MAT ✻ *Medicine Anthropology Theory*

Occupational citizenship

Practice, routine, and bureaucracy among nurses and midwives in rural Burkina Faso

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Abstract

Health workers are an overlooked category in the growing literature on health and citizenship. In this article I describe a 2012–2013 nationwide conflict in the public health care sector in Burkina Faso to explore how ideas about citizenship were mobilized in a situation of political agitation. I examine how public health care is done in a context of material deprivation, technological shortage, and great demand from the population. Three distinct repertoires of *practice*, *routine*, and *bureaucracy* are identified, through which health workers strive to make meaning of their work and engage in the practice of public health care. Drawing on these findings, I argue that adopting a citizenship framework offers an opportunity to improve our understanding of the multiple ways in which health workers manage the difficulties related to being (health professionals) and doing (professional health care) in rural Burkina Faso.

Keywords

citizenship, repertoires, conflict, health workers, Burkina Faso

Introduction

Could a new form of 'occupational citizenship' be developing among health workers in Burkina Faso? This question is inspired by a conflict in the public health care system in 2012 and 2013 in which midwives, nurses, and doctors engaged in strikes that led to fatalities and treatment delays. A mobilization was spurred by the health-worker organization Syndicat National des Travailleurs de la Santé Humaine et Animale (SYNTSHA), which followed several stages: first 'sit-ins', during which all services were suspended until 10 am; then a 'full strike without minimum services', when all health workers stayed away from public health facilities from Monday morning to Friday evening; and finally 'Operation Empty Boxes', during which health workers did not collect fees for consultations or hospitalizations. In petitions to the president of Burkina Faso, SYNTSHA's secretary general linked the material decay in the public facilities to the staff's inability to deliver health services of an acceptable standard.[1] This decay was jeopardizing patient safety and created work-related hazards for health workers. In a mediatized message of support, the president of the Network for Access to Essential Generic Medicines described the state-sponsored hospitals as *mouroirs* (hospices) where people were being left to die, rather than places of care and cure (Karboré 2012). In these statements higher levels of health-worker entitlements were linked to the quality of care and ultimately to the progress of the nation. By directing these claims to the president, the syndicate was reminding the government of its responsibilities for organizing measures to prevent disease and promote health in the whole country, not only in urban areas.

I observed how this conflict unfolded in and around three small public dispensaries. Originally, I had planned to explore how people in rural areas utilize state-provided health care through the dispensaries. Instead I found myself in front of empty buildings a few weeks into my fieldwork. The doors to the maternity rooms were open. The outreach motorbike was parked inside, but no nurses or midwives were to be seen. When people showed up with febrile children or when women in labor arrived as passengers on bicycles, they were sent away by the guard saying '*C'est la grève totale*' (this is a full strike). The strikes caused much suffering in the local communities. Media reports revealed violent incidents when people tried to access services that had suddenly become unavailable (Kani 2013,

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1   The strikes represented an intensification of a conflict between the union and the government of Burkina Faso that can be traced back to 2007, when SYNTSHA made its first claims for better entitlement packages and improved salary scales. In its petitions made in 2012, the union included demands for basic diagnostic equipment, adequate pharmaceutical products, and free-of-charge emergency care and evacuation to the referral hospitals.

Kindo 2013, Zongo 2013). I interviewed women who had been turned away when they arrived in labor at the health facility during the night. They felt a hostile sense of antagonism from the health workers. 'People die too much these days in the hospitals', a friend of mine said matter-of-factly, after stopping by the regional hospital. 'We are disappointed, really disappointed', said a member of the village health committee, as he explained that none of the health workers had stayed on duty to maintain a minimum level of service.

Looking at the empty buildings reminded me of the seminal article by Adeline Masquelier (2001) entitled 'Behind the Dispensary's Prosperous Façade: Imaging the State in Rural Niger'. In her analysis of government-organized health care in Niger in the 1980s, she portrays the rural dispensary as 'a place of emptiness' (Masquelier 2001, 270). This characterization resonates with Claire L. Wendland's (2010, 182) description of rural clinics in Malawi: 'The buildings were there, the doors were open, but it was often hard to see what went on inside as medicine' (Wendland 2010, 182). Masquelier argues that, through techniques of social triage, nurses decided who among the waiting patients should be given the scarce medicines and who should be sent home without any. However, she also argues that, despite its perceived hollowness, the absent state was given specific form through the presence of state-sponsored buildings in remote areas of Niger. I found that the Burkinabé state was not only made manifest to ordinary people through buildings such as dispensaries and hospitals but also through the presence of state-employed health workers. They were ambiguous figures, privileged compared to people in the villages, yet also at the bottom of the health system, where there was a documented shortage of qualified staff and poor working conditions (Ministère de la Santé 2011).

