

Expressions of Power in Health Care Providers' Experiences and Behavior



This brief describes a secondary cross-country qualitative analysis that investigated how power manifests and can be shifted to optimize provider behavior change (PBC) approaches across health areas and geographical contexts. Breakthrough RESEARCH explored how four interrelated domains of power are differentially experienced by health care providers (HCPs) based on one's position and function within the health system in Kenya, Malawi, Madagascar, and Togo. The results are intended to help promote quality reproductive, maternal, and newborn care by offering insights for PBC programming.

KEY POINTS

HCPs' power to deliver high quality care was influenced by a range of relationships and interactions with clients, families, peers, and supervisors.

HCPs' power was often constrained by limited access to resources, opportunities for advancement, and supportive supervision and restrictive or shifting institutional policies.

Additionally, client and HCP perceptions about healthcare interactions, community norms, and inter-provider collaboration norms can affect HCPs' power.

Community-based HCPs reported higher power to practice more autonomously compared to facility-based HCPs working in hierarchical professional environments.

Integrating power-enhancing, equity-promoting approaches in PBC programming can improve collaboration and feedback among HCPs and offer structural changes for quality.

Further incorporation and investigation of power domains into implementation research design, intervention selection, and PBC outcomes—including shifting power dynamics among HCPs—is needed.

Background

A growing body of literature shows that HCPs face a range of challenges in their work that are often internalized and affect how they provide services to clients. HCP behaviors, like all human behaviors, are influenced by hierarchies and inequitable norms in health, social, economic, and gender spheres that intersect.^{1,2} However, few empirical studies to-date have focused on exploring power through provider perspectives in relation to their performance and behavior.³ Experiences and manifestations of power are potentially key factors influencing HCPs' ability to provide high quality services.

Power, defined as the capability to make a choice or act in a particular way for oneself and for others, often derives from various sources and may be expressed differently across HCP cadre and HCP-client relationships.⁴ For HCPs, several types of power may be at play:

- Power within—internal capability or sense of self-worth, self-knowledge
- Power to—agency to act in a certain way despite constraints and opposition (e.g., serve a client)
- Power with—collaborating with other HCPs to provide health services
- Power over—leveraging resources and challenging authority (e.g., medical expertise or age)

Power and gender frameworks can help elucidate how these constructs manifest, what they look like and how they can be shifted to promote quality reproductive, maternal, and newborn care.

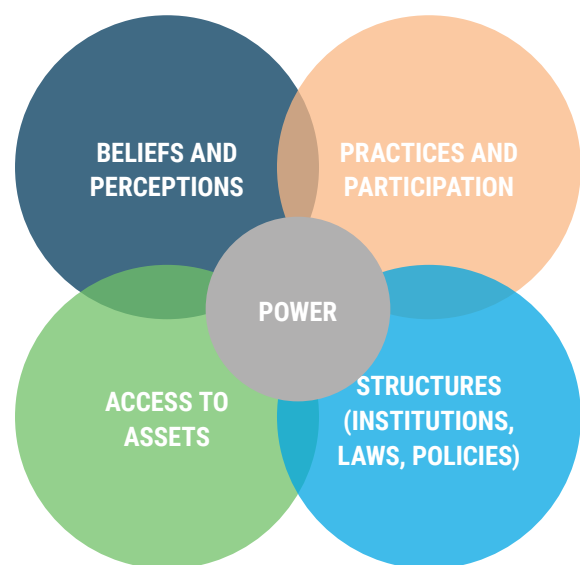
Power framework

To guide our study, we drew on an existing power framework and explored four domains:⁵ (1) **Beliefs and Perceptions** related to the sociocultural context affect provider's power to engage in their therapeutic/counseling relationships; (2) how **Practices and Participation** reflect norms that influence behaviors and engagement within the purview of one's roles; (3) the extent to which **Access to Assets**, including physical, financial, and human resources, influence provider behavior; and (4) how norms are affected by health systems' **Structures**, policies, and governance. We explored how these four interrelated domains of power were differentially experienced based on one's position and function within the health system. We explored manifestations across three generalized cadres including community-based providers,

facility-based providers, and facility-based senior providers/managers.

