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Balancing professional autonomy and authority at the margins of a fragile state: Front-line health workers' experiences in Burkina Faso

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ABSTRACT

The availability of diagnostic equipment, medical products and basic infrastructure is limited in most low-income societies. Poor motivation among health workers as well as recruitment and retention problems are key factors contributing to poor health care services in developing countries. The current paper describes how the front line cope with these difficult working conditions. Data for this study come from anthropological fieldwork in two districts of Burkina Faso and include a total of 27 unstructured and 40 semi-structured interviews with staff at dispensaries and medical centres in the two districts. Analytically, we make a distinction between their professional autonomy and their professional authority. We find that while the health workers experience a certain degree of professional autonomy, in the sense that they rely on their own clinical judgement and their discretion as decision makers and gatekeepers, their professional authority is constantly challenged when working at the margins of the state. Through improvisations and bricolaging, they compensate for the many shortcomings, but many of them feel that their skills are waning and that their professional identity threatened. Thus, massive strengthening of the front-line health worker's capacity is imperative for future improvement of health care services in Burkina Faso.

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Introduction

Health professionals in low-income societies and fragile states face huge challenges due to shortage of equipment and essential drugs. Yet, they nevertheless have to take important decisions about care, treatment and referrals of patients every day. In this article, we explore how front-line health workers compensate for the many shortcomings they face and how the difficult working conditions affect their professional identity.

Shortage of equipment and essential drugs are well documented as major challenges to health care services in low-income countries (Mkoka et al., 2014, 2015; Østergaard, 2016; Thu et al., 2015). Likewise, numerous studies have pointed at poor motivation and problems with recruitment and retention of health workers as key factors contributing to weak health services in developing countries (Bangdiwala et al., 2010; Bocoum et al., 2014; Kouanda et al., 2014; Lehmann et al., 2008; Naicker

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et al., 2009; O'Brien & Gostin, 2011; WHO, 2010; Willis-Shattuck et al., 2008). Furthermore, studies have documented how insufficient and unstable infrastructure, such as lack of continuous electricity and running water, as well as inadequate number of ambulances and other means of transport for referral and outreach activities, further exacerbate the working conditions at rural front-line facilities (Dieleman et al., 2006, 2009; Prytherch et al., 2012). Burkina Faso is one of the poorest countries in the world, and around 46% of the population lives below the poverty line (Zeilig, 2017). With a large rural population and a weak economy with a narrow export base (gold and cotton), it is not surprising that the health care system of Burkina Faso faces enormous challenges. Furthermore, violent and spectacular attacks by various jihadist groups such as AQIM (Al-Qaeda in the Islamic Magreb) and Ansaroul Islam challenge the fundamental security and stability of the country (Hagberg et al., 2019). Parallel to the escalating insecurity caused by terrorist attacks, organised crime has also increased over the last few years. In addition, recent political turmoil has further weakened the government. Blaise Compaoré, who had been the president for 27 years, had to resign in 2014 after a popular uprising; after a short military coup, elections were held in November 2015 (Kaboré, 2016). However, the new elected government with Marc Roch Kaboré as president has not managed to stabilise the country (Hagberg, 2018, 2019; XX, 2020). The government of Burkina Faso has, though, over the last couple of decades, prioritised an increase in the number of dispensaries, in order to bring health care closer to the population and to improve the quality of care at the periphery (Meunier, 2000; Ministère de la Santé, 2011). Yet, health professionals at this level continue to face huge challenges in living up to the official and professional standards and norms they were taught during their professional training, given the working conditions: insufficient diagnostic and treatment equipment and unstable supply of medicines as well as poor basic infrastructure. In this paper, we want to explore the ambiguous role of front-line health care professionals in Burkina Faso by taking point of departure in their own perspectives. We first analyse how they perceive their roles as government employees in a context of shortage of equipment, medicine and personnel. Secondly, we analyse how they see and manage their relationship to the citizens they are employed to serve. We want to explore how they navigate this context of limitations and to discuss how the difficult working conditions challenge their professional identity (Gilson et al., 2005; Kiguli et al., 2009; Østergaard, 2016; Samuelsen et al., 2013).

