

The Provider Perspective: Human After All

By James D. Shelton

For more than 20 years, the family planning and reproductive health field has promoted the understanding of the “user perspective,”¹ and rightly so. We’ve learned that in order to have successful programs that serve clients well, we need a better understanding of the people being served. But what of providers? Although providers are obviously essential partners in service programs, their perspectives have received remarkably little attention. That is a major gap. In the early 1990s, the International Planned Parenthood Federation (IPPF) put forward its seminal work on the “needs of the provider” to complement its “rights of the client.”² But to improve programs further, we need to see the world through the providers’ eyes and understand them better. Who are they? How do they see their jobs, their roles and their programs? What are their needs and motivations? What aspects of their work environments challenge them? What is the human dimension of their overall lives, and how can we best enlist their help to improve access to services and the quality of programs?

The role of the provider in service delivery is crucial and far-ranging. A wide variety of staff can be considered “providers”—from the clerk who first greets clients in a clinic to the surgeon performing a vasectomy, from the peer educator promoting safe sex practices and providing contraceptives to the shopkeeper selling condoms or antibiotics for sexually transmitted infections. Not only do the providers’ technical skills and knowledge affect service, but their opinions, attitudes and advice strongly influence what services clients receive and their clients’ subsequent behavior. The provider’s role as “gatekeeper” can profoundly affect how and when clients receive services, or even whether clients receive services at all.

In recent years, our field has come to realize that training, which often focuses only on skills and knowledge, is often ineffective in improving provider performance, and thereby service delivery. Rather, an alternative approach is “performance improvement,” which seeks to understand

the myriad elements that influence provider and organizational performance and considers the range of possible interventions to enhance service delivery.³ It seems axiomatic that understanding providers better is key to this approach.

The small amount of literature available on the provider’s perspective gives a glimpse of why such an understanding is so important. For example, a study from Sitapur District in India provides poignant insight on the daunting constraints that confront auxiliary nurse midwives attempting to provide family planning and reproductive health services.⁴ These included problems with reimbursement, supplies and equipment, physical space, poor training and supervision, transportation, bureaucratic obstacles, time scheduling and even physical security. After reading the study, one wonders how the auxiliary nurse midwives were able to deliver any substantial amount of service at all.

Another look into the provider’s perspective comes from an anthropological study from Nepal showing that the health staff’s views of their jobs often differed from the official program views.⁵ For example, many of the staff viewed the health program primarily as a source of employment rather than as a means to provide services to or improve the health of clients. Likewise, training and supervision were commonly seen as additional sources of income rather than as means of improving skills.

A few studies have also specifically addressed providers’ views of IUDs and IUD insertion. In Morocco, oral contraceptives are the dominant method of birth control. IUDs are considered underutilized by some program managers, and despite considerable efforts to promote IUDs, including substantial training activities, physicians remain resistant to them. It appears that many physicians prefer oral contraceptives over IUDs partly because providing the pill entails less work.⁶ Studies from El Salvador and Kenya have found that certain characteristics of IUD service delivery make it less attractive to providers, including the time required for insertion, the variety of supplies and

equipment needed for the procedure, the vicious cycle of infrequent insertion and low levels of self confidence that they can insert the device properly, misconceptions about the IUD and concerns about their own risk of infection.⁷

As the literature about the provider’s perspective is sparse, in this article I will sketch some of my own thoughts about how we might better understand and approach providers.

Aspects of Human Character

We all have preconceived notions of providers, from the cold and aloof physician to the dedicated, self-sacrificing nurse-midwife, yet providers are each individuals with the full range of human characteristics. They have gender, age, race and social class. They have families, neighbors and communities. They have dreams and aspirations. They have needs, values, cultural orientations and political views. They have likes, dislikes, fears, biases, superstitions and much more. Still, certain characteristics lead to better provider performance, including altruism, a strong work ethic, technical competence, a proactive problem-solving mindset, self-efficacy, organizational skills and the propensity to interact with clients on a caring, connected human basis.

Why Do They Do It?

A central question to ask is, why do people choose to be providers? For most, it cannot be because of the money. Salaries are so low, especially in the government sector, that many providers augment their incomes in a variety of ways, such as by unofficially charging for “free” services, by having private practices or by receiving compensation through travel and per diems.⁸ In all likelihood, the appreciation and satisfaction received from helping others are primary motivations for many providers.

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Another important motivation for providers is often the social status and respect that come with their positions. This social status has high value in itself, but also may enhance the legitimacy of the provider's extracurricular clinical practice. Moreover, many providers are women, and the health service field may be one of the few opportunities available to them for a career or other out-of-the-house activity. Thus, many women appear willing to act as volunteer community-based distribution agents or depot holders, with little or no monetary compensation. They seem motivated largely by the psychic rewards of altruism and the enhanced social status of their positions.

Medical Culture

The medical field has its own culture that strongly influences most health workers.⁹ Four specific attributes can help us understand the provider's perspective. First, medical culture is hierarchical and conservative, with traditionally strong norms for work routines, division of labor and even rituals. These attributes make it difficult to introduce changes (e.g., "we've always weighed every patient") or to stimulate empowerment and decision-making at "lower" levels (e.g., "I just follow procedures").