The strikes in Burkina Faso were observed by all unionized health workers, which, in an area with few private clinics, gave their campaign weight by effectively preventing people from accessing biomedical health services. As I followed the debate in the national media, I noted how values of citizenship permeated the conflict. Ideas about citizenship were used in two specific ways that revealed a dilemma of occupational solidarity. On one hand, the health worker organization staged the government as the sole party responsible for the current health system crisis, thereby putting health workers on a path to confrontation with their employer, the state. On the other hand, politicians tried to motivate civil servants to serve the population with dedication regardless of difficult and hazardous working conditions. My conversations with health workers before, during, and after the conflict corroborated this impression and inspired me to explore in greater detail whether and how ideas about citizenship were being mobilized by health workers. To make ethnographic sense of public health care includes asking about the practices through which it is enacted in a context of material deprivation, technological limitations, and political agitation. What can these practices tell us about the way citizenship is constructed by health workers in a context like the Burkinabé state-sponsored health system?

To answer these questions, I follow the work of a group of health workers employed at three health care centers in the Central East Region, one of the thirteen administrative divisions, of Burkina Faso. I suggest that public health care here is multiple and enacted through repertoires of practice, routine, or bureaucracy depending on the specific situation. I argue that this multiplicity of public health care is connected to distinct ideas of citizenship that were fleshed out during the conflict. In conclusion, I offer a new concept of 'occupational citizenship' and discuss its theoretical implications for an anthropology of public health care systems.

A certain occupational citizenship of health workers?

It is well established that postcolonial Africa has become the locus of global health interventions, often delivered as technological solutions and pharmaceutical products by supranational agencies in ways that bypass the nation state (Geissler 2014; Prince and Marsland 2014; Biehl and Petryna 2013; Høg 2014). In relation to this development, critical medical anthropologists have struggled to understand how new regimes of medical care foster transformations in representations of citizenship, social relations, and identity (Reynolds 2015; Richey 2006; Kielmann and Cataldo 2010; Biehl 2001). This literature has scrutinized the ways in which the language of medical science is used to make political claims on behalf of people who share a biological condition, as eminently demonstrated in Adriana Petryna's (2004) study of vulnerable populations in post-Chernobyl Ukraine. Petryna introduces the concept of 'biological citizenship' to show how, in the context of the postsocialist state, people use their collective status as 'Chernobyl sufferers' to claim health care that was formerly guaranteed to them by the socialist state (Petryna 2002, 118).

The historian Frederick Cooper combines the political citizenship of the nineteenth century with the social citizenship of the twentieth century in defining citizenship as 'the sense of belonging to a polity, the combination of the rights of the individual and the duties to the collectivity' (Cooper 2014, 76). Citizenship is understood as a platform for making claims to the state regardless of a person's individual status (ethnicity, affiliation). The way that national authorities distinguish between those individuals who are 'potential' citizens and those who are not and then act upon them has been conceptualized as 'citizenship projects' (Rose and Novas 2005, 439). Vinh-Kim Nguyen and colleagues analyzed such projects in the context of Burkina Faso in the late 1990s. HIV-positive West Africans had to practice 'confessional technologies' (learning how to narrate their life stories in specific ways) to be taken in by charity projects in a situation where the nation state was unable to provide people suffering from AIDS with access to life-saving medicines (Nguyen et al. 2007). In 2001, Nguyen suggested the concept of 'therapeutic citizenship' as a heuristic for understanding the social processes through which individuals who share a biological

condition collectively negotiate access to health care (Nguyen 2001). This process was later exemplified in the analysis of how HIV-positive people must negotiate a social and cultural landscape of policies, treatment programs, and local funding arrangements to gain access to treatment (Nguyen et al. 2007). By contrast, Susan Reynolds Whyte and colleagues (2013) have studied 'projectified' access to medical care in Uganda. In the context of East Africa, they suggest replacing citizenship with 'clientship' as a way of representing how patients struggle to establish client–patron relations with those development projects that provide some forms of health care. In these cases, the sense of belonging to a polity in the form of the nation state has shifted towards a desire to become members of potent global projects that provide health services through research programs or service-delivery projects, rather than remaining citizens of impoverished African nation states.

This body of literature has primarily been concerned with patient citizenship, not health worker citizenship. Studies of political activism in this area have focused on patient associations and support groups, rather than on the collective actions of other health-sector actors (Rose and Novas 2005). Given the context of the extreme vulnerability of individuals living with HIV in Africa being stigmatized and denied access to welfare, the reasons for this focus are well founded. As Lucy Gilson notes (2003, 1461), African health workers are by all standards privileged in terms of their access to state-provided social protection compared to the rest of the population, especially those living in rural areas. Yet the observations I garnered from my talks with health workers in Burkina Faso have led me to believe that ideas about citizenship should not be disregarded when it comes to examining the relations between state-employed health workers and the state, and the way this relationship is experienced by health workers 'on the ground'. For example, Noémi Tousignant has studied how private pharmacists in Dakar evoke different qualities of citizenship (concerned, responsible, or efficient citizens) in order to remind the Senegalese state of its responsibility for ensuring the quality of pharmaceutical services (Tousignant 2014, see also Tousignant 2013). In her hospital ethnography, Wendland followed doctors-to-be in Malawi. She argues that they cope with their frustrations with the obstacles to the practice of biomedicine in a resource-constrained setting by distinguishing themselves from the 'clinical officers' of the colonial period and representing themselves as 'citizen doctors' with a certain duty to 'develop' Malawi (Wendland 2010). This literature speaks particularly to the practices of specialized, more highly ranked, urban health professionals. Still, we may expand the anthropological focus on citizenship projects by including those of frontline health workers. As no professional category has more sustained contact with patients than nurses and midwives posted to rural areas, they are the analytical focus here.

