

Role Conflict and Quest of Legitimacy in A Cameroonian HIV/AIDS Oriented Institution

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ABSTRACT: *New structures, professions and actors are regularly created to help in the fight against HIV/AIDS in Africa. These structures and actors are graft to the existing ones, evolving and working together, in parallel, overlapping, with sometimes conflicting relations. This text will try to examine this coexistence taking the case of a "Centre de Prévention et de Dépistage Volontaire du VIH/sida" (CPDV)1. The data were collected during the first fieldwork phase of a postdoctoral research on "burnout and its impact on the caring of people with HIV/AIDS in Cameroon" (ANRS 12144). We want to show how gradually, actors in charge of precise functions, with a contract of limited duration, find chinks in which they slip, creating a place for their selves while "excluding" the statutory nurses. We which to show that this presence of personnel with various qualifications, functions, status, salaries and advantages, creates frustration, raises questions related to legitimacy and positioning within the existing hierarchies.*

Key Words: Actors, role conflict, legitimacy, HIV/AIDS, Cameroon

INTRODUCTION

The fight against HIV/AIDS begins in Cameroon whereas the country was entering a period of economic crisis with severe consequences on the health system (Eboko, 1999i; Aerts & Al, 2000ii). It was also the first years of the Bamako Initiative which one goal amongst others was to set up autonomous health systems (Gruénais, 2001) iii. Twenty years after, the structures promoted by the reform are not really operational or do not exist. With the multiplication of health problems, epidemics, pandemics, many new structures, roles and actors have been created, working with or existing within the old ones. Marc-Eric Gruénais (1999)iv raised the impact this could have on the management of these programs and the health system in general (Gruénais, Idem). But in spite of the importance of this question, this coexistence of actors in a project/public service dichotomy, particularly in connection with the fight against HIV/AIDS has not yet been examined. The paper will help in filling-up this gap. We want to show that this coexistence of personnel, with different

status, qualifications, various functions, unequal/"unjust" salaries or advantages, paid or not, within a dysfunctional health system (Vidal, 2005; Jaffré & Sardan, 2001), creates frustration, raises problems of legitimacy and position within the existing hierarchies.

The data were collected during the first fieldwork phase of a postdoctoral grant entitle: burnout and its impact on the caring of people with HIV/AIDS in Cameroon (ANRS 12144). The data were collected in the West and Far-North Provinces of Cameroon in July and August 2005 and from December 2006 to March 2007 in the Far-North and the North of Cameroun. We carried out (6 to 8 hours per day) observations in the services in charge of people with HIV/AIDS of the biggest public hospitals of these regions. In-depth interviews were conducted with health personnel and actors of the Cameroonian's national program against HIV/AIDS. These interviews were recorded and transcribed. The material was then analysed using key-words which emerged from formal and informal interviews, discussions, observations. The data used in this text are related to one of the three sitesv.

The text in three parts presents in its first part the structures of the health system and the Cameroon's national program against HIV/AIDS. The second part shows how the absence of precise definitions of roles and functions, give place to chinks in which actors in charge of precise functions, with a limited duration contract, could slip, "find their way" and a place in the system. The third part is about frustration and quest of legitimacy which occurs when new professional categories are introduced to perform tasks devoted to others, while new tasks are not assigned.

I- The health system and HIV/AIDS structures

1- The health system

The Cameroonian health system is organized in three sectors: public, private and traditional. The public sector includes all the public health structures administered by the ministry of public health. This public sector which is the focus of our study is organized in three levels: central, intermediate and peripheral. Each level has its administrative, health and community structures. The central level works out the policies, coordinates, control and distributes resources. The intermediate level represented by ten public health provincial delegations, translates into programs the policy worked out at the central level. The health district, at the periphery, is the operational structure of the system. Each of the three levels has its health structures: national reference hospitals for the central level, provincial hospitals for the intermediate level, district hospitals and health centres at the periphery.

2- The HIV/AIDS program

A national program against HIV/AIDS exists since 1987 (Eboko, 1999). His "Comité National de Lutte contre le Sida" (CNLS)¹ is in

1 National committee against HIV/AIDS

charge of the development and implementation of the national policy, the mobilization of resources. The "Groupe Technique Central" (GTC)² is its executive board. The activities defined by the CNLS and coordinated on the whole territory by the "Groupe Technique Central" are managed at the intermediate level by the "Groupe Technique Provincial" (GTP)³ and at the peripheral level by the "Comité Local de Lutte Contre le Sida" (CLLS)⁴. The following-up of people with HIV/AIDS (PWA) is organized in "Centre de Traitement Agréé" (CTA)⁵, (generally attached to provincial hospitals), where "médecins prescripteurs"⁶ use to meet in a "comité thérapeutique"⁷. This "comité thérapeutique" is in charge of defining the appropriate ART combination for each patient. Also attached to the provincial hospitals are "Centre de Prévention et de Dépistage Volontaire du Sida" (CPDV), which are the focus of this paper.

