A peer-reviewed open-access journal indexed in NepJol

ISSN 2990-7640 (online); ISSN 2542-2596 (print)

Published by Molung Foundation, Kathmandu, Nepal

Article History: Received on Nov 23, 2024; Accepted on Dec 17, 2024

DOI: https://doi.org/10.3126/mef.v15i01.73942

Health Facility as a Social Construct: Examining the Dynamics of Staffing, Power Relations, and Negotiated Order

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The author declares that he has no conflict of interest.

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Abstract

Human resources are key to delivering health care services in a health facility. Working in an entity for a certain period, meeting with the same group of people during that time and having continuous interactions and interrelationships amongst the group, may open up the space to have a conducive atmosphere among the staff. Such interactions and interrelationships among the health care workers are crucial windows to peep into the health facility, delivery of health care services, and the emerging negotiated order. Based on ethnographic information acquired from a health facility in the Lakhanpur area in present-day Madhesh Province, this paper shows the dynamics of staffing, power relationships, and the negotiations among the healthcare workers and their collective impacts on the healthcare service delivered through the very institution.

Keywords: Staffing, intra-institution power relation, hospital ethnography, negotiated order, medical anthropology

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When medical anthropologists examine biomedicine and some of its dimensions, we approach it with the epistemic view that biomedicine is a socio-cultural system (Hahn & Kleinman, 1983; Kleinman, 1997). We consider it a typical field of ideas comprising of people pursuing different tasks by their corresponding roles. By doing so, biomedicine is delivered through the formal institutionalized setting governed by rules of practice and interaction. Moreover, Hahn and Kleinman (1983) emphasize that it also enacts "…as a means of socialization through which this domain and its procedures are taught and reproduced; and (enacts as) an enterprise of knowledge construction" (p.311). People encultured through such institutionalized procedures are involved in service delivery to health seekers and are, therefore, critical to the successful operation of healthcare institutions. When we want to expand our understanding of how a health facility operates, delivers health care services, improves the overall patient health outcome and enhances the efficacy of a health facility (Kabene et al., 2006), it is imperative to know the interrelationships among these staff, the human face of the health facility.

Ample anthropological investigations on service providers and patient/health seekers relations (Dahal, 2024; Dahal, 2022; Kohrt & Harper, 2008; Justice, 1986) have been produced in Nepal. However, interrelationships among the service providers themselves and the power dynamics involved in such a process have yet to be adequately dealt with. Therefore, this paper aims to fill this gap based on ethnographic information from an anthropological study conducted in the present Madhesh province of Nepal. Medical practice can be highly stressful (Hahn, 2011, 287) mainly due to long hours of work and the well-being of the physicians also affects their medical practices. Therefore, even to improve healthcare delivery, it is imperative to pay adequate attention to knowing the

human within the human resources for health and the context in which they pursue their tasks maintaining the negotiated order (Klemelä, 2023) in the organization.

Looking at health institutions as a bureaucracy has widely taken pace in gazing at international health and healthcare development programs (Foster, 1987), and, likewise, we can see bureaucracy in national healthcare practices. More than three decades ago, Justice (1986) also pointed out the entangled bureaucracy in the healthcare domain in Nepal. Justice has shown that service providers perform differential roles in pursuing their jobs in the local health facilities even beyond their formal protocol. However, we have yet to explore how a phenomenon of organizational hierarchy unfolds at the local health facility in their everyday interaction, and this paper aims to shed light in this area. Ultimately, how far all these internal dynamics related with the health facility and health care staff influence the concerns of patients in this “era of the patient” (Reiser, 1993) in which the patients are supposed to be heard and paid adequate attention will be further explored here. The thirst that led to the formation of this paper is to know how it had appeared while we gaze into a specific context of Nepal’s Tarai immediate before Nepal embarks towards the federal system of governance.

Research Question and Objectives

The general query behind the formulation of this paper is to expand our knowledge of the prominent facets of internal dynamics in a health facility. The specific objectives of this paper are-

i. To analyze the situation of staffing and internal power dynamics in the health facility,
ii. To examine our understanding of how far such internal power dynamics are mediated by the local social and cultural context, and

iii. To broaden our knowledge of how a health facility manages to deliver health care services to the patients and visitors through the negotiated order in their typical local context.