Study methods

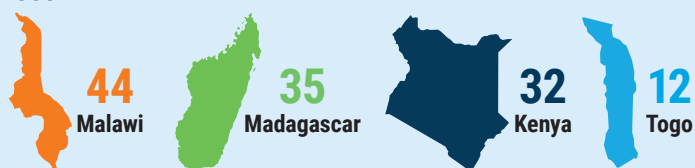
This secondary qualitative analysis of in-depth interviews with HCPs (n=123) across Kenya, Malawi, Madagascar, and Togo drew on four independent studies that focus on PBC interventions across reproductive, maternal, and newborn health in sub-Saharan Africa under Breakthrough RESEARCH, a USAID-supported global social and behavior change evidence generation project. The studies focused on PBC interventions within reproductive, maternal, and newborn health services, including a formative study assessing HCP experience caring for newborn/young children in five hospitals in Kenya, critical care for post-partum hemorrhage (PPH) in health centers and hospitals in Malawi and Madagascar, and enhancing community-level family planning (FP), counseling, and service provision in Togo. Interviews with HCPs included information pertaining to their experiences and perspectives on their work, work environment, and interaction with clients and the community.



Adaptation of Betron et al. 2018. Mapping of power and gender domains to HCP experiences.

NUMBER OF RESPONDENTS BY CHARACTERISTICS (N=123)

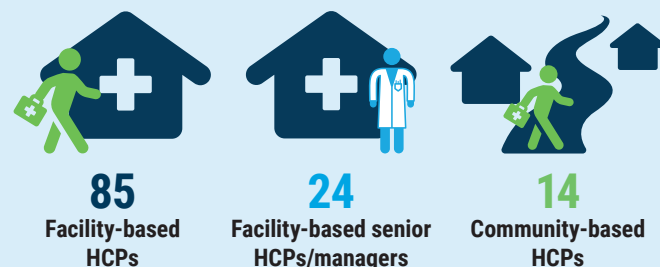
COUNTRY



GENDER*



PROVIDER CADRE



PRACTICE LOCATION



Results

Beliefs and perceptions

HCP/community interaction

Beliefs and perceptions of providers by communities and vice versa gave rise to power dynamics between HCPs and clients/communities. These are underpinned by local assumptions about what it means to be an HCP and a user of health services. Beliefs and perceptions were exhibited in communication quality and provider/facility reputation in the community. For example, provider reputation could be built when positive HCP-client interactions were shared within a community.

“The midwife is not mean.... If you do it [welcome kindly, smile at, and talk] to one person, it extends to the whole locality and it is a good advertisement for you: ‘She’s very cool midwife there.’

—Female, Health Center-based HCP, PPH, Madagascar

Societal beliefs & social norms

Beliefs and perceptions also manifested in the misalignment of cultural/religious beliefs and social norms with necessary medical procedures, which caused friction in the HCP-client interaction. Community preferences for senior doctors over others in facility settings could constrain HCP power to provide care.

“Sometimes when these babies come in, they may need an intravenous [IV] line. This procedure normally is done by a doctor, but as nurses we are trained to come in when the doctor is busy, put an IV, to get medications on time. Somebody may have the attitude...to wait for the doctor.... But it is a procedure [nurses] can do.

—Female, Hospital-based Senior HCP/Manager, Newborn Care, Kenya

Practices and participation

This domain reflects norms of how provider cadres work within their unique roles and responsibilities, collaborate, make decisions, and engage in feedback mechanisms, including challenging authority—all of which shape HCPs’ power with colleagues toward achieving a health service goal.

