Original Research

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HEALTH INSTITUTIONAL SUPPORT FOR HEALTH WORKERS AS ROLE MODELS FOR A HEALTHY LIFE

Dukungan Institusi Kesehatan Terhadap Tenaga Kesehatan Sebagai Panutan Hidup Sehat

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Abstract

Background: Health workers are considered to be credible people in the health field, they are often deemed as role models in healthy behavior. Primary healthcare centers (PHCs) and professional health organizations (PHOs) have to support health workers (HWs) in order that they perform their duty according to codes of work ethics.
Aims: This study aimed to investigate the support from PHCs and PHOs for HWs as health role models in the community.
Methods: This study is an exploratory qualitative study conducted in 2017. It involved three heads of PHCs, six clinical practitioners, three PHOs, and three community members from Pontianak.
Results: The health workers had responsibility, awareness, and commitment towards health workers themselves, the community, and colleagues, and thus they became health role models. Although the community never reprimanded HWs directly, they continued having a healthy lifestyle since they had acquired health education that impacts their behavior. Health institutions provided rules for mandatory daily physical activities and healthy diet; also, they established no-smoking areas, but many constraints were found during the execution.
Conclusion: The code of work ethics should be used as standards to support health workers' role.

Keywords: code of ethics, health institution, health role model, health worker

Abstrak

Latar Belakang: *Tenaga kesehatan dianggap sebagai seseorang yang kredibel di bidang kesehatan. Profesi tersebut dijadikan panutan hidup sehat di masyarakat. Puskesmas dan organisasi profesi kesehatan harus mendukung tenaga kesehatan untuk menjalankan perannya sesuai dengan kode etik profesinya.*
Tujuan: *Penelitian ini bertujuan untuk mengetahui dukungan puskesmas dan organisasi kesehatan terhadap peran tenaga kesehatan sebagai panutan hidup sehat.*
Metode: *Penelitian ini merupakan penelitian kualitatif eksploratif yang dilakukan pada tahun 2017. Penelitian ini melibatkan tiga (3) kepala puskesmas, enam (6) praktisi klinis, tiga (3) pengurus organisasi kesehatan dan tiga (3) informan masyarakat di Pontianak.*
Hasil: *Tenaga kesehatan memiliki tanggung jawab, kesadaran, dan komitmen terhadap diri mereka sendiri, komunitas, dan rekan sejawat. Oleh karena itu mereka menjadi panutan hidup sehat. Meskipun masyarakat tidak pernah menegur tenaga kesehatan secara langsung, tetapi tuntutan penerapan hidup sehat tetap ada karena pendidikan kesehatan yang dimilikinya. Institusi kesehatan telah memberikan aturan tentang kewajiban aktivitas fisik setiap hari dan diet seimbang. Mereka telah menetapkan kawasan tanpa rokok meskipun banyak hambatan dalam pelaksanaannya.*
Kesimpulan: *Kode etik harus menjadi aturan yang kuat dalam menetapkan standar perilaku petugas kesehatan sehingga mereka dapat melakukan perilaku sehat sebagai panutan.*

Kata kunci*: kode etik, institusi kesehatan, tenaga kesehatan, panutan hidup sehat.*

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Introduction

Role models are people whose behavior is imitated. There is an unwritten contract between patients and health workers (HWs) that requires the profession and working commitment to be a role model (Hoare, Mills and Francis, 2013). Being a role model for a healthy lifestyle is a professional matter, which eventually will affect patients' beliefs towards medical actions, patients' obedience to treatment, and patient satisfaction towards health services (Howe *et al.*, 2010; Mold and Forbes, 2013; Birden *et al.*, 2014). Furthermore, role models for healthy lifestyles will influence patients' confidence in therapy (Darch, Baillie and Gillison, 2017; Kelly, Wills and Sykes, 2017). Doctors with normal body mass index (BMI) have more confidence to deliver counseling on diet ($p = 0.002$) and physical activity ($p = 0.001$) (Bleich *et al.*, 2012). Strong desire comes up when role models show healthy lifestyles and provide better counseling and motivation to patients (Lobelo and de Quevedo, 2016). In spite of that, the level of patient trust towards doctors is still high regardless of their BMI condition (Bleich *et al.*, 2013).