Research Methods

This article is based on information generated through an ethnographic study carried out over three years from 2012 to 2015 as part of my doctoral fieldwork. The study was conducted in present-day Madhesh Province in a socio-spatial cluster; I have given the pseudonym of Lakhanpur. Lakhanpur comprises a Primary Health Care Centre (PHCC), an Ayurvedic health facility as well as some private pharmacies. This article is developed primarily based on the information generated through the PHCC located in Lakhanpur. As part of a study based on the hospital ethnography (Long et al., 2008) approach, interactions with the service providers and observations in the same health facility were the main data collection strategies. Ethnographic data is acquired through this process of "committed localism" (Skovgaard-Smith, 2024) by paying attention to the local everyday comprised of activities, interactions, and relations among the multiple actors in a health facility.

The main building blocks of this article are primary qualitative information. The qualitative information generated from the field was thematically analyzed upon completion of the formal data collection phase. The researcher took utmost care in upholding the ethical compliance essential in conducting an ethnographic study among human subjects. Ethical adherence was fully taken throughout the data collection, data analysis, and while presenting them through publications. The researcher was copiously aware of maintaining anonymity and confidentiality of the data. As a conscious effort to maintain the researcher has chosen the strategy of assigning a pseudonym and defending it, as Rössler and Röttger-Rössler (1991) did while carrying out their ethnographic study in a rural community in Indonesia- I gave pseudonym to the place and the

health care facility staff whenever they are referred here in this writing. I always sought informed consent from the research participants while looking for information. I have realized that acceptance in the community and frequent in and out of the field setting over the period made it convenient to acquire layers of required data. Nevertheless, my positionality as an outsider/insider in the field setting has also played a critical role (Dahal, 2023) in generating the data.

Various forms of Service Providers

The service providers in this health facility comprise of different health workers and supporting staff. Understaffing is not limited to the retention of medical doctors in rural and remote areas only (Russell et al., 2021) but also in relatively convenient areas of Madhesh and that of the supporting staff can affect the performance of a health facility. This health facility is not an exception. Additionally, in such context, how the staff navigates to go beyond their official designated status roles is another crucial arena that prevails as a typical phenomenon.

The health facility's in-charge maintained that despite the central government providing Rs. 6.00 crores for the development of the PHCC building, the organization was experiencing a manpower shortage. The facility lacks a cleaner, a vaccinator, and a peon (the office assistant). The in-charge added, "Our job is just to guide them; these are the real service providers." Given the situation as Justice (1986) found that "the peon was the only real local worker in the health program" in Nepal—that is, someone who lived in the village, spoke the local dialect, and knew the patients and their families—it is noteworthy to connect these findings to the prevailing trend she had already observed. Even though they lack professional medical training, they serve as "invisible health workers", usually the only employees in the medical facility, offering medical care to visiting patients (pp. 101-106).

I have seen multiple individuals working as doctors in this medical facility on my follow-up visits. A third of Nepal's PHCCs (WHO, 2008) often had no medical doctors, either because the positions were unfilled or the doctor would have left. I had noticed that this PHCC has two doctors working there on a winter day in 2013. Both of them had contracts; the MBBS had a two-year contract, while the MD had a six-month contract. Due to a government regulation requiring government fellowship recipients to serve in rural areas for two years, the MBBS doctor is there. He is a resident of the District headquarters and runs a clinic out of his residence. Every working day, he travels to the PHCC from his residence. Senior staff are referred to as "doctors" by both locals and PHCC junior employees. Just the lab assistant, office assistant, and auxiliary nursing midwife (ANM) are not doctors at this PHCC; the other five employees can be called "doctors."

The government of Nepal mandates that the person in-charge of the health center must be a medical officer. However, it also states that the office's financial matters can only be managed by permanent employees. In this facility, there is controversy and confusion because neither of the medical officers is permanent. The medical officer with the MD must be in charge, according to the portfolio. A Health Assistant (HA) was in charge prior to his arrival. Yet the Senior Assistant Health Worker (Sr. AHW) is the most influential employee in this facility due to his nearly three decades of local service and political ties.

The PHCC has a lab assistant who frequently assists in the dispensary area. He is not local, but neither is the ANM. The office assistant hails from Lakhanpur. He informed me that his duties included cleaning the office, giving the doctors drinking water, and caring to the patients' wounds. But I noticed that he offers services to the visiting patients in the dispensary and registration area. He enters their name in the register. He gives the patients their medications after checking the prescription that the "doctors" gave him. In this PHCC, boundary

crossings in other employees' workspaces appear to be regular occurrences. Such behavior breaches the general code of conduct, and it demands employees to operate within their professional limits. Additionally, it makes the patient more at risk of receiving the wrong prescription at the same time. Merely because one has been hired by a biomedical institution, administering services to patients with no necessary training, expertise, or experience is similarly akin to the abuse of biomedical power.