In our examination of the ambiguous role of public health workers in Burkina Faso, we draw on Herdt and Olivier de Sardan's analysis of African bureaucracies (Herdt & Olivier de Sardan, 2015). We find their emphasis on African bureaucrats as 'individuals (who) are neither rational nor blind norm-followers, but both, and much more' (Herdt & Olivier de Sardan, 2015, p. 96) of particular relevance for our analysis of district health workers in Burkina Faso. We also draw on Lipsky's analysis of *street-level bureaucracies*. Lipsky characterises street-level bureaucracies in the following way: 'These are the schools, police and welfare departments, lower courts, legal service offices, and other agencies whose workers interact with and have the discretion over the dispensation of benefits or the allocation of public sanctions' (Lipsky, 2010, p. xi). Lipsky's original study of street-level bureaucracies was conducted in the US, but his main points are very relevant also in an African context. Lipsky argues that street-level bureaucrats often exercise discretion in their interactions with citizens and that often they cannot perform according to the highest standards – or as expressed by Olivier de Sardan, according to the *official and professional norms* (Olivier de Sardan, 2015). This is particularly the case for the health care workers in Burkina Faso, where shortages of equipment and infrastructure are part of their everyday working life. We here use the notion of *front-line health workers* to characterise our interlocutors as they all work at district level interacting directly with the local citizens and they have some degree of discretionary power in relation to their patients.

On a more theoretical level, we want to discuss how front-line health workers employed at the margins of a fragile state creatively use and negotiate technologies of power in their efforts to balance their roles in the 'street-level bureaucracy' when mediating between the state and the citizens (Das et al., 2004; Poppe, 2013). We are interested in contributing to the analysis of what Olivier de Sardan has called the 'problem of the gap', which he defines as 'the divergence between norms and practice,

between what we are supposed to do and what we actually do' (Olivier de Sardan, 2015, p. 20). We explore this 'gap' by taking point of departure in the health professional's own perspectives and formulations about the official norms and their actual practices. Drawing on Grimen's reflections on the role of power in modern health care systems (Grimen, 2009), we want to make a distinction here between professional *autonomy* and professional *authority*. Control over the technical aspects of work is a core element of professional autonomy and includes considerable space for discretion and judgment. According to Grimen, professional autonomy 'leads to a massive use of discretion and clinical judgement, which are difficult to make accountable' (Grimen, 2009, p. 18). The professional authority of the health workers is based on their formal education and their legitimate position within the governmental hierarchies. While institutions themselves cannot have minds of their own, as pointed out by Mary Douglas (1986), their functioning depends both on a recognised legitimacy and the collective actions of authority, as well as specific cognitive acts. Public institutions, like the health care system, depend on participation and recognition and public servants are part of a collective network of governance. This also applies to the front-line health workers in Burkina Faso, whose professional authority depends on recognition from their employer, the government, as well as from the communities they serve. Thus, professional authority relies both on trust from patients, and continuous recognition from colleagues and superiors within the government system.

Background

The public health care system in Burkina Faso is organised hierarchically in three levels: central, regional and district level. Prevention strategies and national guidelines for disease treatment are implemented at district level, specifically at the dispensaries called *Centre de santé et de promotion social* (CSPS) and district hospitals. A dispensary (CSPS) covers a population of approximately 7000–12,000 inhabitants, with variations across the country (Ministère de la Santé, 2015). Each dispensary is headed by a nurse *Infirmier Chef de Poste* (ICP) or chief nurse. In addition to the chief nurse, there is also an assistant-midwife or *matronne* and an assistant-nurse or *agent itinérant de santé*, as well as a community representative in charge of the medical depot. More than one nurse may be employed at some of the larger dispensaries. The head of the dispensary is responsible for reporting to and communicating with the chief medical officer at the district level. The equipment at these facilities is limited to tools required for elementary examinations, such as thermometers, scales, consultation and delivery tables, delivery kits, neonatal resuscitation kits, decontamination containers, bandage boxes and some rapid diagnostic tools for malaria and pregnancy (Ministère de la Santé, 2004). In reality, some of these technologies may often be absent in disrepair at the rural health facilities. The district hospital (CMA) is staffed with physicians, assistant-doctors, or *attachés de santé*,¹ midwives and nurses, as well as laboratory technicians and staff responsible for the hospital pharmacy. When there is no medical doctor available, the assistant-doctor is in charge, and this is also the case when there is a shortage of specialist doctors. Compared to the dispensaries, the district hospitals have more advanced facilities and equipment, with several buildings for consultations and hospitalisation, laboratories and a surgical department – as well as specialists in epidemiology, odontology, ophthalmology, gynecology and mental health. Most of these specialists are trained as assistant-doctors. However, shortage of functioning equipment is also a common phenomenon at the district hospitals. The *Centre Medical* (CM) is basically equipped like the dispensary, but includes a medical doctor and sometimes a midwife and a laboratory technician if there is a laboratory. Referral of a serious case is, however, usually done from the dispensary directly to the district hospital, as the facilities there are more advanced than those at the Medical Centre. However, the expectation is that the dispensary refers patients to the Medical Centre if there a doctor is required, without the need for 'advanced' equipment (Ministère de la Santé, 2011, 2012, 2015). In addition to the health workers, the district staff includes a number of administrative personnel (secretaries, drivers and financial and administrative managers). In Burkina Faso, it is generally considered an advantage to be employed in the public sector, compared to the private sector. It is a