Background and methods

The backbone of my material has been produced through eight nonconsecutive months of ethnographic fieldwork in the Boulgou province of Burkina Faso. In 2012 and 2013 I studied health care practices at three small Centres de Santé et de Promotion Sociale (CSPS, health care and social promotion centers). These state-organized dispensaries are the designated entry point for people's contact with state-organized health care. In the context of this study, this entry point was also their only access to biomedical health services, as the fees charged by the owner of the private clinic were too high for most people. The CSPSs are staffed by two categories of workers: state-employed health professionals (interns, nurses, and midwives of different ranks), and lay workers employed by the local health committees (managers of the pharmaceutical depot, cleaners, guards). Equipped with official research permission and the verbal blessing of the local chief, I was introduced by a colleague from the University of Ouagadougou. I began following the daily activities of health workers, accompanied by my interpreter. I interviewed all professional health workers at the three dispensaries included in this study: thirteen nurses (eight men and five women), four midwives (all women), and two male interns who graduated as nurses during my stay. Most were interviewed twice and all formal interviews were complemented by extensive observations of their work. All interviewees belonged to the category of health professionals commonly referred to as 'frontline health workers', a term that denotes those health workers with the most continuous patient contact, as compared to the higher ranked, city-based doctors, dentists, and psychiatrists. Frontline health workers are the interface between the state-sponsored health system and the community and therefore an obvious choice for the study of how the state is made manifest to ordinary people. I refer to them as 'health workers' rather than using their specific professional categories because in my observations all of the professional staff were polyvalent: nurses perform deliveries just as much as midwives and they diagnose diseases, insert drip lines, and prescribe medicines. Where there is no doctor, nursing care cannot be separated entirely from curative practices. Thus, in the understaffed dispensaries it was not possible to uphold a professional separation of tasks.

I chose to work in and around two rural CSPSs and one semiurban dispensary in Boulgou Province in two different health districts. I selected health facilities by convenience but made sure to include facilities located in two different health districts. My aim was to study how state-sponsored health care is carried out in a rural setting, but including a dispensary located in the outskirts of Tenkodogo, the regional capital, provided a fruitful contrast in terms of organization of work and connection to the local community. Each dispensary served between six and ten thousand people. Their activities primarily included outreach, administrative activities, and clinical work. Once a month, a health worker went by motorbike to the villages in the catchment area. Upon arrival, a community health worker

organized the classic task of baby weighing. The administrative work included meetings with the local health committee, collections of reports by the community health workers, the production of performance reports, and monitoring by the district medical chief. Finally, clinical work was the activity that took up most of the staff's working time with consultations, hospitalizations, deliveries, and child immunizations, followed by the distribution of food supplements to malnourished children.

The dispensaries are hardly neutral field sites, whether to the villagers, the employees, or the ethnographer (Long, Hunter, and van der Geest 2008; van der Geest and Finkler 2004). Geographically the small compound cement buildings that constitute the dispensaries were located on the outskirts of the villages. Visually they stood out compared to the much less robust private dwellings. In rural areas with little public infrastructure except a primary school, these state-organized facilities constituted places for the emergence of wider civic values through social interactions between health workers, patients, their companions, and the particular villagers who had been elected as members of the health committees. Since colonial times, public health care has been represented as a way for the state's leaders to create a social contract with their citizens by demonstrating the power of the state to offer some level of social protection (Werbner 2002; Prince 2014; Langwick 2008). In this sense, past forms of state-provided health care became part of a project to build the nation state aimed at transferring people's loyalties from smaller kin groups to the larger political system in an attempt to turn colonial subjects into citizens with bonds to the nation state (Martinussen 1997, 171). At a rhetorical level, African governments presented public health as state-sponsored social protection; at a practical level, the ministries were centrally involved in the regulation and organization of services (Arhin-Tenkorang and Conceição 2003). State-provided health care in Burkina Faso is based on a cost-recovery principle of user fees, with only basic services for pregnant women and children under five years of age being subsidized (Belaid and Ridde 2015; Samb, Belaid, and Ridde 2013). However low the fees are, they still constitute an obstacle to health service utilization. That was easy to grasp as I witnessed the precariousness of life in this poor area of an already poor country, and it has been well documented by health-system researchers (De Allegri et al. 2011).

