Poor Working Conditions, HIV/AIDS and Burnout
A Study in Cameroon
Josiane Tantchou

ABSTRACT: The aim of this study was (a) to use anthropological research tools to produce a thorough description of health providers’ working conditions in a low-income country; (b) sketch the impact of a specific dimension of the national HIV/AIDS programme on this environment and (c) sketch the existence and examine the extent of burnout among health workers. We conducted intensive fieldwork in a large public hospital in one major town of the far-north region. We relied on three research tools: observations, in-depth interviews and the Maslach Burnout Inventory (MBI). The data were analysed manually. We found a working environment characterised by an acute lack of equipment, lack of recognition and equity, lack of community and fairness, and value conflict, all of which are factors implicated in burnout. This was exacerbated by the implementation of a psychosocial dimension in care for people with HIV/AIDS, which created exclusion and reinforced feelings of unfairness. However, despite their challenging working environment, health-care providers were not ‘burned out’, leading us to suggest that burnout is a syndrome of ‘rigid’ working environments, as opposed to ‘porous’ working environments.

KEYWORDS: burnout, Cameroon, health workers, HIV/AIDS

Introduction

Health systems are currently facing a human resources crisis that is particularly acute in Africa (Chen 2004; Delanyo 2005; Marchal and De Brouwere 2004; Narasingham 2004). This crisis affects the number, quality and distribution of health workers (Delanyo 2005; Kushner et al. 2004; Muula 2005; Raviola et al. 2002; Sartorius 2005). Three key reasons are cited to explain it: neglect, the globalisation of human resources for health and the HIV/AIDS pandemic. Raviola et al. (2002: 56) referred to a human resource ‘crisis centered on HIV/AIDS’.

Sub-Saharan Africa continues to bear a disproportionate share of the global HIV burden. In mid-2010, about 68 per cent of all people living with HIV globally resided in sub-Saharan Africa, a region with only 12 per cent of the global population. The 1.9 million people who became newly infected with HIV in 2010 in sub-Saharan Africa represented 70 per cent of all the people who acquired HIV infection globally (WHO 2011). The pandemic has led to an increase in workloads (Chen and Hanvoravongchai 2005; Kushner et al. 2004). Health systems that were mainly set up to deliver maternal and child health services and care for acute episodes of diseases suddenly have to cater for large numbers of people living with HIV/AIDS (PLWHA), in need of lifelong chronic disease care (Van Damme et al. 2008). It has increased absenteeism (Charles et al. 2004; Marchal et al. 2005; Ncayiyana 2004), reinforced the stress related to risks of contamination and level of emotional fatigue due to palliative care (Chen and Hanvoravongchai 2005; Dieleman et al. 2007). However, with some sense of exaggeration, as noted by Marchal et al. (2005), one could say that the pandemic is just the latest plague falling upon the health workers, since the classic health workforce issues of maintaining adequate
levels of training and inflow in the professions, ensuring adequate distribution and skill mix and retaining health professionals are continuing to undermine health services in many countries (Marchal et al. 2005).

Over the past few years antiretrovirals (ARVs) have become more affordable, and new global health initiatives are bringing in considerable financial resources for scaling-up antiretroviral treatment (ART), thereby introducing new actors and new institutional arrangements. Today, it is the implementing capacity of the health systems of those southern African countries whose societies are ravaged by AIDS that appears to be the main limiting factor. This capacity depends mainly on the health workforce who has to ‘do the job’ (Kober and Van Damme 2004). There is growing consensus that a long-term perspective on ART scale-up has to address the issue of human resources (Schneider et al. 2006).

We conducted this study with the following objectives: (a) use anthropological research tools to produce a thorough description of working conditions in a health-care facility; (b) outline the impact of a specific dimension of the national HIV/AIDS programme on this environment and (c) sketch the existence of burnout among health workers.

Burnout is a syndrome of emotional exhaustion, depersonalisation, and reduced sense of personal accomplishment, which can occur among individuals working with people in some capacity (Leiter and Maslach 1988; Truchot 2004). It appears to be a factor in job turnover, absenteeism and low morale; it also seems to be correlated with various indices of personal distress such as physical exhaustion, insomnia, use of alcohol and drugs, and marital and family problems. It can lead to deterioration in the quality of care (Maslach and Jackson 1981) as can be observed in many health-care facilities in sub-Saharan Africa.