Interprofessional collaboration and mechanisms

We found differences in how collaboration arose in critical care in hospital settings and routine community-based services; levels of required teamwork and autonomy variably affected HCP power. HCPs’ reflections showed that collaboration between cadres was seen as positive in practice, but current processes of collaboration could reinforce cadre-specific power relations.

“The stress in the execution of my work... often the problem comes from the matron! What she could not do properly I have to do my best to take it back calmly...find out how to achieve this.

—Female, Hospital-based Provider, PPH, Madagascar

Power with other HCPs manifested in and is influenced by a variety of communication channels (*ad hoc* and routine meetings) and co-development of action plans for acute care.

“We receive support from our fellow health workers...there is teamwork; when there is a complication with a woman and you are not sure of what to do, you can consult and the other health workers are always there to help.

—Female, Health Center-based HCP, PPH, Malawi

Challenging authority

Given the HCP cadre-associated norm of deferring to medical authority, community- and facility-based providers have low levels of power to challenge senior HCPs/managers' decision-making. This was consistent across male and female providers.

“If someone says no when you know that it is not the right thing – that stresses you because you know the right way [to manage PPH], but because he or she is a consultant she is saying no it gives you a hard time.

—Female, Hospital-based HCP, PPH, Malawi

Access to assets

We found limited access to assets across HCPs in all four study settings, though HCPs at health centers described these gaps more acutely than hospital staff.

Opportunities for advancement & remuneration

Limited opportunities for advancement and remuneration were described across all cadres, gender, and work locations. HCPs reported stagnation in skill/salary and feeling undervalued, limiting their abilities to provide high quality care.

“What I don't like as much is the fact that the work of a CHW is really heavy. We are the ones doing all the upfront work before people come to see a [facility-based] provider but we are not treated as we should be. That is discouraging.

—Female, Community-based Provider, FP/RH, Togo

Access to material/spatial resources

There was a lack of material and spatial resources that constrained HCP power to effectively care for clients across all countries and facility types. While these complaints were least described in Togo, providers described the challenge of having available but dysfunctional materials in facilities—in Madagascar, cases of basic utility (water/electricity) deficiencies were a further constraint.

“The equipment used daily at the health center are all obsolete... The materials are worn, beds all broken and even the most minimal objects - step ladders [are broken].

—Male, Health Center-based Provider, PPH, Madagascar

Supervision quality and emotional support

A supervisor's availability, response to provider concerns/queries, feedback, and emotional support in addition to their technical support affected HCPs' power within.

“When something affects your psychological wellbeing, it interferes with your work and your home relationships, so there is need to have mental health personnel to assist...having psychological debriefings is vital.

—Female, Health Center-based Provider, PPH, Malawi

Structures

Structures, or underlying institutional and workforce policies and rules, indirectly affect power relations between HCPs and quality care, even if they are not always transparently communicated. Power manifests in structures through the scarcity of human resources and limited policies, protections, and practice guidance, with little difference by HCP cadre or gender.

Human resource availability and capability

Human resource shortages posed a structural challenge to teamwork and sharing of power—which could lead to suboptimal quality care. Even when resources existed, time and workload could render HCP cadres unable to carry out their respective roles.

“ If one care provider is going to run a clinic with thirty to forty patients... we don't have enough time to [provide] dignified care and [cater to the] needs of these children.... Because of time shortage because you end up doing, clearing, and forwarding.... It's a challenge—you don't have one-on-one attention.

**—Female, Hospital-based Senior HCP/Manager,
Newborn Care, Kenya**

Policies, protections, and guidance

While health area-specific technical and operational policies and protocols existed, there was little mention of provider protections or institutional mechanisms to guide/improve practice in the longer term. For example, norms around intra-facility transfers of providers affected the power an HCP experiences in his/her ability to care for a patient.

“ I have experienced someone working at a ward... someone who isn't supposed to deal with a newborn is brought to the newborn unit...now she must catch up because this is not an area that she's trained in.

