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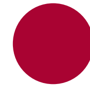

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Job motivation and frustrations in the public health care sector in rural Burkina Faso: A health worker perspective

This Ph.D. study shows that front-line providers of global health enter the workforce with a high level of motivation , but in order to maximize their daily effectiveness must be better supported in their daily work when posted in rural areas –for example through appreciative supervision and better organization of daily operations.

1. Introduction

On September 1st of 2011, a group of women and men from Bobo-Dioulasso, the second largest town in Burkina Faso, set the maternity ward on fire. The group was led by the husband of a woman who had died the previous night during delivery at the public health facility, while the midwives on duty allegedly were watching television in the room next to the delivery room. According to the participants in the attack, it was the fourth case of maternal death in that same facility that year.

In 2013, the national union of health workers in Burkina - SYNTHSHA - declared a series of strikes that included:

- *'Sit-in's'* with reduced opening hours in every national health facility for three consecutive weeks
- Five days of full closure with no minimum service in all public primary, secondary and tertiary facilities
- *'Operation caisses vides'* where the personnel at the state sponsored services refused to collect payment for consultations and hospitalizations.

The conflict was the outcome of an unsuccessful round of negotiations between the Union and the Minister of Health. Both conflicts were widely reported in the national media and health worker's ethics and performance were frequently discussed among health personnel and users of the health system.

2. The problem

Universal health coverage is being emphasized by the United Nations' General Assembly as a key element in human development and it urges national governments to use the primary health care sector as an entry point for such an effort (UnitedNations 2012). Health worker performance is key to the delivery of universal access to health especially in rural areas of poor countries, where there are few health workers (Chen et al. 2004; Manongi, Marchant, and Bygbjerg 2006; Mbindyo et al. 2009). In Burkina Faso, utilization of modern health services has risen from 0.6 contacts/habitant/year in 2010 to 0.7 in 2011, but overall utilization rates remain low. At 9.1% health expenditures consume the second largest portion of the national budget after education according to the Ministry of Health 2011. However, the Government is making an effort to strengthen the sector by building new primary health facilities in rural areas, reducing fees and increasing the availability of generic drugs (Haddad, Nougtara, and Fournier 2006). Even though geographical accessibility has been improved, patients regularly bypass the primary care level and it seems clear that the effectiveness of the public health care system can be improved.

In Burkina Faso health workers take an oath at their graduation ceremony, during which they swear to *'serve with loyalty the population'* wherever they are posted. In the public health care sector, job postings are assigned regardless of individual preferences and the cultural and linguistic competences of the employee. Staff in rural areas receives incentives including free housing; and rural as well as urban based staff gets overnight allowances and occasional training. Dissatisfaction with the level of these allowances, as well as with the poor access to basic medicines for patients was one of the main arguments for the initial strike. Few studies have examined how rural health workers in Burkina Faso perceive their job situation and their relationships with the patients. However, health workers' attitudes toward the patients, their companions and in a larger sense the community that they serve are important to the daily operations of a rural health facility.

3. Purpose of the study

The aim of this study was to use the national conflict of 2013 as a lens to explore the attitudes of primary health care workers' in rural Burkina Faso and to issues analyze relevant including motivation, de-motivation and corresponding response strategies.

4. Study area and population

The study was conducted in two health facilities in the Central East region of Burkina Faso over eight non-consecutive months in 2012 and 2013. It is predominantly a rural area where the livelihoods of most people are from subsistence farming and raising livestock. In the rural areas of Burkina Faso, 50.7 % of the population are estimated to live below the poverty line and life is characterized by a constant search for money to pay for the next meal. The region is dominated by the ethnic group of the Bisa as well as large groups of Mossi and Peuhls. The dominant languages are Bisa and Moré, and only a few speak French.

In the two villages covered by this study, there is little infra-structure and the only state-sponsored facilities are the primary school and the health facility *Centre de Santé et de Promotion Sociale*. These centers function on a very basic level, without running water and with solar panels as only source of electricity. They are led by a state-licensed nurse and regularly monitored by the district medical doctor. The villages are situated 30 km. by dirt road from a town with more infrastructure and where the third facility included in this study is located. Each of the three centers in this study has a utilization rate above the average for the country (0.7 contacts/habitant/year) with 0.9, 1.2 and 1.08 contacts/habitant/year respectively. Malaria is endemic and fever *(le corps chaud)* is one of the greatest health concerns for caregivers of young children. In the health facilities covered by this study 46% of the consultations over 6 consecutive months ended with a malaria diagnosis. The health care system in Burkina Faso is best characterized by medical pluralism and people use self-medication, traditional healers and modern, bio-medical services inter-changeably (Fainzang 1986; Samuelsen 2004).

