumption in the working place and abandonment of their health.41,42 The mentioned factors were similar to our study results that found the threat was from health workers themselves because the main reason for not implementing healthy lifestyle, due to their lack of self-willingness to change unhealthy lifestyle, lack of time, and overloaded work schedule. Therefore, their self-confidence was a factor that influenced their willingness to become role models of healthy lifestyle and giving health promotion.43-46 On the other hand, age and sex also influenced becoming role models of healthy lifestyle. The older they were, the lower their self-willingness, and women were more concerned about their roles and more often implemented a healthy lifestyle.47

As stated in our study, support from the working place was well enough for health workers to do healthy lifestyle with provided sport facility and smoking prohibition even thought healthy eating consumption was yet to be arranged. One experimental study in Israel with health workers found the benefits in implementing healthy lifestyle programs were not only changes in waist circumference but also in self-confidence for giving health counseling even though it was done in a short time.48 Moreover, attending exercising and eating programs will raise self-efficacy and self-motivation to achieve weight goal setting and continue the program, whereas at the end the results will increase effectiveness and productivity in work.49 Workplace-based health promotion intervention was considered more feasible and beneficial to become the method of implementing healthy lifestyles for health workers because it was more possible to maintain sustainability and motivation of doing the daily activities of a healthy lifestyle.50

Our qualitative study had some weakness because we were counting on completely honest answers given by the informants. Moreover, our study did not count quantitatively the impact of health programs that are done in PHCs about health workers’ changing behavior and could not measure the impact of the implemented healthy lifestyle in the community’s changing health behavior. Our results are limited to doctors, nurses, and nutritionists so it could be different with other health workers and could not be generalized to other health care settings.

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