In 2013, on a summer day, neither of the two physicians had visited the hospital. That day, the lab assistant was also absent. Human resources were experiencing a crisis. I talked to the ANM about how she felt at this medical facility while I sat at the registration/dispensary. Around 11:30 a.m., a pregnant woman came for a check-up. This patient and the ANM headed to her room. That day, there was an ongoing flow of patients. About 15 patients had already arrived at this point. The office assistant then stepped up and started registering the patients. He wrote their name in English with no trouble whatsoever. In addition, he gave the patients medication or advised them that “you had to buy this cough medicine from the market because it was not available here.” I talked to him and saw him perform all of these tasks, which were ideally supposed to be done by the health workers.

Typically, the office assistant seldom inquired about the patients’ conditions while giving them their medications. He appeared uncertain about what to do at one point since he was unable to read what was written on the prescription. And it was only then that he enquired about the patient's condition. The patient informed him of his fever. He then administered a medication. Upon the patient's departure, I inquired as to why he had questioned him about the illness. He explained to me that he used that technique for determining the medications rather than consulting the prescribing “doctor” because he was unable to figure out the prescription. Although the office assistant was smart

enough to look up the names of the medications this time, nobody can be sure that such a clever move will always have the desired effect.

Intra-organizational Power Dynamics and Negotiated Order

By assessing various aspects of their interactions, the relationships between the staff members of the health facility can be identified. Their relationship with one another influences how they reach to the negotiated order (Klemelä, 2023) in the health facility as an organizational unit and its potential to provide healthcare support for patients.

I had witnessed even in my presence the Sr. AHW sometimes greets the HA by saying “Hello!” (Oe!) In-Charge. In the local dialect, calling someone lesser than oneself is carried out with the phrase “Oe.” I have witnessed the HA get upset yet never answer when he calls him in this manner. The HA informed me that the he was previously an in-charge, but that he no more is once the medical officers are present.

The manner that HA had been administered suggested that the formal structure and authority of the government is not necessarily always an indicative of how the power hierarchy is actually experienced in the context of Lakhanpur. Instead, it can be thought of as locally mediated at times. As seen in the previous paragraph with the scenario of HA being continuously insulted by a lower staff member, the powerful may become ineffectual in such negotiations. When I use the term “resistance,” I do not imply deliberate action towards members of the social strata. Such insults to their seniors also occur when informal hierarchies replace formal hierarchies in a modern organization, such as a PHCC (Diefenbach & Sillince, 2011).

When observing these employees executing their various responsibilities within the formally established organizational space, it seems that they are mimicking the most recently approved government plan to promote all employees who have held the position for a specific amount of time. In actuality, this

promotion came about as a result of continuous lobbying and objections from different sections of government employees' associations, which were established as sister organizations belonging to major political parties. There is a lot of criticism and objections about lower-level employees being elevated to positions with greater responsibility based only on how long they have held their current positions. Service providers themselves consider that this is making it tougher to put new hires in relation to their capacity to carry out the obligations of the higher position.

The District Public Health Office (DPHO) and the staff at this facility acknowledge that it is hard to find staff members who are not connected to any political parties these days because government healthcare personnel have been affiliated with various political parties. They frequently join the sister wing of a powerful political party, either locally or nationally. This allows them to obtain authority locally, which they can utilize in a variety of ways, including negotiating with the facility's in-charge, their coworkers, or the DPHO for a promotion, transfer, or training. During my visit to DPHO, I learned that he was primarily preoccupied with managing his staff's travel allowance, overtime compensation, and staff management.

They can also utilize their influence in politics to prevent unwanted transfers from a facility near their home or from a facility of their choice. Only 5% of the staff in this district are from other districts, and DPHO acknowledges that this is the primary cause. Due to their political acquaintances, local employees who are *ateri*, disobedient, and disregard directives and regulations may still not face punishment or transfer. In support of his affirmation, I've also heard that local employees in Lakhanpur are *ateri*. This makes it difficult to get anything done from them, particularly if the person in charge is not from within.