Research evidence to date suggests that environmental factors, particularly characteristics of the work setting, are more strongly related to burnout than are such personal factors as demographic and personality variables. Burnout is not intrinsic to the workers themselves, but the result of the social environment in which they work (Leiter and Maslach 1988). Potential sources of burnout include role stress or conflict, lack of control, lack of reward, inadequate working space, the sedentary nature of the job, large caseloads, lack of community, lack of fairness and value conflict (Gillespie and Cohen 1984; Maslach and Leiter 1997). Consistent with these ideas, empirical research on burnout has focused on job satisfaction, stress (workload, role conflict and role ambiguity), withdrawal (turnover, absenteeism), expectations, relations with coworkers and supervisors (social support within the workplace), relations with clients, type of position, length of time in job and agency policy (Schaufeli et al. 1993). Didier Truchot notes that the majority of the populations studied are in developed countries, while studies of sub-Saharan Africa, South America, the Middle East and most Asian countries are scarce (Truchot 2004). This study will contribute in filling this gap.

Study Methodology

Data were collected in the Extrême Nord province of Cameroon. A large public hospital served as the study site. Given the characteristics of the working environment described, we chose not to identify the informants, hospital and town in which the study was carried out. We conducted eight months of fieldwork. As research tools, we relied on observations, in-depth interviews and informal interviews. Observations (three to eight hours daily) were carried out in services that work with PLWHA (maternity unit, laboratory and an HIV counselling and testing centre). Observations lasted until data became repetitive. We took notes, which we transferred daily into a ‘log book’. This period was also used to collect health workers’ comments on their working conditions through informal interviews. They took place as we accompanied them in the course of their duties. Informal interviews were organised with doctors, nurses and nursing assistants, and laboratory technicians. In contrast, more formal in-depth interviews were organised with heads of services and their assistants, and usually arranged as scheduled meetings with the informant. An interview guide was used, and the data recorded and transcribed verbatim. Additional data were collected in focus group discussions, which took place spontaneously as workers congregated on a veranda during rest periods or in a colleague’s office for tea. We both listened to discussions and prompted issues related to our topic. The groups consisted of four to six persons. These discussions were not recorded; we took notes and subsequently explored key issues more deeply during in-depth or informal interviews. Data were analysed manually using the key words that emerged over the course of the research.

The following text presents the results of this study. The bulk of studies dealing with burnout do not take into account the state’s policies and health systems, which largely determine working environments. We hypothesise that these policies weigh heavier than an imbalance in relations leading to different outcomes as far as burnout is concerned. Our study describes health professionals experiencing simultaneously a
double experience of lack of reciprocity in a triadic relation (state<->health workers<->patients). In this triad, the central position of health workers can guarantee enhanced productivity, better delivery of services and successful health programmes. We use the dichotomy of ‘porous’ versus ‘rigid’ system to deal with this specific working environment. We associate these concepts to specific administrative ways of functioning and suggest that burnout is a ‘rigid’ working environments syndrome, as opposed to ‘porous’ working environments. In ‘rigid’ environments, employees cannot ‘escape the system’ or appropriate and ‘use’ it to satisfy their personal interests. In ‘porous’ environments, they can appropriate and use chinks in the system for their personal benefit as we will show, thus overcoming the limitations of their working environment. As a consequence, they may be frustrated, not burned out. The text is structured in two parts. The first part deals with the working environment, notably physical working conditions (Dieleman et al. 2007), professional status and relations with coworkers. The second part is about the impact of the implementation of psychosocial care for PLWHA on the working environment. The conclusion addresses the study’s limitations and some of its practical implications.

The Working Environment

Physical Working Conditions and Dissatisfaction

One hundred and two people work in the studied hospital. These include three general practitioners and three specialists (gynaecologist, urologist and radiologist); the other ninety-six are nurses, midwives, nursing assistants, laboratory technicians and administrative staff. There is a horizontal service for general care and vertical health programmes for specific conditions (HIV/AIDS, tuberculosis, malaria). Doctors usually work as focal points for these health programmes. This of course has an impact on their workload but, as we show, it can also be perceived as rewarding. In the following paragraphs, we describe physical working conditions using the hospital laboratory as illustration.