more secure position and perhaps most importantly, being a civil servant includes a pension system, which means that it is possible to continue to sustain one's family even after retiring (Prytherch et al., 2013). The health sector in Burkina Faso is largely financed by external aid and the health policy is therefore heavily influenced by international institutions, international donors and Non-Governmental Organizations (Gautier & Ridde, 2017).

Study setting and research methodology

This study was conducted in two health districts of Burkina Faso: Dandé health district located in a rural area about 60 km from Bobo Dioulasso (the second biggest city of Burkina Faso) and Tenkodogo health district, an urban district located 170 km south-east of the capital, Ouagadougou. Both study sites were included in a larger collaborative research project, 'Fragile Futures: Rural Lives in Times of Conflict', an anthropological project focusing on citizens' relationship to public services in the domains of health, water and administration.² The selected study sites are located in different parts of the country with different socio-economic and ethnic profiles.

A total of two district hospitals and six dispensaries were selected, based on their geographical location: urban, peri-urban and rural. Two of the selected dispensaries belong to Dandé district, and four to Tenkodogo district.

Fieldwork for this study was conducted during 2015 and 2016, starting with a series of unstructured interviews with health staff at the district hospitals and dispensaries (the district medical chief, nurses, midwives and assistant midwives) focusing on their personal careers and their perceptions of constraints, challenges and opportunities. Based on a preliminary analysis of these conversations, a semi-structured interview guide was developed, including questions regarding the daily duties associated with the various positions and their perceptions of their working conditions and their specific tasks within the health care system. Semi-structured interviews were then conducted with physicians, assistant-doctors, nurses, assistant-nurses, midwives and laboratory technicians. In some cases, the same person was interviewed twice, first as part of the preliminary set of interviews and then as part of the series of semi-structured interviews. A total of 27 unstructured and 40 semi-structured interviews were conducted in the two districts (see Table 1). All interviews were conducted in French, by the first author and a research assistant. Each interview took between 1 and 1½ hours. Informed consent from each of the interviewees as well as the regional health administration was obtained before data collection, ensuring confidentiality and anonymity. We took notes during the informal conversations, and the semi-structured interviews were recorded,

Table 1. Categories of interviewees (Total number of interviews: 67).

Profession	Dandé district		Tenkodogo district			TOTAL
	District Hospital (CMA)	Dispensary (CSPS)	District Hospital (CMA)	Dispensary (CSPS)	Regional Hospital	
Unstructured interviews						
Physicians	3		3			6
Assistant Doctors	4					4
Nurses	2	3	3	4		12
Midwives	1		1	1		3
Assistant midwives		2				2
Total	10	5	7	5		27
Structured interviews						
Physicians	3	–	5	–	2	10
Assistant Doctors	3	–	1	–	2	6
Nurses	2	3	3	5		13
Midwives	2	1	2	1		6
Assistant midwives			–	5		5
TOTAL	10	4	11	11	4	40

transcribed and analysed thematically. First, we analysed the informal conversations and the semi-structured interviews by district looking for main themes. Secondly, we compared the site-specific data to identify similarities and differences between the two districts. We found a high degree of similarity between data collected at the two research sites. The three analytical key themes came out of this analysis: health workers' perceptions of their position as health professionals at district levels, working conditions and availability of medical equipment, and strategies for dealing with difficult working conditions. The data analysis was done jointly by the two authors.

Ethical clearance

The project received ethical approval from the Ethical Committee at Centre Muraz under the Ministry of Health, General Secretariat, no. 18-2013/CE-CM.