Junior employees use their years of experience, which sometimes are significantly greater than those of young senior employees, as a negotiating tool

for overturning the official organizational structures (Diefenbach & Sillince, 2011). They maintain that experience is more important than training when determining a person's senior status. Only skilled professionals can accurately diagnose and satisfy patients. Teaching can be accomplished through knowledge, but becoming a doctor requires practice! The medical officers, on the other hand, consider that people who had their medical science educations decades ago are incapable of diagnosing patients and subsequently assisting them in their recovery. These individuals truly are defrauding patients by simply diverting their funds to their own palms.

Differential and conflicting explanatory models (Kleinman, 1980) thus turn out to function at the level of institution. There is controversy throughout the many echelons of service providers as well as between patients and healers over what it takes to be a good doctor. Health workers have occasionally argued about whether the experience is more important or educational attainment is decisive. Since paramedics make up the majority of the local health workforce, they have been observed lobbying for experience above formal education. The situatedness of their claim lends itself to their positionality.

Absenteeism, Frequent Transfer, and Service Quality

There are barriers to women's "quest for therapy" (Janzen, 1978) in the Madhesh area both in the home and in medical facilities. Health staff absenteeism is one of the primary variables influencing women's utilization of healthcare services. Periodic training, regular staff changes, open positions, and the tardiness of medical professionals have all added to the normalization of absenteeism in healthcare facilities. Women's health is negatively affected by the gendered repercussions of this. Women may occasionally have to wait a long time to receive care. Family members would then chastise her for not doing work from home. In this sense, absenteeism impairs those who try to seek health care and adds to structural violence (Galtung, 1969; Farmer, 2004; Gupta, 2012).

Similar to this, employees at public healthcare facilities are often transferred after two years of tenure. As a result, patients will ultimately become unable to depend on medical professionals for their prescriptions. Instead, a patient's therapeutic relationship, or at least their perceptual dependence cannot be reliant on a single "doctor." Transferring healthcare professionals between facilities is a common occurrence that may have "unintended consequences" (Smith-Oka, 2009) on their path to seeking medical attention and which will eventually end up them to the private pharmacies and clinics.

I occasionally felt that the medical staff at this clinic had largely absorbed the fundamental principles of biomedicine. They rarely used the disease name in local words while discussing the ailment types that are common in the area, both with other people and among themselves. If they ever describe the disease to patients, they do so in a biomedical fashion. To understand illnesses, they have internalized the biomedical categories and values (Dahal, 2022). In a similar vein, they support their claims with statistical data to demonstrate their propensity for biomedical objectivity (Hahn & Kleinman, 1983), even if they are unable to provide enough numerical data.

"Local people have learned that free drugs cannot cure 20% of the health conditions for which people attend this health facility," my interaction with the PHCC's Senior Community Medical Assistant at one point revealed. I asked him, nodding, how he obtained these numbers. He assured me that it is based on his observations of the locale. Here is an indication of how these service providers frequently select to validate their claims by this kind of "evidence." They have the tendency toward numerical testimony, however not in a methodical manner, even though the data may not be adequate for use as evidence.

Conclusions

The bunch of ethnographic information that have provided basis to formulate this article show that biomedical health facilities like a PHCC in the

study area are lively organizations comprising of different categories of human resources. While working together at an institution, their styles of doing work, everyday interactions and interrelationships among themselves make the health facility a culturally construed entity. I would argue that regardless of prevailing contradictions and deviation from the normative formal organizational structure, the PHCC as an entity can construe a negotiated order to pursue its everyday tasks.

We can see that understaffing is neither confined to the remote and rural areas (Russell et al., 2021) nor only related to that of the physicians and medical doctors but also to that of the supporting staff. Nevertheless, as an organization comprising of variety of “doctors” and non-doctors workforce, they can offer health care services to the patients and visitors. Amidst the hierarchy and friction among the staff, they have been employing multiple strategies to construe the image of the health facility in a particular way, which helps them to undertake the task of maintaining negotiated order in the health facility to accomplish the perpetual maintenance of health care delivery. In the days to come, it will be interesting to explore further ethnographic accounts of how such power dynamics and negotiated order are evolving in the unfolding federal context of Nepal.