Eight laboratory technicians work at the main desk and in rooms assigned for data recording, blood transfusions, biochemistry and parasitology. The latter are equipped with four microscopes. Two of these are damaged; of the two others, one is provided by the national programme against tuberculosis and is exclusively dedicated to sputum samples. It is therefore with the other functioning microscope that, one after another, laboratory technicians usually analyse all the other samples. There is a centrifuge described as ‘already damaged, but almost the only one we have’. Beside the parasitology room is a door marked Blood Bank. According to the head of the service, ‘It says blood bank but we don’t have a blood bank. It has a bed for the donor, but even the bed linen is better not spoken of’. Separated from the ‘blood bank’ by a curtain is a space with a gynaecological table used for vaginal and uterine sampling. He continued to describe inadequacies in their working facilities:

It was in the sixties that one had this type of equipment. Today, there should be well-arranged, clean gynaecological tables which give a sense of safety. When a woman comes here for gynaecological sampling, I don’t feel good. I even had the idea of suspending it, but people would take it badly. They would not understand I’m doing it for patients’ safety. When you arrived this morning, you saw me carrying cotton soaked with alcohol. I was cleaning the space for a lady, to reduce the risk to zero. But how many people do this? (Head of the service)

His colleague adds: ‘if you lay down there for an examination, you will be infected. The sheet covering has not been washed or changed for nearly three years’. Opposite the ‘blood bank’ is the biochemistry room with its three haematology analysers. Despite some problems related (among other issues) to electric circuit inadequacy, it is possible to analyse blood samples using one of the analysers. We observed the technician in charge of these samples while he was doing his work. Several times, he was obliged to stop and restart the machine, re-introduce a blood sample or use his imagination and knowledge of the machine in order to screen all samples of the day: ‘We became mechanics’, he said. ‘One is obliged to manage with these few resources; if not, we cannot work’. A central processing unit is used for a wide range of sample analyses. Its printer being damaged, the technician must write up results by hand. This takes more time and increases the workload, particularly when there is a shortage of reagent needed for T4 lymphocytes count. After such a shortage, patients with HIV/AIDS will all come the same day to avoid a (new) postponement of their antiretroviral drug prescription. Reagents for sample analysis are provided by the hospital. But gloves, syringes, needles, and so on, which are necessary for daily work, are not provided. The state of the laboratory was a source of embarrassment for some of the lab technicians. Once, as we were taking pictures of it, a technician exclaimed, ‘Eh! Must you take photos of our laboratory like that? People will not come here anymore’. The head of service chimed in, ‘this is the Third World. We are a warehouse for old...
equipment’. This lack of equipment extends to items necessary for routine care activities and for daily life at work (running and drinking water, toilets, textbooks, paper, pens, etc.), and obstructs the provision of care. This is perceived by staff as a lack of recognition of their work.

Professional Status: Insecurity, Lack of Recognition and Equity

Health workers are classified according to their status: HIPC health workers, ‘volunteers’, civil servants and community health workers (CHWs). The following sections deal with each of these in turn.

HIPC Health Workers

The term HIPC health workers serves to designate those health workers who are recruited through the funding provided by the Heavily Indebted Poor Countries Initiative. HIPC health workers are recruited for a period of three years, after which they must join the civil service. Some of them are medical doctors trained abroad. On their return to the country, they are not hired as civil servants because the recruitment of physicians in public health facilities is reserved for those trained in the country (Beyeme Ondoua 2002). Among them, there are also university graduates in jobs that are not directly linked to their original training. Although borne with realism, such a situation is a source of frustration. As one put it, ‘I have a Master’s degree in biochemistry and my training matches only partially with what I do here. I do not feel useful. My satisfaction is purely material; I have my daily bread, and help my family’.

Community Health Workers

In the 1990s and by the beginning of the 2000s care for PLWHA was purely clinical. In 2006, to address the psychosocial dimensions of HIV/AIDS a new category of community health workers (CHWs) was created. CHWs are mainly involved in the running of HIV counselling and voluntary testing centres. In the hospital studied, CHWs do not have any specific qualifications. They are mostly PLWHA and therefore have an ‘incorporated’ expertise.