CPDV were created to encourage voluntary testing; in addition, they ensure the counselling's and sometimes ART dispensation. One is generally sent to the CPDV by a doctor, for a HIV test after a consultation for another disease. But people are coming more and more because they want to "know", "to be sure" of their serology. Their first contact in the structure will be with the "welcome team". The team will register the patient or candidate to the test and send him to the pre-test counselling, then to the lab for the blood sample. The results are delivered few hours later after a post-test counselling. The positive patients are directed to the prescriber of the test or the chief consultant of the CTA.

II- slipping in the chinks

2 Central Technical Group

3 Provincial Technical Group

4 Local committee against HIV/AIDS

5 Treatment centre

6 Doctors formed to the prescription of ART

7 Therapeutic committee

G. was until recently the chief of the CPDV “welcome team”. His professional career began with a position as chief of personnel in a department of the ministry of forestry. He has a “very good salary” as he said, but was not “fonctionnaire”, civil servant. That the reason why he chose to apply when the State decided to recruit, through an internal examination, some contractual agents working in the public services. He succeeded and chose to work in the health sector. He was instructed in lab techniques and sent to the provincial hospital direction, then to the CPDV. He cumulates the two positions because of his connections with some “big men” at the central level. His office is the biggest of the CPDV.

As we mentioned, he was until recently the chief of the “welcome team”, in charge of the management of statistics report and the organization of the “comité thérapeutique” meetings to which he attended to make sure all was going well. Then a secretary and two PWHA were recruited to reinforce the “welcome team” and help in ART dispensation. One did not tell him which were his new functions or attributions in the CPDV. The secretary “chose” to work on statistics and the organization of the “comité thérapeutique” meetings while G. Turned to his position at the hospital direction. He worked there every morning and spent the rest of the day in the CPDV, where he regularly invites his colleagues in his big office for a tea time.

Mrs. S is now doing the resting part of the job originally devoted to G. She is HIV positive. She was recruited by the “Réseau Camerounais des Associations de Personnes vivant avec le VIH/Sida” (RECAP+)⁸ as “chargé de l’observance”. She uses to work with the ART dispenser, giving treatment and nutritional advices to help patients comply with their treatment. The contract which was for six months came to its end since more

than one year. But she is still working in the service. She is neither paid by the RECAP+, nor by the Cameroonian public service and she has already been replaced as “chargé de l’observance” by another PWHA, still recruited by the RECAP+. When one asks why she does not leave, she answers as follow: “I am still here because of the patients. When you get attached to them, sometimes, somebody will tell you: hey, this patient asks for you! And that’s touches you very much and you do not want to live”. Being present in the CPDV, even if one is not paid, has advantages. One get connected with health personnel, other PWHA, members of associations, international organizations and NGOs officers, and as information circulate in this network, one can have access to some specific advantages (drugs, financial or food aid), not mention the racket of the patients and their family members which as some nurses say, justifies Mrs S. presence in the service.

III- Quest of legitimacy and frustration

ARC in quest of legitimacy and place in the CPDV hierarchy

Till recently, the caring of PWHA was especially clinical. But since about one year, a new category of professional has been created to ensure the psychosocial aspects of this caring: the “agents de relais communautaire” (ARCs). Recruited by the GTP, they intervene in the CPDV where they administered counselling, follow-up patients at their home to ensure that they really take their medication, have enough food and do not suffer from any symptoms or disease. If necessary, they will lead them to a health centre, require a food support, inform the attending practitioner, etc. The recruitment of ARCs for the CTA is done on candidatures deposited by PWHA associations or associations fighting against HIV/AIDS. The recruited ones organize to assure a daily presence of their members in the structure. In the CPDV we are talking about, the ARCs do not have any precise qualifications. They were

⁸ Cameroonian network of associations of people with HIV/AIDS

trained during five days on the various activities which they would have to carry on. They have a monthly wages of 65.000FCFA (100 Euros) which is not regularly paid.