In Indonesia, the codes of health work ethics explicitly state that doctors, nutritionists, and nurses should serve as role models and maintain a healthy lifestyle (IDI, 2012). Moreover, the president has given specific instructions to reduce non-communicable diseases by adjusting people's lives to healthy lifestyles as can be seen in the Healthy Community Movement or GERMAS (*Gerakan Masyarakat Sehat*). This policy needs high awareness and motivation of all individuals, families, and communities (President Instruction number 1 of 2017 concerning The Healthy Community Movement/ GERMAS). To support GERMAS, the Indonesian Ministry of Health has implemented gymnastics as a planned activity for all civil servants (blue-collar workers) to reduce muscular tension and relax the body from working. It also aims to allow workers to perform physical activities in between working hours and healthy lifestyles at work. Therefore, this initiative is expected to prevent occupational-related diseases among the workers (Law No. 36 of 2009 Concerning Health).

The GERMAS is conducted in health facilities by encouraging health workers and communities to live healthy lifestyles. Health organizations have to support this initiative since it may reinforce healthy lifestyles in the community. Research about multidisciplinary views of healthy lifestyle programs in Indonesia is limited. Therefore, this study aimed to describe types of support from PHCs and PHOs in Indonesia for health workers regarding healthy lifestyles.

Method

This study which applied exploratory qualitative methods was conducted in May to December 2017. The data collection took place in three months. This study involved three heads of PHCs in Pontianak City, six clinical practitioners comprised of two doctors, nurses, and nutritionists from different PHCs, one member from the Indonesian Medical Association (IDI), one nurse from Indonesian National Nurses Association (PPNI), and one nutritionist from Indonesian Nutrition Association (PERSAGI), and three community members.

The informants were selected using a purposive sampling method. Informants involved were contacted via message or telephone to receive introductory explanations such as the research aims and procedures. Informants and interviewers had never met each other. The initial meeting was conducted to build interpersonal relationships and develop a more relaxed ambiance.

Confidentiality of informants was secured in this study. Informants' names were coded as H1-H3 for head of PHCs, C1-C6 for clinical practitioners, O1-O3 for PHOs, and P1-P3 for community members. Five semi-structured questions were delivered to guide the discussions in the interview, which mostly lasted 60 minutes.

Verbal transcriptions from the interview were read twice to ensure data completeness and clarity. All analyses were

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recorded and reported manually utilizing a computer after inductive content analysis was done. An expert in qualitative research rechecked the data to ensure codes and personal bias. Furthermore, to gain a deeper understanding of naturalistic results in this study, data were descriptively analyzed, and some informants' answers were quoted (Lambert and Lambert, 2012).

Result and Discussion

Participants had extensive experience in their related fields and at least three years of working experience.

HWs as role models of healthy lifestyles: responsibility, awareness, and commitment

All informants stated that HWs as role models are viewed as people able to give an example for the community, mainly in regards to healthy behavior since the function of HWs is as agents of change and channels 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 center of examples in the community. The most attention was paid to HWs' performance by informants from both HWs and the community, with good looks being second. HWs considered to have good performance are the ones who are energetic, vibrant, and rarely sick, accompanied with appealing physiques.

Based on the role as someone who can be imitated by the community, HWs felt responsible to live healthy lifestyles and share health information in accordance with their activities. Additionally, HWs' actions should also correspond with what they tell the community. Being responsible as role models is a part of HWs' conscience. Since they received health education, they should understand their own health. Part of the function of health workers is to promote health to the community. Moreover, the responsibility of HWs as role models is to give examples and remind each other as colleagues about the importance of having healthy lifestyles. HWs are supposed to have self-awareness and perform as role models. Maintaining personal health is one of the forms of non-verbal communication and professional attitudes to patients (Cant and Aroni, 2008).