Volunteers

These are nurses trained in public or private schools. As the Ministry of Public Health is not recruiting staff apart from doctors, in order to ‘keep their hand in’ these students apply after their training to work in health-care facilities as trainees – but they are literally volunteers, having the same workload as civil servants but no salary. A shortage in the health work-force renders their presence essential for the running of services. In many of these services, their number exceeds that of civil servants: ‘We are the ones running hospitals. If we decide a strike, everything will stop’. Yet, the precariousness of their status prevents them from forming a pressure group to request better working conditions and salaries.

Civil Servants

Both HIPC health workers and volunteers aspire to become civil servants. But are the latter really better off? Let us start with the process by which the status of civil servant is bestowed. Although confirmed by the assignment of a registration number, which initiates the payment of monthly wages, actual payment is not automatic. For example, my respondents explained that a doctor will wait an average of two years before receiving his first salary, suffering from an administrative system in which the user has to ‘know someone’ or ‘give something’. Once registered, they need to advance in grade, and, again, they will suffer the effects of the administrative system. The situation is especially complicated for those working in remote areas like the far north. The files are processed in Yaoundé, the country capital. The government mail service is not reliable and e-administration is not a reality yet. Therefore, they explained, it is better to travel to Yaoundé and deposit the files in the offices, ideally in the hands of the employee in charge. The files are reviewed by several departments; the transition from one to another largely depends on the ability of the person concerned to mobilise his social and professional networks and financial resources. Files not ‘weighted with a bank note’, in the words of Blundo and Olivier de Sardan (2007: 20), are left waiting. Each civil servant has a unique experience of this aspect of public administration, but variations occur around the same pattern: files move from one department to another when ‘one gives something’ or ‘knows someone’. This situation led a physician to say:

Even the State doesn’t respect us. When I remember that some of the people with whom I received my Bachelor’s degree began to receive a scholarship as soon they were admitted to the National School of Administration. Then at the end of their training, they did not wait for their salaries. After 7 years of studies, I still have to face hard times before having my first salary. It’s really frustrating.

Low Wages, Remoteness and Lack of Motivation

Wages and incomes are ‘hygiene factors’ (McCoy et al. 2008) influencing motivation, performance, morale and the ability of employers to attract and retain em-
employees. When revenues are insufficient, employees seek alternative sources of funding (ibid.). Thus, low wages are often seen as an explanatory factor in corruption and extortion of patients (Blundo and Olivier de Sardan 2007; Israr 2000). The economic crisis and Structural Adjustment Programmes (SAPs) have brought a decline in civil servants’ wages in general. Wages were increased in the early 2000s but are still perceived as insufficient. Several doctors provide care in private clinics in addition to their hospital duties; they are also obliged to attend seminars organised to monitor vertical health programmes implemented in the region. Participants’ per diems – allowances to fulfil such obligations – sometimes exceed their monthly wage. We also noted that the majority of physicians and some of the professional nurses expressed regret at having left the cities of Yaoundé and Douala. These towns host the most prestigious training institutions, reference hospitals and private clinics of large capacity. Working in these facilities provides attractive additional incomes. These towns also host international NGOs and international development agencies’ health programmes. When involved in these programmes, one gains in experience, income and symbolic recognition. In contrast, the Extrême Nord region is, to use Blundo and Olivier de Sardan’s (2007) terminology, a place of dry, remote, isolated outposts, where the quality of life is poor, opportunities for enrichment limited, and one runs the risk of being forgotten by the hierarchy. Civil servants from the south of the country perceive assignment to this province as punishment. Many arrive to take up their duties and immediately return to the capital city where, while working in private clinics, they use their networks to get a change of assignment. This attitude of civil servants from the south to the far north prompted the former Head of State to develop incentives in order to retain staff: ‘At the time of Amadou Ahidjo, there was motivation. During holidays, the State provided an airplane ticket to staff from the south so that they may visit their family members.... We need something to motivate us, but there is nothing’ (Laboratory technician). A few physicians appreciate this remoteness, which allows them to gain experience in dealing with pathologies that are uncommon in towns; it also allows them to avoid intrusion of family members in their private lives. But for most of them, it is problematic. They complain about misunderstandings due to their incapacity to meet their social obligations and maintain peace in family relations. It is important to note that despite regression in salaries, the prestige attached to these professions has not decreased. Therefore, health workers have to struggle to maintain the social standing associated with their profession. The actual context renders this difficult and even impossible to achieve, leading to conflicts with family members.