References

Dahal, K. B. (2024). Ethnographic investigations into medical violence in Nepali healthcare facilities. *Ciencias de la salud*, *22*(1), 1-21. https://doi.org/10.12804/revistas.urosario.edu.co/revsalud/a.12944

Dahal, K. B. (2023). A native anthropologist's positionality of being an insider/outsider: A reflective account of doing ethnographic research in Nepal. In N. Uddin & A. Paul (Eds.) *The Palgrave handbook of social fieldwork*. Palgrave Macmillan. https://doi.org/10.1007/978-3-031-13615-3_22

Dahal, K.B. (2022). Engrained with modernity: Commodification, medicalisation, and cross-border medical travel for health care in Nepal. *Humanities & Social Science Communications,* 9, 128. https://doi.org/10.1057/s41599-022-01155-y

Diefenbach, T., & Sillince, J. A. (2011). Formal and informal hierarchy in different types of organization. *Organization Studies, 32*(11), 1515-1537. https://doi.org/10.1177/0170840611421254

Farmer, P. (2004). An anthropology of structural violence. *Current Anthropology*, *45*(3), 305-325.

Foster, G. M. (1987). Bureaucratic aspects of international health agencies. *Social Science & Medicine, 25*(9), 1039-1048. https://doi.org/10.1016/0277-9536(87)90009-8

Galtung, J. (1969). Violence, peace and peace research. *Journal of Peace Research*, *6*(3), 167-191. https://doi.org/10.1177/002234336900600301

Gupta, A. (2012). *Red tape: Bureaucracy, structural violence and poverty in India*. Duke University Press.

Hahn, R. A. (2011). *Sickness and healing: An anthropological perspective*. Yale University Press.

Hahn, R. A., & Kleinman, A. (1983). Biomedical practice and anthropological theory: Frameworks and directions. *Annual Review of Anthropology*, *12*, 305-333.

Janzen, J. (1978). *The quest for therapy: Medical pluralism in lower Zaire.* University of California Press.

Justice, J. (1986). *Policies, plans and people: Foreign aid and health development.* University of California Press.

Kabene, S. M., Orchard, C., Howard, J. M., Soriano, M. A., & Leduc, R. (2006). The importance of human resources management in health care: A global context. *Human Resources for Health*, *4*, 1-17. https://doi.org/10.1186/1478-4491-4-20

Klemelä, J. (2023). Negotiated order in organisations revisited and straightened out. *Journal of Organizational Ethnography*, *12*(3), 261-266. https://doi.org/10.1108/JOE-10-2023-096

Kleinman, A. (1997). *Writing at the margin: Discourse between anthropology and medicine*. Univ of California Press.

Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry.* University of California Press.

Kohrt, B. A., & Harper, I. (2008). Navigating diagnoses: Understanding mind–body relations, mental health, and stigma in Nepal. *Culture, Medicine, and Psychiatry*, *32*, 462-491. https://doi.org/10.1007/s11013-008-9110-6

Long, D., Hunter, C., & Van der Geest, S. (2008). When the field is a ward or a clinic: Hospital ethnography. *Anthropology & Medicine*, *15*(2), 71-78. https://doi.org/10.1080/13648470802121844

Reiser, S. J. (1993). The era of the patient: Using the experience of illness in shaping the missions of health care. *JAMA, 269*(8), 1012-1017. https://doi.org/10.1001/jama.1993.03500080060033

Rössler, M. & Röttger-Rössler, B. (1991) The anonymity of persons and places in ethnography: A comment. *Anthropos, 86*(1/3), 204- 207.

Russell, D., Mathew, S., Fitts, M., Liddle, Z., Murakami-Gold, L., Campbell, N., Ramjan, M., Zhao, Y., Hines, S., Humphreys, J.S., & Wakerman, J. (2021). Interventions for health workforce retention in rural and remote areas: A systematic review. *Human Resources for Health*, *19*(1), 103. https://doi.org/10.1186/s12960-021-00643-7

Smith-Oka, V. (2009). Unintended consequences: Exploring the tensions between development programs and indigenous women in Mexico in the context of reproductive health. *Social Science & Medicine*, *68*(11), 2069-2077. https://doi.org/10.1016/j.socscimed.2009.03.026

Skovgaard-Smith, I. (2024). Ethnography beyond the tribe: From immersion to “committed localism” in the study of relational work. *Journal of Organizational Ethnography*, *13*(2), 233-249. https://doi.org/10.1108/JOE-05-2023-0025

World Health Organization (WHO). (2008). http://www.nep.searo.who.int/en/Section10.htm 2008.