In designing this study, I have been inspired by the Manchester school and its situational analysis, and not least by its sensitivity to the open-endedness of the way people deal with the situations in which they find themselves (Kapferer 2005). This was useful when I followed the health workers. Unlike most villagers they spoke French, so it was possible for me to engage with them without interpreters. Our long conversations and my visits to their homes helped to build up some level of familiarity with them, allowing me to acquire insight into their situated concerns. There were variations in the ways they reacted to my presence, but most were eager to share their thoughts about their work. A few seemed annoyed by the sight of me and only cheered up when we engaged in private small talk. As John Law (1994,

4) writes, there is no point in the ethnographer pretending to be invisible because of the interaction taking place between what I observed and myself being the observer. As in classical hospital ethnography, being neither a patient nor a health professional, there was no obvious position available to me. I had to negotiate my presence there, as Gitte Wind (2008) found in her hospital ethnography experience. I placed myself behind the nurses, either just sitting or more actively by helping out, for instance during baby weighing. I used a wide range of methods, from in-depth individual interviews, document analysis, and focus-group interviews, but I acquired the 'thickest' data from interactive observations.

My analytical approach invokes discourse analysis, enactments, and repertoires. My discourse analysis is inspired by the work of Law in *Organizing* Modernity (1994). In an ethnographic study of a laboratory, he showed that, through the study of peoples' stories about their workplaces, we can identify a certain number of discourses and modes of ordering, and thereby ways of acting out human agency (Law 1994, 62). Secondly, I draw on Annemarie Mol and her notion of enactment, whereby public health care can be approached as an object of inquiry that comes into being by means of the practices through which it is handled (Mol 2002, 5). This approach makes it possible to see that public health comes in different versions, not meaning the same thing to all health workers in all situations. Thirdly, I use the concept of repertoires to order my data. Jeanette Pols has employed this notion in a study of psychiatric nursing to describe 'specific actions, ideals, and knowledge, forming "modes of ordering"' (Pols 2006, 79). I outline three repertoires for doing public health care, which are each connected to different ideas of citizenship. These repertoires were not verbalized by my interlocutors in our conversations but I discerned them by listening carefully to their tales about what motivated them to do their job beyond the paycheck or what compelled them to look beyond the immediate damage done by a work conflict. I employ this analytical lens to describe the distinct yet intertwined ways of making sense of their work and how they related to different ideas about citizenship. The health workers did not stick to just one repertoire; depending on the circumstances, they were able to shift between them. The analytical benefit of using repertoires rather than, for example, 'personality types' is that they shed light on the flexibility of health worker strategies.

Repertoire I: Public health care as practice

In this repertoire, public health care is performed to reduce the suffering of the population. It is a nonroutine activity enabled by the health worker's ability to improvise in a context of technological limitations. In this repertoire patients are cared for as individuals. Patients are perceived as fellow citizens rather than passive recipients of care. The most prominent example used was pregnant women. The health workers described these women as those who suffered the most in Burkina Faso and as the most worthy of being helped, with a right

to receive state-sponsored health care. Here, health workers can make a difference by putting to work the clinical skills they acquired at nursing school and within this repertoire health workers, more often than in the two others, recounted examples of professional pride and satisfaction.

Sambare,[2] a male nurse, offered an example of a sustained effort to make a difference. An elderly woman was found by some villagers in the bush in a state of dehydration, barely dressed. She was brought to the dispensary, where Sambare's wife washed and fed her. As she was not carrying her identity card, Sambare took her photograph, went to town to develop the photos, continued to the nearby villages by motorbike, and distributed the photos in the hope that she would be identified. After several days, a relative came to pick her up. Sambare then went to her village to pay her family a visit and saw that she was well. Asking Sambare whether the municipality's social protection service would have done the same, he answered that the municipality neglected the poorest.

Sambare was one of those few nurses who had been recruited to a region where he had ethnic affiliations. He did not describe this as an advantage – villagers' familiarity with him developed into expectations that he should treat them in their homes, and they were more suspicious of local gossip about him. This observation was corroborated by other nurses, who described the workload as 'endless' because of the population's expectations of 'one of their own'. However, this cultural and linguistic congruence between Sambare and the villagers also seemed to enable some recourse to practical solutions and mediation in cases where social conflicts and traditional practices were at work – for instance, he easily engaged in joking relationships in which people from different ethnic backgrounds interact in a ritualized way (Diallo 2006). He described this as the basis for the community's trust in themselves as professionals.

Within this repertoire, while being able to care for the patient, the biggest concern for the health workers remained their lack of ability to cure their patients. The kind of health that could be produced at the dispensaries seemed as precarious as other conditions of village life. Treatable episodes of childhood diarrhea or malaria seemed to turn into chronic conditions of malnutrition and anemia. The lack of diagnostic equipment forced health workers to improvise and tinker. This can create a sense of pride when a solution is found. Sambare showed me the maternity ward:

2   I have used pseudonyms for my interlocutors in order to protect their privacy.

> See how we are doing here! Look what state our hospital beds are in! One night when I was on night shift, I was doing three deliveries at the same time. Do you know what I did? I put on a pair of gloves and each time I turned towards another woman, I put on a new pair. And when one had finished pushing, I took off her pair of gloves and continued with the first one to do her delivery. Just like that – I was wearing three pairs of gloves!