Civil servants from the south also complain about difficulties to plan their careers: ‘We suffer too much here. You are not only separated from your family, but you cannot even make plans for the future, buy a piece of land or build a house if you don’t have in your homeland somebody you can trust’. This state of affairs is not without consequences for professional relations.

**Relations with Coworkers: Conflict, Lack of Community**

On arriving at the hospital, one easily notices that young nurses are volunteers and heads of service are gadamayo (as people from the south are called in the local language). The latter are usually local people with more experience, who have spent years in the hospital as assistants. Professional relations are characterised by tensions between ‘local people’ and gadamayo. ‘They don’t like us’, say the gadamayo:

They say we are here to steal their money. A Chadian lives a better life here than a southerner. At the market for instance, if something costs $1, they double the price because you are gadamayo. Even house rental is difficult. Did you ever see a poster with house to rent written somewhere? It is mouth-to-mouth that things work. Sometimes, somebody will come and tell you, I saw a house to be rented over there. You reach the place five minutes later and they say there is no house to rent. Then someone else from the region comes afterwards, and the house is rented to him.

To this, local people reply that gadamayo abuse their confidence. They contract debts which are not reimbursed, and wreck houses they have inhabited when living in the place. At the same time, ‘We have friends from the south, good friends from the south’, some of them remark. The far north is the most beautiful as well as the poorest region of the country. North–south connections (transportation, communications) are difficult. Cholera and meningitis strike the population every year. For many southerners it is ‘a place to visit, but not to stay’. Civil servants assigned there always have in mind being ready to leave at any moment, without worrying about relocation. Consequently, they do not share the same expectations as their co-workers. Whereas, like local people, they want recognition and to see their work valued, gadamayo await the day when they will leave the place definitely:

I cannot lie. When I travel here from Yaoundé, I always have tears in my eyes. I feel like a man who is about to be thrown in prison. I look calm in the train but my heart bleeds. I speak to myself, ‘When will you
This tension between ‘local people’ and gadamayo is fuelled by suspicion and accusations of corruption, as well as by the implementation of vertical health programmes employing people (gadamayo or local), many of whom are not health workers, yet are better paid. Because job definitions are unclear and task-shifting procedures are lacking, some workers find themselves suddenly excluded from their offices and with no role to perform in the hospital. This creates frustration and feelings of unfairness, as we will see from the example of what we call the ‘HIV/AIDS structure’. But let us consider the issue of corruption value conflicts first.

**Case Study of the Impact of the National HIV/AIDS Programme on the Working Environment**

HIV counselling and voluntary testing centres were created to encourage voluntary testing. They also provide counselling and ART distribution. In general, one is sent to the centres by a general practitioner for an HIV test after a consultation for another disease. Once in the centre, their first contact will be with the ‘welcome team’. The team will register the patient and send him or her to pre-test counselling and then to the lab for blood sampling. The results are delivered a few hours later, after post-test counselling. The positive patients are directed to the prescriber of the test or the chief consultant of the centre. The latter is a general practitioner who supervises the centre activities in addition with his hospital duties. He therefore provides general consultations, and receives HIV-positive patients, both those sent by other health centres in town and those for whom he is the attending physician; this represents a heavy workload. Two lab technicians are in charge of the centre’s blood sampling and analysis. A senior nurse manages ART provision. G. (who is a lab technician) and M. (a nurse) also work in the centre. Finally, a secretary and a group of community health workers provide counselling. The involvement of these new actors within a dysfunctional, unregulated health system, without specific job definitions, creates gaps through which they can ‘slip’ or ‘find their way’, while excluding professional nurses (Tantchou and Gruénais 2009); the new roles create tensions and frustration.