These valid expectations were also confirmed by the community that "examples came from the ones who knew more about health" (P2); therefore, HWs should demonstrate their commitment to give examples of appropriate behaviors in accordance with the knowledge they have. HWs, as agents of change, sources of health information, and health educators who have knowledge, skills, and work professionally in the health field, are obligated to show appropriate health behavior to develop community trust, mainly by adopting healthy lifestyles (Biernat, Poznańska and Gajewski, 2012).

According to the clinical practitioners, unhealthy behavior by HWs will breed pessimistic attitudes from the community. They will see the health promotional program as useless and it will be harder to educate patients who consider this irresponsible behavior. Eventually, the community will become skeptical towards health workers' behavior and feel unmotivated to follow health advice.

Community demands performance from HWs as healthy role models

According to several clinical practitioners, the community was considered to not yet demand HWs to be role models of healthy lifestyle behavior, rated from the number of complaints conveyed to HWs that had inappropriate healthy behavior or performance. These performances were indirectly linked with attractive physical appearance, which was similar with study results that showed HWs' performance was the first aspect judged by the community. Other behaviors such as having a clean and neat appearance, decent and healthy working place, and having excellent professional behavior were found to be more important than BMI or smoking behavior (Pistikou *et al.*, 2014). In addition, attractiveness and beauty from physical appearance had the ability to influence self-confidence and other people's judgment about someone's ability in working and socializing (O'Brien *et al.*, 2013).

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This leniency is because the community only sees HWs' behavior in the working place and are not able to see what they do at home. Besides that, HWs felt that becoming role models requires more meeting time because of the short meeting time between community and HWs in the workplace. Thus, judgment and imitation of behavior cannot immediately happen. Moreover, it was stated that clinical practitioners still doubt themselves as role models because they never received reprimands from the community or saw the influence of their actions towards the community.

However, this opinion was opposed by the heads of the PHCs, and was strengthened by the answers from the community. Even though the people did not reprimand directly, they were very concerned about HWs' behavior.

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)

The reason for the demands from the community was the opinion that HWs are responsible to "practice what they preach" in both formal and informal conditions and they were considered as credible sources who had obtained more knowledge about health (Rush, Kee, and Rice, 2005).

Furthermore, the community assessed that daily performance of HWs has been healthy already; therefore, the community does not explicitly reprimand unhealthy behavior of HWs or reprimands them in the form of jokes. Interestingly, the first informant from the community chose to look past inappropriate health behavior from HWs and tried to understand those behaviors. Moreover, they contended that HWs are not only seen from their behavior but also their abilities in service.

Reprimands from the community towards HWs usually happen because of close relations with HWs, and are said in the form of satire jokes to lessen offence. However, this has had extraordinary impacts on the attitude of HWs. Some changes happened in HWs' behaviors such as not smoking in public areas and providing fruits in every community meeting. Although the results showed the community is actually not pushing HWs to become role models of healthy lifestyles, it is still best for them to show proper behavior based on their knowledge, supported by their ability in service.

Many studies showed positive effects of healthy behaviors by HWs. They not only build patients' trust, empathy, and closeness, but also increase intensity, ability to give counseling, and willingness to promote health (Blake and Harrison, 2013; Fie, Norman, and While, 2013; Fraser, Leveritt, and Ball, 2013; Jochemsen-Van Der Leeuw *et al.*, 2013; Florindo *et al.*, 2015; Lobelo and de Quevedo, 2016).

Support from institutions for HWs to fulfill their function as role models of healthy lifestyles

The practice of healthy lifestyles in PHCs is performed through increasing physical activities, consuming fruits and vegetables, and forbidding smoking. 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 by purposively banning smoking for patients, PHC visitors, and HWs whether working as health professionals or not.