This pride was contrasted with the frustrations that arose when damaged instruments could not be repaired or bits of equipment could not be patched together to fulfill multiple functions. On our tour Sambare stopped in a stuffed storage room and took out one of three blood pressure cuffs: 'Please take a look here. You see, none of them are working! I've tried to repair them myself several times, but it just doesn't work. . . . And it's the same thing with the electrical installations here. They're all broken'.

In these narratives, the health workers placed their own agency and their ability to change the course of events in the foreground by telling what have been called 'realization stories' (Shapin 1993, 338), narratives that underplay the contingencies of life and let light shine on the resilience of the narrator. To Steven Shapin, these stories are 'warehouses of values', and as such they provide important insights into how health workers make sense of their work, including their motivation for becoming a health worker in the first place. Two reasons predominated in health workers' narratives. One revolved around childhood experiences with the health system in which they had come to admire the omnipotent health worker and subsequently dreamt of 'wearing the uniform'. The other reason was linked to hopes of 'uplifting the nation'. Some reasons were self-interested, for example, the ability to earn a salary and provide for one's family, while others were not. All health workers commonly stressed the importance of having pledged to serve the nation, and many said the same sentence: 'That day was the most important in my life'. I had the opportunity to witness one ceremony in which nurses, midwifes, and hygiene personnel 'took the oath' in front of the governor of Boulgou Province. In these realization stories health workers linked the pledge as a source of inspiration to these improvisational practices. The pledge appeared as a moment of intensity in which the state's citizen project was voiced out loud. In the health worker ethnography, this is described as a defining moment in forming an identity as professionals (Wendland 2010). Through the action of raising one's hand and repeating the words out loud in front of the governor, the health workers-to-be were eager to identify themselves as a special kind of citizen with ties of obligation towards the nation state.

It was within this repertoire that the health workers felt the most challenged in their professional ideals during the strikes. All unionized health workers stayed away from hospitals and dispensaries for five consecutive days and nights and were therefore prevented

from providing care to patients. Younger health workers especially experienced this as a dilemma. A nurse described it as being split between solidarity with her group of colleagues and compassion for the community:

> The strike – well, that was something we were doing together. In life you have to submit to the collectivity. At the dispensary we are one, so I had to do the strike. Yet, I had to move quickly when I left my home. I couldn't bear to see the suffering, especially the febrile children. That breaks your heart. You know I'm from here, so when nobody looked, I took the children and wrapped their hot bodies into a wet piece of cloth; you know *zap-zap* [rapidly] and made a prescription. In the end, God will get to you if you don't do your work well.

Younger health workers, as well as health workers posted to a location where they had ethnic, cultural, and linguistic affiliations with the population, were more likely to practice the first repertoire. The health workers were a part of the community, but also apart from it. They lived in the village, but they rarely had kinship ties there. Their presence was transitory, and they were multiply positioned: civil servants embodying the state, health professionals with medical authority, individuals with family obligations (Poppe 2013; Olivier de Sardan 2010). They were better educated and more exposed to state institutions than the population, and also more aware of national issues as consumers of media than most villagers. Yet, the boundaries between the state and nonstate realms were fluid. For example, the local authorities offered health staff land to cultivate. This nonmedical income compensated for the fact that in rural areas there was no market for a private clinic. The health workers belonged to the local elite and were equipped with resources such as a motorbike, cell phones, and a guaranteed salary with a package of benefits covering their families. They were comparatively well resourced not only in terms of wealth but also in health: their solid bodies stood out in contrast to the thinner bodies of the villagers. As part of their medical training they had entered a community of practice (Wenger 1998) in which they learned how to act (with authority), walk (fast), and talk (with determination).

What was valued in this repertoire was a practice that is sensitive to local circumstances and the individual patient. The health workers saw themselves not only as compassionate but also as engaged citizens. Doing state-provided health care well seemed to be a way to enact citizenship as a 'health worker-citizen in the community'.

Repertoire II: Public health care as routine

Within the second repertoire, health care is a matter of delivering standardized services at the expected level of quality. It is a repetitive exercise made possible by the health workers'

ability to process patients-as-a-group in compliance with professional standards. Here, health workers value processing as many patients as possible as quickly as possible: diagnosing them, treating them, and enabling them to return to a productive life. In this repertoire of routine, the patient is defined as work and the health workers as state employees. As a corollary, the state is talked about as an entity that is supposed to facilitate health work by providing conditions, regulations, and supplies.

According to the health workers, the processing of patient cases is challenged by two factors: material limitations and what are perceived as noncompliant patients. Thus both the state and the patients are perceived as obstacles rather than as assistance. One example of material limitation is the fact that the rural dispensaries had no electricity. Thus, health workers perform night deliveries with only the help of solar lanterns. Vaccines were kept cold in a gas-powered refrigerator. Water was fetched from the nearby communal pump. Documents were stacked in piles wherever possible. Evacuations of pregnant women in obstructed labor had to be organized on a case-by-case basis, as the dispensaries did not have access to a car; such evacuations were done by motorbike. The kinds of health care services that could be delivered at these dispensaries were interventions independent of technology. The diagnostic equipment was often limited to a thermometer, a scale, and malaria test kits. At a clinic with much more technology, the diagnosis of a suspected case of malaria typically follows official guidelines and includes microscopes and the use of laboratories. At the dispensary, malaria test kits could run out, and the thermometer could be broken.