**Difficult Relations between Nurses and Community Health Workers (CHWs)**

Originally, care for people living with HIV in Cameroon was purely clinical. In 2006, a new category of actors was created to provide a psychosocial dimension to care: community health workers (CHWs). Their relations with professional nurses are characterised by tension. According to the professional nurses, ‘They are paid and hardly do anything’. Moreover, ‘they are receiving wages for nurses’ activities’; ‘One could have asked the nurses to do this work with a small increase in the salary’. The respective positions of nurses and CHWs vis-à-vis the national HIV/AIDS programme have fuelled this tension. Nurses, unlike CHWs, do not attend the therapeutic committee meetings, to which they are not invited. As a consequence, nurses feel CHWs are in a much better position in terms of relations with the national HIV/AIDS programme and its institutions. When seminars, trainings or any other activities are organised, CHWs have the opportunity of gaining per diems which, in the context of low salaries, are highly valued (Hane 2007; McCoy et al.)
2005). This situation creates a status insecurity and what Isabelle Baszanger (1990) called *revendication d’utilité* — the powerful desire to prove one’s usefulness and legitimacy. Whereas the supremacy of doctors is not doubted, nurses and CHWs are involved in a subtle struggle to reinforce their hierarchical position immediately behind the doctor, in the case of the nurses, and in the case of the CHWs, to prove their utility, legitimacy and find their place in the hierarchy. To do this, nurses respect working hours (7:30 a.m. to 2:30 p.m.): only nurses will be present in the service by 8:00 a.m. and after 1:30 p.m. They ‘educate’ and ‘train’ CHWs about ‘good practices’ in counselling, and criticise them in front of patients as doctors do with nurses. CHWs for their part use the ‘no man’s land’ in the health system to prove their utility, which is how they were able to gain decision-making power over which patients will have free access to ART (Tantchou 2007, 2008).

It is important to note that before the creation of this new category of actors, many nurses and nursing assistants were trained to perform counselling and sent to the centre for counselling and voluntary testing. Today, some of them like M. are in search of a new place in the system: ‘We all were trained for it but there is no place for me anymore, I do not have anything anymore to do. From time to time, I still get involved; they call me for “special cases”, the “hard people” [difficult to convince or who reject their result]’. M. usually sits on the verandah of the centre, talking with researchers and colleagues, or with patients waiting to see the doctor and awaiting their blood sample or exam files. ‘Excluded’, he envies the situation and position of his new volunteer colleagues and the position of colleagues of his age and qualification who are head of services; he criticised the whole system:

> See, my salary has not changed for 12 years. I’m not a minister’s child. Nobody knows me at the public health ministry. My promotion files are still waiting in an office there because I have no money, no relations. Like they say, if you have money, or if you are a minister’s child, you can do everything you want, you can have what you like.

**Health Workers Burned-out?**

Lack of job security and of symbolic recognition and equity, issues related to the legitimacy of new actors, heavy workload on one hand and idleness on the other, tensions among coworkers and patients which are reinforced by the national programme against HIV/AIDS – all of these factors commonly associated with burnout merge to form an overwhelming working environment. We used the Maslach Burnout Inventory (MBI) to examine the existence and evaluate importance of burnout in this working environment.

The Maslach Burnout Inventory was designed to assess the three components of the syndrome as defined by Maslach and Jackson (1981): emotional exhaustion, depersonalisation and personal accomplishment. It consists of twenty-two items, written in the form of statements about personal feelings or attitudes. These items are structured to allow an exploration of all the three dimensions of the syndrome. Fifty-four health workers of the fifty-five we met completed the MBI. Three questionnaires were handed in incomplete and were not included in the analysis.

The results show low levels of emotional exhaustion and depersonalisation, and a moderate score of personal accomplishment. We note a variation among categories of health workers: while we note low levels of depersonalisation in all categories, emotional exhaustion was moderate among doctors and low among nurses and CHWs. We also note a moderate score of personal accomplishment among doctors and nurses, and a low score of personnel accomplishment among CHWs. The overall score indicates an absence of ‘burnout’ (see Table 1).

<table>
<thead>
<tr>
<th>MBI results</th>
<th>Emotional exhaustion</th>
<th>Depersonalization</th>
<th>Personal accomplishment</th>
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<tr>
<td></td>
<td>Doctors</td>
<td>Nurses</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>12.07</td>
<td>15</td>
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<tr>
<td>Total:</td>
<td>13.67</td>
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Reminder: The level of emotional exhaustion is considered as low, moderate, or high for scores respectively set to ≤ 17, 18-29, ≥ 30. The scores are set to ≤ 5 (low), 6-11 (moderate), ≥ 12 (high) for depersonalization; and ≤ 33 (low), 34-39 (moderate), ≥ 40 (high) for personal accomplishment. The overall score is not used in practice (Cathébras, Begon et al. 2004).