**—Male, Community-based Provider,
Newborn Care, Kenya**

Implications

- Participatory mechanisms for routine community feedback (positive and negative) about the experience of client-provider interactions can support HCPs and facilities to provide high quality care.
- Policy changes that ensure adequate supervision, equitable access to resources, opportunities for advancement, and improved task sharing can facilitate provider performance.
- Team building strategies (e.g., routine meetings) could help to address the current processes of collaboration that HCPs note reinforce cadre-specific power relations and build trust to challenge authority when it's needed to improve care.

Summary

Using a power lens to understand provider behavior can help illuminate how interpersonal, social, and structural relations influence HCPs' power to provide high-quality care. PBC interventions should be designed to consider addressing factors that influence HCP power. Further examination is needed to investigate how power among sub-groups of the community and facility providers intersects with and varies by gender, and to assess the influence that PBC programs have on shifting power dynamics between HCPs and communities using implementation research.

References

1. Renfrew, M. J. et al. 2014. "Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care," *The Lancet* 384(9948): 1129–1145. doi:10.1016/S0140-6736(14)60789-3
2. Spielman, K., M. Silva, E. Tobey, and L. Dougherty. 2020. "Provider behavior change approaches to improve family planning services in the Ouagadougou Partnership countries: a landscaping review," *Breakthrough RESEARCH Final Report*. Washington, DC: Population Council. doi:10.31899/rh14.1111
3. Sriram, V. et al. 2018. "10 best resources on power in health policy and systems in low- and middle-income countries," *Health Policy and Planning* 33(4): 611–621. doi:10.1093/heapol/czy008
4. Kabeer, N. 2005. "Gender equality and women's empowerment: A critical analysis of the third millennium development goal 1," *Gender & Development* 13(1): 13–24. doi:10.1080/13552070512331332273
5. Betron, M., T. McClair, S. Currie, and J. Banerjee. 2018. "Expanding the agenda for addressing mistreatment in maternity care: a mapping review and gender analysis," *Reproductive Health* 15: 143. doi:10.1186/s12978-018-0584-6

Acknowledgments

This brief describes work led by Breakthrough RESEARCH team members Pooja Sripad, Summer Peterson, Charlotte Warren, Brady Zieman, and Sanyukta Mathur of Population Council and Natacha Stevanovic-Fenn of Columbia University (formerly Institute of Reproductive Health at Georgetown). We'd like to thank Laura Reichenbach and Amanda Kalamar of the Population Council for their technical guidance and review; Sherry Hutchinson of the Population Council for editing and design support; and Lindsay Swisher, Angie Brasington, Joan Kraft, Ephrem Rae, and Kate Howell of the United States Agency for International Development, who provided valuable feedback during the development of this brief.

Suggested citation:

Breakthrough RESEARCH. 2022. "Expressions of power in health care providers' experiences and behavior," *Breakthrough RESEARCH Programmatic Research Brief*. Washington DC: Population Council.

Cover photo credit: Samy Rakotoniana (United States Government Works); this photo was taken prior to the COVID-19 pandemic.

©2022 The Population Council. All rights reserved.

Email

BreakthroughResearch@popcouncil.org

Breakthrough RESEARCH | Population Council

4301 Connecticut Ave., NW, Suite 280 | Washington, DC 20008
+1 202 237 9400 | breakthroughactionandresearch.org



Breakthrough RESEARCH is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of cooperative agreement no. AID-OAA-A-17-00018. The contents of this document are the sole responsibility of Breakthrough RESEARCH and Population Council and do not necessarily reflect the views of USAID or the United States Government.



Breakthrough RESEARCH catalyzes social and behavior change (SBC) by conducting state-of-the-art research and evaluation and promoting evidence-based solutions to improve health and development programs around the world. Breakthrough RESEARCH is a consortium led by the Population Council in partnership with Avenir Health, ideas42, Institute for Reproductive Health at Georgetown University, Population Reference Bureau, and Tulane University.