Second, medical culture strongly values various technical procedures involving the laying on of hands or technology. Thus, providers may give a large amount of attention to physical exams, lab tests and technical procedures, but little attention to the "software" aspects of communicating well with clients.

Third, medical culture insulates health staff from clientele. While other groups of employees remove themselves from their clientele, partly for reasons of practical logistics (think of airline check-in staff), medical staff do it partly out of emotional self-preservation. Without some distance, dealing with large numbers of sick and distressed people would be extremely draining emotionally.

Lastly, the predominant mindset of the medical field has the provider as *the* decision-maker; *they* decide what therapy to prescribe. This mentality may not be conducive to providing preventive care and to promoting healthy behavior and decision-making—all central to reproductive health interventions. Recognizing these aspects of medical culture not only helps us understand why providers behave in certain ways, but also helps us understand the challenge that exists in promoting the flexible, proactive, humane and connected provider we would like to see.

Control and Comfort

Like other people, providers try to control their work environments. They strive for an environment that is both physically and psychically comfortable. They too want their breaks, their perks and even their diversions. To a large extent, they also seek control over the timing, pace, volume, ease, stress and predictability of their jobs. This is not necessarily easy, since the nature of health care is often unpredictable. To help achieve control, providers use a variety of formal and informal regulatory mechanisms. Client flow in clinics is often strongly dictated by the convenience of the provider and longstanding practice rather than by functionality. An example of such behavior by providers was described earlier: providers avoiding the additional work of IUD insertion, especially when the clinic is busy.

The preference providers have for habit and ritual, such as with routine pelvic exams and much of current antenatal care practice, may partly be explained because these practices, although often superfluous, promote a controlled and predictable work environment. Another often-used method to control the volume and pace of work is through scheduling. In a striking example of such time regulation from Brazil, appointments were only accepted on certain days during the week, and clients had to stand in line for hours just to get appointments as far as one or two months in advance.¹⁰ Subsequent revisions of scheduling procedure, along with a major reorganization of work procedures, resulted in a substantial improvement in access for clients.

Similarly, it is almost universally true in developing countries that in busy clinics, the vast majority of clients are seen in the morning, and often after an elaborate system of queuing. In contrast, few clients are seen in the afternoon, even though the same services are theoretically offered. In their role as gatekeepers, providers strongly influence their clients' behavior patterns, thus lightening their own workload in the afternoon. Notably, it is likely that a number of procedural barriers to service delivery, such as requiring women to be menstruating to receive contraceptives,¹¹ allow providers a "legitimate" rationale to regulate and reduce their workload, even though it means clients may not receive services.

Systems and Social Issues

To fully understand providers, one must also consider the systems and social context in which they work. For example, the

social network of supervisors, peers and other program personnel is pivotal. As in any organization, the social norms of behavior among providers are very strong. A classic explanation for why training too often is ineffective is that staff are trained off-site and then return to their work sites, only to find that pressure from other staff, as well as other situational constraints, undermine their ability to implement newly acquired skills and knowledge. Similarly, if the common unofficial practice calls for staff to leave the clinic at 2:00 P.M. rather than at the official time of 4:00 P.M., few individual providers are likely to swim hard against that tide. Likewise, bureaucratic and personnel systems and policies influence a provider's behavior. They can lead to inspiration and motivation, or they can lead to disillusionment and alienation. How often do clients bear some of the repercussions of a provider's disgruntled feelings toward "the system"?

Resource-poor environments promote a scarcity mentality, which makes providers highly protective of supplies. Understanding this phenomenon helps us understand a variety of provider behaviors, such as providing only a few cycles of pills or a few condoms at a time, shying away from removing a "valuable" set of contraceptive implants or resisting providing multiple antibiotics for syndromic management of reproductive tract infection symptoms.

A final issue is how providers relate on a social basis to the communities and clients they serve. Providers are not immune from class, caste, race and gender issues in their society. Service providers are often of a higher socioeconomic status than their clientele, and the medical culture only serves to increase that social distance. Moreover, providers often do not come from or even live near the communities to which they are assigned, disconnecting them even further from their clients. On the other hand, service delivery programs that recruit staff (even with less formal education) from within the villages and towns in which they then serve tend to be more successful.

Engaging Providers

Given the pivotal role of providers in service delivery, it is somewhat surprising that we do not know more about them or how to better engage them to improve programs. This article only scratches the surface. The good news is that many wonderful service providers do great work under very difficult circumstances, but we

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need to build on that. As we design and implement programs, we need to be mindful of the perspectives of the providers on the front line. We must give them a voice, just as we seek to engage clients and communities to promote access and quality in complex service delivery systems.

Moreover, we need more descriptive research about who providers are, how they relate to their roles in programs and how successful providers are able to succeed. We also need intervention research to test and assess promising approaches to reward and motivate providers, to improve their performance and to enlist their help as agents of change who strive to improve quality of and access to services. As our

field continues to advance, we must remember that providers are human after all, and must be full partners to further improve reproductive health.

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