5. Sampling

Two small, rural primary health facilities and one large, semi-urban primary health facility were selected for the study. These facilities have multiple cadres of public health employees. In the two rural facilities, all public health employees were interviewed twice; in the large facility at least two representatives of each staff category were interviewed twice. For all three facilities, members of the local health

GRADE	AWARD	M	F	NUMBER INTERVIEWED
Health Center Chief *(major)*	Nurse diploma grade A	2	1	3
State licensed nurses *(IDE)*	Nurse diploma grade A	1	3	4
Registered nurses *(IB)*	Nurse certificate grade B	1		1
Auxiliary nurses *(IAS)*	Nurse certificate grade C	1	2	3
Nurse students		2		2
Midwives	Midwife diploma		2	2
Auxiliary midwives	Midwife certificate		3	3
District Health Chiefs	Medical doctor	1	1	2
Regional Health Director	Medical doctor	1		1
Health Committe members		10	3	2
Total		**19**	**15**	**34**

Table 1. Overview by grade and sex of health actors interviewed

committees were invited to participate in focus group discussions. The two district chief medical doctors, as well as the regional director of health, were also interviewed twice. Government health facilities were chosen because they are the only available modern health centers in the rural areas, are the most utilized in the urban area, and they employ the most health workers.

6. Data collection, methodology and analytical approach

The study is based on ethnographic fieldwork which made it possible to become a part of the social life of the health facility and to know the context in which the interactions between the personnel and the patients take place. The long term stay also made it possible to supplement the formal interviews with informal conversations at appropriate times for the interlocutors. Multiple qualitative techniques were used including in depth individual interviews with different types of health system actors, focus group discussions and observations of clinical consultations. Semi-structured interview guidelines were used allowing for flexibility in the questions and probing.

The individual interviews with the health workers were conducted in French by the researcher. Some interviews were tape recorded. Those interviews which were recorded were transcribed and quality checked by a second researcher. Extensive notes were taken and typed the same day as the interviews had been conducted. Everybody who was approached agreed to participate and the large majority was eager to discuss the questions related to their job situation and the recent conflicts. The focus group discussions with the health committees were conducted in Moré by a trained assistant, audio recorded and transcribed.

Participation at the health facilities and in important events such as the annual graduation ceremony helped form a better understanding of the complex social fabric which shapes the motivation of the health workers.

Ethical clearance to carry out the study was obtained from the Ministry of Scientific Research and Innovation and from the Directorate of Health Center-East. Individual oral consent was sought from all the informants after the researcher had explained the purpose of the study and emphasized that participation was voluntary.

The analysis of the data based on the summaries of the notes were performed as follows:

- Familiarization of the data by reading the field notes and editing summaries of the interviews and the clinical observations.
- Developing of themes emerging from the texts using grounded theory.

7. Findings

From the interviews, three themes appeared which were of particular importance to understand how the health workers perceive their job situation: (i) their initial motivation for joining the health workforce, (ii) what motivates them in their daily work and (iii) what demotivates them. The findings of relevant response strategies for dealing with lack of motivation were gathered from observations of the daily operations at the health facilities. *(See table 2).*

Dilemmas related to the national conflict

In all three facilities the sit-ins and strikes were observed, but in two of them the center chief tried to mobilize non-unionized students to maintain a minimum level of service. In the most rural facility, the doors to the facility were open but the staff stayed in their houses on the facility premises during the five days of national strike. The dilemmas between their mission as public health workers and striking - which cut-off the access to life saving services for the population - was described as painful to most but not to all. The younger health workers were especially bothered by the situation, as were those who were motivated by a strong wish to alter the afflictions of the patients. A young female auxiliary midwife summarized her frustration succinctly by describing it in this way: *"We work a lot here but our salaries are insufficient. And it's not okay. During nights shifts we sometimes have to do deliveries with no other light than a torch. And the risk allowances are also insufficient, it's 7500 F CFA (ca. 11,50 euros) and we are exposed to HIV and then 7500 is not nearly enough to get treated. But after all, with my conscience I know it was not good to strike, to see people suffer like that without being able to help them. But our working conditions are really not good. Personally, I found it very hard but when all my colleagues were fighting that battle, I had to follow".*

On the contrary, during the strike an older auxiliary midwife at the most rural facility had this to say when asked about the women who would go into labor during the strike. *"They can come and do their thing and die, we won't look to their side, it's the strike now"*. Later when asked her how she viewed the strike in hindsight she said *'it went well, we did it for our working conditions'*.

The most common feeling among those who were explicit about the reasons for entering the strike was a high level of frustration with the government who had not met the demands of the Union until the 'operation casses vides' threatened to empty the Government's coffers. A male nurse student explained why his colleagues had entered the conflict by saying: *"It's striking to see another human being suffer like that without being able to help. But they (the colleagues) were not wrong because the Government didn't listen and they were called upon by the Union so they didn't have any other choice than to strike"*.