I suggest this can be interpreted in four ways:

1. In a context of low salaries, with workers hoping for upgrading, they do not want to present them-
selves, even to a researcher (of whom they did not know the connections with the stake-holders at the central level), as ‘unsatisfied’, ‘exhausted’, and so on.

2. The MBI may need to be adapted to the context. While the completion of the questionnaires seems easy for doctors, we translated some of the MBI statements in Cameroonian-French for nurses, nursing assistants, midwives and lab technician and we asked the respondents to call us if they did not understand a statement or were not sure of its meaning. When called by a respondent, we first of all asked how he or she understood the statement. If this understanding was not correct, we took examples from our observations and helped the respondent re-formulate the statement in his own words. The results varied according to each individual’s level of vocabulary. In addition, the statement ‘I feel I treat some recipients as if they were impersonal objects’ was perceived as shocking. Informants said, ‘A human being is not a thing and cannot be treated as a thing … In spite of all constraints and difficulties, compassion is an immediate, instinctive reaction when facing human suffering’.

3. Burnout is a syndrome more often associated with ‘rigid’ working environments, as opposed to ‘porous’ or ‘flexible’ working environments. In rigid environments, employees cannot ‘escape the system’ or ‘use’ it to satisfy their personal interests. In porous ones, they can use chinks in the system for their personal benefit (selling of drugs, external activities like agriculture or private clinics etc. to counteract frustration, find a sort of satisfaction in their job and supplement their monthly wage, for example). As a consequence, they may be frustrated, but not burned-out; however, quality of care may still suffer. Thus, one might interpret the tensions that characterise patients–providers and coworker relations as being a consequence of coping strategies (Roenen et al. 1997) adopted in response to a difficult working environment, as Lindelöw and Serneels (2006) also suggested.

4. We may be witnessing a frustrated workforce and a burned-out health system. While burnout was not found among health workers, our research provides an insight into a health system that is ‘out of breath’. This suggests what might be called structural burnout, or health system burnout. The hypothesis deserves further thought.

**Conclusion and Practice Implications**

This study had three objectives: (a) use anthropological research tools to produce a thorough description of working conditions in health-care facilities; (b) sketch the impact of a specific dimension of the national HIV/AIDS programme on this environment and (c) examine the extent of burnout among health workers. The existence of the syndrome was not established with the tool used. As we pointed out, it would be interesting to adapt the MBI to the specific context, or use other research tools to measure the health workers’ levels of satisfaction with their job, and assess the existence of psychological distress. It seems appropriate to assume that such a working environment has an impact on the ability to cope with professional, family and social life. If the syndrome was not detected among health workers, we nonetheless observed a health system that I term ‘out of breath’, suggesting the idea of a structural or health system burnout.

The findings bring to the surface several questions:

1. Doctors and nurses are working in poor conditions. Can they nevertheless give more than they are currently motivated to do? One solution should be to create conditions for structural empowerment, by ensuring employees have access to the information, support and resources necessary to accomplish work and that they are provided ongoing opportunities for development. The literature on which we relied in this article linked empowerment to a variety of outcomes, including organisational commitment (Kraimer et al. 1999; Spreitzer 1995), and organisational citizenship behaviour (OCB) 17 (Gilbert et al. 2010; Park et al. 2009). Because doctors and nurses deliver care to patients on behalf of hospitals, hospitals have to enhance their patient-oriented perception and spontaneous organisational citizenship behaviours for the sake of higher patient satisfaction and better patient care (Chang et al. 2011). Promoting structural empowerment and Organisational Citizenship Behaviour could help the health workforce and health systems flourish despite current challenges (Gilbert et al. 2010).

2. Community health workers find a sense of value through their job. The job helped these housewives and widows discover hidden skills, and opened up chinks in the system through which they can receive some wages, ‘find their way’ to become civil servants at the end (a position that is supposed to guarantee financial security). Has this made their situation more desirable?

3. How is this going to evolve? We hypothesise a situation in which more and more HIPC workers will be integrated in the general health system, while more and more civil servants (nurses, doctors and specialists) will find other strategies to develop their careers and empower themselves such as working with NGOs, creating NGOs and associations, going
abroad for specialisation, emigration and partnerships with European or American research. In such a context, these strategies seem almost normal, which is noteworthy.