Yet, when Wendland describes 'Malawi's grim clinical situation' with reference to the state of the hospital buildings and writes that the conditions were deteriorating so severely that it was hard to recognize what went on as biomedicine (Wendland 2010, 183), this is not entirely reflective of the situation in the much worse equipped dispensaries in my study. The fact that little diagnostic equipment was available did not mean that biomedicine could not be performed; it meant, rather, that health workers had to rely on their clinical skills. If a child was brought in with a 'hot body', the nurse would place her hand on the patient's forehead. If it was hot, the child had a fever. Then the health worker would lower an eyelid: if the eye was pale, it was a signal of anemia. A prescription of antimalaria medicine would then be made out, but sometimes the treatment would be interrupted prematurely. This happened if the mother saw progress in the child's condition. Then she would save the remaining tablets for the next episode of sickness. Or if the family saw no progress, they might decide that it was time to try out traditional medicines. In either case, patients kept coming back, often in a weaker state than before, creating much frustration among the health workers over what they perceived as the mothers' sporadic and inconsistent way of dealing with suspected cases of malaria. The limited ability to cure diseases seemed to cause patients to show up only with afflictions that they have reason to believe can be treated at this level, thus creating a

situation in which the demand for services is adjusted to the supply of services. This 'supply–demand nexus' renders afflictions not related to fever, diarrhea, respiratory infections, and birthing invisible. One consequence is that patients who suffered from anything other than what could be addressed at this level, or who were too poor to make it to the health facility, became 'non-citizen patients', a term suggested by João Biehl (2001). They were invisible to the system and under the health workers' radar.

By contrast to the first repertoire, patients were described as a group rather than as individuals. Patients and their companions were frequently the target of criticism because of their 'ruralness' and habits of taking traditional medicines behind health workers' backs. Health workers ascribed the delays in patients' decisions to seek health care to cultural habits rather than to widespread poverty and to patients' confusion over the organization of services.

The citizenship of all repertoires was enacted through some kind of social relationship, resonating with Gilson's (2003) analysis of health systems as social institutions that are inherently relational. Thus, for health professionals to become health worker-citizens, the people who use public health care must act as citizens. They must come to the dispensary to enable the health workers to perform their medical duties, collaborate during consultations, and enable the publicness of the dispensaries by participating in health committees and in the corps of community health workers. Health care is performed as a basic clinical skill in quiet coordination during the consultations between patients, their companions, and health workers, who interact in a routinized set of silent procedures. The collaborative nature of these activities does not, however, imply equality in terms of power or autonomy. Health workers invest great efforts into representing themselves as state representatives and to distancing themselves from the villagers, who are discursively constructed as either 'ignorant' or as 'suffering subjects'.

Within this routine repertoire, the health workers referred to the mismatch between their initial vocation for the métier and their working conditions. This mismatch was a theme repeatedly brought up in conversations about the conflict, as they requested better working conditions under which they could carry out basic clinical work with less risk of being exposed to hazards such as infection with HIV and hepatitis. Only a few of the younger, unmarried health workers said they did not feel demotivated because of the low salary levels. For those responsible for extended families, especially women living separated from their husbands, dissatisfaction levels were high. This frustration seemed to take the form of a certain detachment towards the patients and was enacted as roughness in social relations. The level of frustration was increased by the fact that they continuously heard of donations of medical equipment being made to the government, yet they saw little of it in their dispensaries. During the sit-ins, when, upon instructions from the union, the health workers

stayed away from work in the morning hours, I sat with the midwife and the male nurse, Abdoulaye, under the canopy. We listened to the national news on a transistor radio, and Abdoulaye said:

> We hear on the radio all the time how the Danes have given billions to health in Burkina. . . . But what do we see of it? One day a big donation is announced on the radio for the CSPSs, the next day everything is the same here. We don't see the impregnated mosquito nets coming – we don't even see the training seminars. . . . I haven't been on a seminar for two years now.