Furthermore, one of the PHCs in this study has been distributing fruits every Friday for every staff member, visitor, and everyone in the area, while other places have made it mandatory to provide vegetables and fruits in every meeting at PHCs. Meanwhile, in order to increase physical activity, gymnastic activities are being performed every Friday and Saturday starting at 7 a.m. with additional stretching exercises. Stretching has been performed between service hours, every 10 a.m. (Monday-Saturday) for 10-15 minutes. In other PHCs, stretching has also been performed at 2 p.m. for almost 5 months.

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All these activities were considered by the informants as indirect examples of a healthy lifestyle for the community by watching HWs doing physical activity, eating healthy food, and not smoking. One of the heads of a PHC hoped that "PHC is the center of community health education" (H2), further implementing healthy lifestyles would impact the PHC staff 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 exercises. Afterwards, staff receive medical check-up results as well as counseling and treatment if they are experiencing medical problems.

Although all these activities have been facilitated for PHC staff to live healthy lifestyles, a healthy canteen has not been facilitated in the PHCs yet. Recently, there has been no special food provision for staff, meaning they have to buy meals outside the PHC. High fat and low fiber food was still a favorite, because the nearest available food shop to PHC has limited offerings (menu and flavor), which is not ideal for healthy eating. Another limiting factor was the short one-hour breaks. This forces employees to divide their time for prayer and lunch, causing some informants to bring their meal from home or wait until they get home to eat.

According to one of the PHC heads, it has not been possible to provide a healthy canteen because there are no rules nor clarity about financing and income systems in community healthcare centers. Policy makers and management systems in the workplace were considered to play an important role in providing health facilities for staff, but to date they are still in the form of recommendations and demands on the awareness of each individual to apply healthy lifestyles.

Professional organizations have been giving suggestions to change behavior and adopt healthy lifestyles, but they have not been implemented yet. They put a bigger emphasis on the prohibition of smoking and consuming drugs for HWs. One of the informants explained that healthy menus were not implemented yet in organization meetings. Buffet menus still did not list nutritional content and often served high protein and fattening food, meaning HWs need to be self-aware in choosing healthy food according to their nutritional needs. Character as role models of healthy lifestyles 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 (Kelly *et al.*, 2016).

Obstacles in implementing health lifestyle for HWs

Not all HWs had healthy lifestyles, even when equipped with sufficient facilities. From observations by the informants toward HWs' behavior in the workplace, it was observed there still was a smoking area despite the prohibition for smoking. Furthermore, smoking was considered as something commonly and secretly done. As mentioned in one study, smoking should not be done while wearing nurses' uniforms (68.6%) (Blake and Harrison, 2013). Smoking behavior is difficult to change because it has been normalized as an individual right. HWs' responsibility as healthy lifestyle role models was considered to not exist anymore while not wearing health attire and outside the PHC area, meanwhile this smoking behavior still biased their status as HWs.

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 HWs, he/she (HWs) already knows the effect of smoking but he/she feels it's their rights (C3).

Several obstacles have been felt by HWs in doing physical activity. Daily stretching exercises in working hours was considered troublesome because they had to stop their work suddenly, stand up, and stretch, while morning exercises on Friday and Saturday were constrained by time. Early morning exercises are not ideal for women, since, as housewives, they have to prepare breakfast and escort their children

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to school and arrive on time at work. Moreover, there is an intersection between exercise at 7 a.m. and the start of working hours at 7:30 a.m., leading to more of the staff not coming. “Only one quarter of 20 staff come for exercise” (C3), and this was confirmed by the head of the PHC (H1).