8. Discussion and conclusion

The large majority enter the health workforce with a high level of motivation and with a strong wish to serve the patients, the community and their country. Among those who have newly entered the health corps that feeling is most pronounced. When posted in rural and semi-urban areas the level of frustrations grows in proportion to the time spent serving there. From the viewpoint of the health workers, the main factors that caused demotivation was poor salaries and allowances; but when asked for solutions they did not stick to only monetary incentives, but also mentioned supervision and the possibility of improving their own skills as factors that could improve their job motivation. They responded to their frustrations in various ways, and in facilities with seemingly poor management, their frustrations led to suboptimal services characterized by routine and unaccounted for absenteeism and by differential treatment of patients with rough treatment of villagers and especially of 'the worst off patients'. Differential treatment runs through the social fabric of Burkina Faso and other West African countries (Jaffré and Olivier de Sardan 2002; Andersen 2004), but it has consequences for the quality of care for the poorest patients.

According to the health workers, the conflict was both the outcome of and source of mistrust between the health workers and the Government, which also appeared insensitive to their claims.
This study indicates that financial incentives are important, but that supervision and lifelong learning opportunities could improve the motivation of the health workers. It also suggests that rural health workers are front line providers of global health and that their frustrations are complex, interlinked and operate at different levels which the Government need address in order to reestablish the trust lost in the conflict.

THEMES	EXAMPLES OF SPECIFIC ISSUES
Initial motivation for joining the health workforce Childhood dream Finding a future	• Childhood aspiration often inspired by frequent visits to hospitals or a significant family member in the health workforce who 'carried the uniform' • Wish to become a public employee regardless of sector with a guaranteed minimum salary, a steady job prospect and some benefits to oneself and family (often framed as *'to become a somebody'*)
Motivational factors: Doing good Pride Supervision	***Intrinsic motivation:*** • Commitment to help people in their afflictions and to save lives • Joy in being shown gratitude by patients after having done a good job • Feeling proud of 'doing good' towards own clan (if posted in own region of origin) • A sense of citizenship: serving the people and the state thus contributing to the development of the country • Pride in the social status which downplay other aspects of personhood such as age or gender • Supervision which is appreciative and a learning experience for the staff ***Extrinsic motivation:*** • Supervision which is appreciative and delivered in a manner that turns it into a learning experience for the supervised
De-motivational factors Risks Poor working conditions Low salaries Lack of training Rural patients	***Systemic factors:*** • Exposure to workplace hazards such as needle and syringe-sticks and cuts during deliveries with women of unknown HIV serology • The lack of basic medico-technical equipment such as blood pressure monitors, scissors, tweezers and generic drugs for emergency cases • The condition of the health center - which all appear deteriorating, unclean due to the presence of animals, cluttered, lacks electricity and up to standard beds for patients • Low salaries, low allowances and lacks of rewards for individual performance • Poor working conditions in rural areas where proximity of house to the dispensary allows patients to show up at all times of the day and night • Housing in rural areas often lacks latrines • Lack of training prevents one from improving their skills and exchange experiences with colleagues • A persistent feeling of being 'out of the loop' - hearing on the radio the Government accepting donations of medico-technical supplies or large grants from development partners which is announced to the population but which they rarely receive. ***Contextual factors:*** • Frustration with villagers who are perceived to be 'the worst patients/companions' (later show-up's, less adherent, more rude) than patients and their companions in urban areas
Corresponding strategies Entering in a conflict Tinkering Absenteeism	• Conflicts: Joining a national strike , which offered a sense of agency and unity within the medical corps • Tinkering : Using creative skills to mend broken equipment, to assist the worst-off patients, etc. where the system fails • Routine absenteeism : Absences from workplace for discretionary reasons • Differential treatment of patients: some patients are greeted warmly, others are barely acknowledged

Table 2. Overview of themes emerging from the interviews and observations

About the project 'Fragile Futures: Rural Lives in Times of Conflict'

Fragile Futures is funded by The Consultative Research Committee for Development Research ('FFU') of the Danish Ministry of Foreign Affairs under the theme of 'Fragile state, conflict and civil society'. It is a collaborative research project between the University of Copenhagen and the University of Ouagadougou as well as with the Burkinabe institution 'Institute of Research in Science and Health'. The ambition of the project is to describe and analyze imaginaries of the state and its local representatives from local, village based perspectives.

The project will be conducted in the provinces of Boulgou and in the Kou Valley in order to collect ethnographic data from different rural communities. Helle Samuelsen, Head of Department, Associate Professor, Department of Anthropology, University of Copenhagen, is the principal investigator. The Post docs in the project are Gabin Korbeogo, GRIL, Department of Sociology, University of Ouagadaougou, and Lea Paré Toé, Institute of Research in Science and Health'. The Ph.D. fellows are David O. S. Ilboudo, Tidiani Oueadraogo, Issah Sombié and Lise Rosendal Østergaard.

For more information go to http://antropologi.ku.dk/

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