Formed to be part of the health professions, the status and functions of the ARCs are however criticised by the rest of the personnel, principally nurses who says “they are paid and do not do almost anything” or “they are receiving wages for “nurses activities”. One could have asked the nurses to do this work with a small increase in the salary”. We should note that nurses do not attend the “comité thérapeutique” meetings were they are not invited whereas the ARCs do attend these meetings. They thus do not have any decision power on all that’s relates to the caring of PWHA and they estimate that in terms of relations with the national program against HIV/AIDS and it’s structure, ARCs are in a much better position. This position can give them, when seminars, trainings, or any other activities are organised, the possibility of gaining per-diems which in a context of low salaries are highly valued (Hane, 2007)vii. These contribute to a sort of “status insecurity”. Whereas the supremacy of the doctors is not doubted, nurses and ARCs are involve in a subtle struggle to confirm their hierarchical position immediately after the doctor (nurses) and to prove their legitimacy and find their place in the hierarchy (ARCs). The nurses will “use” ARCs insufficiencies and prove by their implication in the functions which are especially devoted to them (counsellings) ways to show that they can do with more efficiency the tasks for which unlike some of them, the ARC were trained to perform. They will “educate” them and “form” them to “good practices” in counselling; they will conform to works hours (7h30-14h30): only nurses will be present by 8 o’clock and after 1h30 PM. They will criticize them in front of patients as doctors do with nurses. In reaction to this, ARCs will use the “waste lands” of the system to prove their legitimacy and utility. That’s how they came to decide of which patients

will have a free access to treatment (Tantchou, 2007)viii.

It is important to note that before the creation of this new professional category, many nurses and nursing assistants were formed to counselling and send to the CPDV. Today, some of them as M. are in search of a new place in the system.

A frustrated actor

Before the intervention of ARC, M. was with one colleague in charge of the counselling. “We all were trained for it, he said, but there is no place for me any more, I do not have anything anymore to do. From time to time, I still intervene; they call me for “special cases”, the “hard people” (those difficult to convince or who reject their result). Because he do have nothing to do anymore, no office or place in an office, he usually sits on the veranda or in the court of the CPDV, discussing with researchers, colleagues or patients waiting to see the doctor, their blood sample or exams files.

“Excluded”, M. looks at the situation and position of his “colleagues” in the service: “look at those women, they are not paid, but they still come here. You know why? If they find a way to have money from a patient or his family, they will not hesitate. They are taking our place and we cannot protest”. He looks at the position of colleagues of his age and qualification: “look at them, we have the same age, the same qualification, they are head of service, but no one wants to give any responsibility to me!” And he criticized the whole “system”: “see, my salary has not changed since 12 years. I’m not a child of minister. Nobody knows me at the public health ministry. My files to advance in grade are still waiting in an office there because I have no money, no relations. Like one says, if you have money, or if you are a child of minister, you can do everything you want, you can have what you like. ” Finally, M. wants to “go and see elsewhere”: “I want to leave the

CPDV, I have send letters in other departments saying that if ever a place is released, that one thinks of me.”

Conclusion

The HIV/AIDS pandemic is giving place to the creation of several types of structures and functions. These new structures and functions are grafted to the existing ones in health system with tasks, functions not clearly defined. We wanted to show that

This context facilitates the “incrustation” of non statutory actors and the “exclusion” of the statutory ones.

The presence of personnel paid or not, with various qualifications, functions, status, remuneration and advantages, creates frustration and raises problems of legitimacy and position within the existing hierarchies.

If the implementation of health programs sometimes requires new types of structures, actors and professional categories, it is important to redefine roles and build clearly defined task-shifting procedures so that each actor could still find a place in the whole system.

Notes

i Eboko, F., 1999, Logiques et contradictions internationales dans le champ du sida au Cameroun, in Fay, C., *Le Sida des autres: constructions locales et internationales de la maladie*, *Autrepart*, (12): 123-140.

ii Aerts, J.J. & al., 2000, *L'économie camerounaise. Un espoir évanoui*, Paris, Karthala. Collection Les Afriques, 287P.

iii Gruénais, ME., (Ed.), 2001, “Un système de santé en mutation : le cas du Cameroun”, *APAD bulletin*, N°21.

iv Gruénais, M.-E., 1999, Les dispositifs de lutte contre le sida à l'heure d'ONUSIDA et de la démocratisation, C. Becker, J.-P.

Dozon, C. Obbo and M. Touré (Eds), *Vivre et penser le sida en Afrique*, Paris, Dakar, Karthala/Codesria/IRD, 455-471.

v We choose not to give the name of localities or people.

vi See quotation in page 7, third paragraph.

vii Hane, F. 2007, *Emergence de la fonction soignante. Reconfigurations professionnelles et politiques publiques autour de la prise en charge de la tuberculose au Sénégal*. Thèse pour l'obtention du grade de Docteur en Anthropologie Sociale, Marseille, EHESS, 372P.

viii Tanchou, J., 2007, Nouveaux métiers dans la lutte contre le sida: croisement, chevauchement, revendication d'utilité au sein des structures existantes. Atelier d'Amiens, “ACI : normes, pratiques et régulations des politiques publiques”, Amiens, 14 et 15 mai 2007. The first line treatment are now given free of charge to patients. The cost were 3500FCFA (about 5 €), and 7000FCFA (about 11€) for the second line in march 2007.