Abdoulaye's 'even' represents a social critique directed at the government. It may refer to the outrage at the lack of possibilities to improve his skills or to the fact that opportunities for accessing seminars (and their allowances) were unequally distributed. It contributed to a deteriorating trust in the fairness of the government and was lived as a paradoxical contrast between the abstract presence of resources that they had heard about and the concrete absence of these same resources in their facilities. The health workers connected the miserable working conditions to national corruption and to the government's failure to care for its carers. They compared their situation to that of the uniformed services and the teachers, being envious of the first group's privileges, but also recognizing that at least health workers had better access to training seminars than teachers. In their narratives this outrage was grafted onto a diffuse feeling of being 'out of the loop', of not being where you can access resources: '*là où on mange*' (where you can eat). Abdoulaye's reaction echoes the African idioms of eating and being eaten as a way of referring to government corruption (Bayart 1989). The confusion about how material and nonmaterial resources were being circulated, combined with growing frustrations about poor levels of protection from workplace hazards, fueled the health workers' participation in the conflict. Gilson argues that trust in the legitimacy of state action is central to cooperation between health care providers and their employers (Gilson 2003, 1463). Following this line of thought, we can see that the perceived lack of transparency in the way the state-organized health system was regulated, managed, and funded eroded the health workers' sense of being valued as citizens by the government.

In this repertoire, health-worker citizenship is enacted as a 'citizenship of quality work'. Whereas the topic of concern in the practice repertoire was the limited ability to produce health, in the routine repertoire health workers were concerned about their limited ability to reproduce an adequate standard of nursing care. By directing their requests to the government to establish, as a basic right, a health care system that treated health care users and providers decently, they placed their pleas in a citizenship framework.

Repertoire III: Public health care as bureaucracy

The doing of public health care was also a matter of bureaucratic paperwork. Health workers must document prioritized interventions in monthly performance reports and weekly epidemiology updates. In this repertoire, public health care was an activity that required health workers to craft data for the state bureaucracy. This repertoire is more complicated than the two others in the sense that it is not as straightforwardly about nursing care but rather about the production of counts and reports required by the state. These measure the extent to which the dispensary has reached the target of 'expected number of deliveries' against 'actual number of deliveries' in the 'catchment area'. At first glance, this activity seems to not make things better for either the health workers themselves or their patients. Yet bureaucratic practices establish the preconditions for the other repertoires, as documentation and data are exchanged for the right amount of medicines, access to training for health workers, and protective equipment such as gloves.

One set of data was produced by counting the cases that have been processed within different categories: babies delivered, vaccines administered, and contraceptives prescribed. What was essential was the ability of the health worker to catch and count the cases correctly. Another set of data was produced during consultations in which health workers scribbled down patient data, probable diagnoses, and prescriptions in a logbook. What was critical here was the presence of either a diagnosis or a referral to a higher-level facility. Combined, these activities take up 'a lot of time', as the nurses said. Each quarter, the district supervisors received the reports when they inspected the dispensaries, during which the extent to which the health workers had reached the targets was checked. To the health workers this feedback mechanism was perceived as proof of their being connected to the state system, but they had mixed feelings about which qualities of their citizenship were being valued by their superiors. On the one hand, health workers emphasized this as one of the rare moments when they had a chance to be given direct recognition by the system (either as verbal encouragement or in the form of an official letter). On the other hand, many longed for the kind of supervision in which they could discuss the quality of their work and be motivated to do better. At the policy level, accountability in the Burkinabé health system was framed as 'results based' and therefore depended on results being made visible. At the level of practice, health workers perceived accountability as involving a relationship between the health workers and the district supervisors that was mediated by the reports, rather than a relationship between the staff and the village health committee.

Within the bureaucracy repertoire, the concern was to produce enough of the right kind of data, as discussed in Ramah McKay's study (2012) of how documentary practices in a NGO-supported clinic in Mozambique served to manage the multiplicity of medical authority. Producing such data required cooperative patients. Thus, the patients who were valued were

those who played their part, who showed up without delays, who were diagnosable, and who brought their health booklets with them. Nurses inspected the health booklet at baby weighings: if the child's gain was insufficient, a porridge supplement was handed over. This was counted as an intervention, but one with few chances of addressing the root causes of the malnutrition that was afflicting the child. In a study of AIDS care in South Africa, Reynolds (2015) argues that the process of being counted implied recognition for project participants, and that filling out forms seemed to be the only service provided. These documentary practices, which were enabled by the circulation of counting technologies (forms to be filled out, handed over, and then entered into computerized systems, which were identical to those I observed in Burkina Faso) constituted a meaningful service, as they created a space of civic engagement between AIDS workers and the people being counted.

The production of data was part of state-sponsored health care that contributed to 'crafting the state' and maintaining the state apparatus. Statistics and numbers figure predominantly in the way the dispensary presented itself visually: one of the first things to catch the eye in the waiting area were posters displaying performance achievements. They were placed next to official-looking documents displaying the government seal and not far away from a portrait of the president. This gave the dispensary an appearance of statehood, through which it came to stand for the state through 'banal techniques of representation' (Sharma and Gupta 2006). Through standardized data, it became possible to create a grid of demographic surveillance data for monitoring purposes, which is well established as central to the state's citizenship project (Scott 1998). During the strikes no data were produced. One of the interns noted that no audit was made of the deaths that had occurred as a consequence of the health facilities being closed, which he interpreted as a way for the government to avoid having to account for the costs of the conflict in terms of lives lost.

Within this repertoire, the health workers valued their opportunity to enact a state relationship (Street 2012). Health workers became accountants, and patients were perceived as standardized units. Thus, the patient that suited was one whose affliction could be classified according to the standard list of diagnoses. Within this repertoire, the rural health workers performed their citizenship as 'interface bureaucrats'.