One limitation of this study is the silence of patients and clients of services, who proved reluctant to respond within the hospital setting. It was interesting, however, to note the comment of a chief of service, ‘patients have not fled the public hospitals’. Why, in spite of inhospitable medicine, do they continue to ask for care in the public hospitals? I suggest three hypotheses: (a) public facilities are more numerous than private ones; (b) patient–practitioner relations (chronic disease specifically) change over time, becoming more empathetic (Hane 2007) and (c) private hospitals that lack equipment and specialists are referring their patients to public hospitals, making the latter indispensable. The patients’ experiences and views will be addressed in a future publication.

Finally, this study reinforces the need to think hard about ways to alleviate sub-Saharan Africa’s human resources crisis in health. Inadequate supply, poor distribution, low remuneration, perception of not being valued (particularly for nursing staff) and accelerated migration of skilled health workers are increasingly regarded as key system constraints to the scaling up of HIV treatment (McCoy et al. 2005; Schneider et al. 2006). In many African countries, current concerns about the health labour market focus on overall poor working conditions, shortages of skilled personnel, skewed distributions within countries, a rapidly increasing external brain drain and the impact of HIV/AIDS, which is aggravating and accelerating these problems (Delanyo 2005; Kober and Van Damme 2004; Narasimhan 2004; Thupaya-gale-Tshweneagae 2007; Van Damme et al. 2008; WHO and UNAIDS 2006). By the end of 2005, the countries with the weakest human resources for health (HRH) base were those with the lowest ART coverage (WHO and UNAIDS 2006). Thus, as noted by Kober and Van Damme (2004), tackling the issue of human resources for health is of paramount importance for the survival of health systems in the age of AIDS. But it is not just about HIV/AIDS: the concern is a more general one. A health system cannot function effectively without a motivated workforce; therefore it is important to empower health workers through a strong human resource policy. From this perspective, more participatory research projects are needed.

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Acknowledgements

The author acknowledge the ‘Agence Nationale de Recherche sur le Sida et les Hépatites’ (ANRS-France), which funded the project (ANRS 12144). We are also grateful to the hospital director, the administrative staff, nurses, nursing assistants, medical doctors and specialists we met during our fieldwork.

Notes

1. Feelings of being emotionally overextended and drained by one’s contact with other people (Maslach and Leiter 1997).
2. Unfeeling and callous response towards the people who are the recipients of one’s care (Maslach and Leiter 1997).
3. Decline in one’s feeling of competence and successful achievement in work with people (Maslach and Leiter 1997).
4. When people lose a positive connection with others in the workplace (Maslach and Leiter 1997).
5. A workplace is perceived to be fair when trust, openness and respect are present. This is particularly evident during evaluation and promotion processes. Lack of fairness is evident when there is inequity of workload or pay, when people cheat in order to get ahead, when people are blamed for things they did not do (Maslach and Leiter 1997).
6. It occurs when there is a mismatch between the requirements of the job and personal principles (Maslach and Leiter 1997).
9. This structure did not exist before the pandemic and was created for a specific purpose related to the fight against HIV/AIDS.
10. This Case Study section was first published in the International Nursing Review (Tantchou and Gruénais 2009).
11. They have a monthly wage of U.S.$122 which is not regularly paid. Note that a nurse receives approximately the same salary at the start.
12. In contrast, two CHWs are supposed to attend therapeutic committee meetings. They are sometimes invited to give details on a patient who has received counselling and they sometimes correct information provided to doctors by patients, which sometimes differs from what was said during counselling.

13. In a study conducted in South Africa (Walker and Gilson 2004), lack of consultation with nursing staff in the planning and implementation of a range of new health policies was the source of much anger and frustration. Nurses perceived this as a barrier to the implementation of the programme studied.

14. Problems which have no ‘routinised’ solutions.

15. First-line treatment is now given free of charge to patients.

16. We used a French version, which can be accessed at www.masef.com/scores/burnoutsyndromeechellembi.htm.

17. Organisational citizenship behaviours (OCB) are discretionary behaviours that are not rewarded directly by the organisation but have been linked to positive outcomes, such as increased job satisfaction and lower turnover intentions (Gilbert et al. 2010).

References