Another obstacle is the heavy workload, leaving no time for physical activities. Their main jobs as clinicians in hospitals and PHCs consume most of their time, and additional community service in the field is energy-consuming. Therefore, they assumed that this reason can be accepted by the community, which commented “HWs were too busy so they cannot do physical activity” (P1). Another opinion by the community was HWs were doing physical activities according to their habits, and this was also said by one informant that was an exercise activist in a PHC, that HWs 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 the heavy workload was forcing HWs to work overtime, with lots of meetings. Factors that inhibited doing a healthy lifestyle were overloaded work, improper work schedule, and shift work, which are considered job problems (Amani and Gill, 2013; Kim *et al.*, 2013; Phiri *et al.*, 2014; Patra *et al.*, 2015). Others explained lack of time, lack of motivation, lack of facilities, and feeling tired are personal barriers for physical activities and healthy food patterns (Gupta and Fan, 2009; Patra *et al.*, 2015). On the other hand, age and sex also influenced becoming role models of healthy lifestyles. The older they were, the lower their willingness, and women were more concerned about their roles and more often implemented healthy lifestyles (Hurley *et al.*, 2018).

Furthermore, food was served in every meeting, in the form of a snack or main meal without adjusting for balanced nutritional principles. This has caused health problems in HWs as stated by one of the clinician informants, “when there were so many meetings ... it will cause ‘tingling’ (blood glucose rise) when I go home ...” (C2). Moreover, healthy food in the workplace was also lacking, especially at night, and the most interesting aspect observed was the habit of unhealthy food consumption in the workplace and abandonment of health (Tyzuk, 2012; Phiri *et al.*, 2014). Another obstacle was taste, even with high education about healthy food, HWs selected their food based on taste and flavor without looking for the nutritional content and health effects, and they were easily tempted into unhealthy choices. 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 what we say” (C3). Becoming role models of healthy lifestyles was considered a burden for HWs and the community.

Ethical code as a binding rule, not just a word

As health professionals, they are expected to not break the social norms and moral principles stated in the medical ethics code. According to some informants, the ethics code is defined as standard rules that control behavior, and clearly act as provision for HWs as role models of healthy lifestyles. Furthermore, it was explained that the ethical code should motivate HWs to implement healthy lifestyles and indirectly form a culture of healthy lifestyle. One clinician at a PHC suggested that the ethics code should not just be treated as important words, but a strong doctrine with clear punishment for violating rules.

The above opinion was rejected by one PHO informant, explaining that implementing healthy lifestyles was supposed to be personal. The ethical code is a set of written rules, and not all the implementers agree with its content or 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 should be a consequence. In fact, the community was questioning HWs’ ability to maintain a healthy lifestyle perfectly although it was stated in the ethics code, because they are

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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).

As stated in this study, support from the workplace was sufficient. Implementing healthy lifestyle programs has not only physical benefits, but also in self-confidence for giving counseling and to become role models (Shahar *et al.*, 2009). Moreover, attending exercising and eating programs will raise self-efficacy and self-motivation to achieve weight goal setting and continue the program. At the end, the results will increase effectiveness and productivity in work (Simfukwe, Van Wyk, and Swart, 2017). Workplace-based health promotion intervention was considered more feasible and beneficial as a method of implementing healthy lifestyles for HWs because it was more possible to maintain sustainability and motivation of doing the daily activities of a healthy lifestyle (Chan and Perry, 2012).

The respondents in this study were limited only to doctors, nurses, and nutritionists, and thus the results could not be generalized to other health workers. This study gave ideas about health institutional support for health workers, and it could be used to evaluate the impact of health programs on community’s health behavior.

Conclusion

Healthcare institutions have provided rules and given suggestions and motivation to change health workers' behavior. Healthy behavior such as physical activities, eating a healthy diet, as well as forbidding smoking have been implemented.

Health workers’ responsibility, awareness, and commitment towards themselves, the community, and their colleagues should be emphasized and realized to perform as healthy role models.

Abbreviations

PHC: primary healthcare; PHO: professional health organizations; HWs: health workers.

Declarations

Ethics Approval and Consent Participant

This research 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 and all respondents were addressed before and taken verbal consent.

Conflict of Interest

The authors declare that there is no conflict of interest that may have influenced them in writing this article.

Author Contribution

AATT contributed to the conception, design of the study, collected, organized and conceived the initial manuscript draft.

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