Discussion

The context of this article is the fragility of state-provided health care in one locality of Burkina Faso, as exemplified by a national conflict. Even though collective action in the public sector was not unknown in Burkina Faso (the higher education sector has been torn by strikes for years), the health workers were not just any professional group on strike, but civil servants who had pledged to serve the population in its suffering. The absence of one

of the few public institutions that is present even in remote areas was followed by a debate at all levels of society about whether this collective action had been justified. I argue that a kind of occupational citizenship was consolidated within the bounded group of rural health workers throughout this conflict. The practice repertoire represents the ideal that most health workers wish to retain. The routine repertoire has become the source of daily frustration because health workers are unable to live up to a minimum professional standard of care, while they perceive the bureaucracy repertoire as a way of creating value for the state rather than for their patients.

The conflict was challenging with respect to all three repertoires, but in particular to the practice and routine repertoires. It was the younger health workers who experienced the strike as a dilemma because the suspension of health services contributed to suffering in communities. Refusing to provide health care to those in need is close to opposing the most fundamental moral values of public health care. Thus, involvement in the conflict became difficult when they saw the face of the suffering patients, but it was also difficult in relation to the distant government, as they owed their social positions, employment stability, and financial benefits to the state. Despite dissatisfaction with their salaries, none of the interviewed health workers aspired to work in the private sector (because the income is not guaranteed), and no one mentioned the possibility of migration to Europe (only those with family in West Africa left for short-term assignments in neighboring countries).

The work stoppages were permeated by ideas related to citizenship projects at two levels. First, the health workers' union emphasized in its claims to the government that the commitment of frontline health workers to improving the health of their communities was being undermined by the lack of the essential tools and resources to do so. In their narratives, the health professionals often referred to '*le manque de moyens*' (lack of means) to describe how material shortages were hindering them in realizing their duties as health worker-citizens. Not only was it impossible for them to enact their duties as public health workers, it also violated their fellow citizens' rights to basic care of a minimum standard. Secondly, frustration at their exposure to work-related risks, combined with financial dissatisfaction, fueled a growing perception that the government was neglecting its responsibilities towards its employees. The conflict fleshed out already existing conflicts between the state and its civil servants. In their pleas for a reallocation of resources in favor of the public sector, the health workers (via their union) appealed to the government to set a framework for a joint project of citizenship. In one interpretation, their collective action confirmed the centrality of the state as responsible for a basic level of quality in the public health care sector. The health workers arguably contributed to the crisis in the health system in Burkina Faso, but, in the words of Tousignant, they addressed the state in their capacity as 'concerned citizens, on behalf of a vulnerable public, and as responsible citizens who are entitled to state protection' (Tousignant 2014, 111), thereby also indirectly reaffirming the

state's role as a regulator. In contrast to the HIV-positive individuals in Nguyen's research in Burkina Faso (2010), the health workers in this study could not turn towards international institutions in their quest for protection. They had to look towards the state as the only large, relatively stable institution that could regulate the health sector.

My aim here has been to explore how the citizenship ideas of health workers were mobilized in a situation of crisis and change. Olivier de Sardan (2010) has urged social anthropology to engage more intensely with the study of public spaces in Africa, and this includes public health centers. I suggest that we pay closer attention to the complex social processes through which rural health workers engage in their daily work. Being a civil servant is grafted upon individual hopes for a better future, collective ideals about citizenship, and ideas about how these should be realized. In these we find registers of values related to state-provided health care, but also problems that health workers live with as messy paradoxes.

This is an intellectual debate in its own right, but in light of the Ebola outbreak in West Africa, frontline health workers' key role in the delivery of health services has been fully demonstrated. The epidemic represented a condensation of the existing fragility of health systems, but with particular effects on the level of trust between health workers, the state, and the population at large (American Anthropological Association 2014; Yates 2015). Media coverage of the epidemic included reports about state-employed nurses who went on strike and deserted their duty stations (Mark 2014), but also stories of those who carried on regardless of their own exposure to infection (Linshi 2014). The extent to which health workers feel connected to and protected by the government is critical to the planning, delivery, and sustaining of health care in Africa (Sidibé and Campbell 2015). One implication for state-provided health care in the context of occupational citizenship is that African governments need to be attentive to the social contract between health workers and the state to avoid further eroding the basis of trust between them. I suggest that we approach ideas about citizenship as both a category of practice and a category of analysis (Cooper 2005). By turning our empirical lantern towards the citizen projects of health workers, we can expand the existing literature on citizenship and clientship. Occupational citizenship should be considered a heuristic device that may help us better understand the particular perspectives of health workers. It makes possible critical thinking about the (technological) conditions, (practical) norms, and (relational) competencies inherent in being a state-employed health professional in a context of limitations. It contributes to the existing body of literature on health and citizenship and will thus be useful for anthropological studies of health systems that include both patient and provider perspectives.

About the author

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