Findings

Front-line health workers: Representatives of the state

All the professional staff interviewed in this study express a very clear and distinct sense of devotion to the health care profession. In each of the interviews, we asked about their individual professional trajectory, and why they had chosen to become health professionals. 'It is a noble profession', 'I always loved the nursing profession', 'I always wanted to treat and heal people', 'You tell yourself that in this sector, it is really a privilege to be able to help people. You are also admired in the society', 'It was science that attracted me ... and then the love for care, you envied the people with white shirts and the myth that characterizes the profession' – these are some of the typical answers given. They all express affection for their profession as Wendland also found in her study of medical students in Malawi (Wendland, 2010). The majority of the health workers at the district level take their role as the local representative of the state very seriously and they feel privileged to be part of the state apparatus. In the words of a chief nurse at a dispensary in Tenkodogo district,

I can say that in this village, I represent the Ministry of Health. Everything concerning health passes through here. We are the eyes and the ears of the Ministry, on the ground. I consider myself a representative of the Ministry here. I can even say, a representative of the Prime Minister.

The following excerpt from an interview with a midwife at a dispensary in Tenkodogo illustrates the ambiguities of being both a representative of the state and to serve the local population:

- Interviewer: *Do you see yourself as a representative of the state working for the Ministry of Health?*
 Midwife: *Yes, I can say that I am a representative of the Ministry, because I work in a state service. As a midwife, I represent the Ministry of Health.'*
- Interviewer: *What do people think about your work, as a representative of the Ministry of Health?*
 Midwife: *As it is part of the social services, I am there to help the population, to work in the name of the state.*
- Interviewer: *You say that you see yourself as a representative of the state. If someone criticizes your CSPS (dispensary), do you recognize this critique or do you think it should be addressed to a level above you?*
 Midwife: *If there is a critique of this dispensary, I will accept it because I work at this dispensary. If there is a problem we will have to solve it together. If somebody says that this is how the health workers are, I will try to convince them that not all health workers are like that.*

When asked what people generally think about the Ministry of Health, she says: 'In terms of health care, people criticise us a lot. People think the health care is not about relieving or helping, but about filling our pockets. Now, the profession is no longer a vocation. Perhaps, it is more about repaying the credits you took when signing up at the nursing school. This makes it complicated. You take a loan, you go to school for three years. You finish and pass your examination; you hurry up and pay your loans.

Normally, it should not be like that. I think it is like that because we lack control and we lack sanctions. Often, you totally forget about morality and you do as you please.'

In this passage, the midwife is very conscious about her role as a representative of the state and her own interest in serving the population, while at the same time acknowledging the general critique of the health care services. She furthermore provides a justification of the critique when saying that health workers might be more interested in paying back their loans arguing that there is too little control with the performance of the health workers.

However, health professionals at the district level also express frustrations about their employer:

If the people of the Ministry [those in charge of elaborating the programs and communicating the messages] can broadcast information to say that such a thing is free, they must also address the people in case of missing or shortage of kits. In that way nobody is going to accuse us, the health workers. (nurse at Dandé district)

A midwife formulated it even more directly: 'They [the people of the Ministry] do not do their job. Let them make an effort to review their policies.'

Front-line health workers: Serving the community

As mentioned above, most of our interlocutors expressed a strong devotion to the profession and to their willingness to serve the community. Many saw themselves as mediators between the Ministry of Health or the government in general and the local communities where they are posted, as expressed by this nurse at Tenkodogo:

You are in the front line, which means you are in direct contact with the patients, you have an obligation to provide them with care because it is your job [...] despite the difficult working conditions. We overcome these to satisfy the patients because we are obliged to satisfy them.

Front-line health workers are held responsible by patients and communities whenever there are protests against the manner in which a policy has been implemented. Weak coordination between the announcement of new policies and implementation of plans exposes front-line health workers to community critique and leads to a sense of frustration.

For instance, to reduce maternal and infant mortalities, the government initiated a programme of free prenatal consultations and provision for obstetric emergencies. A nurse in charge of one of the dispensaries in Tenkodogo reported: '*You know, we had a lot of troubles here with state subsidies for prenatal consultations and obstetric emergencies. According to the new policy, all deliveries and emergencies are supposed to be free for women. But, often, we have shortage of supplies, in which case the woman must pay for care. Communities are not happy with that. They agree to pay only after some intense discussions with health workers. The Ministry of Health spreads information across the country without taking into account the problem of supply shortage.*' In case of shortages, patients protest against the health workers and accuse them of blocking the implementation of new health programmes, as described by a dispensary nurse (Dandé district): '*People have heard on the radio that the care is free but when they arrive at the health centre, we hand out prescriptions to them because there are no free medicines or kits. They are unhappy and think that it is the health workers who refuse to give them the free medicines supplied by the Ministry.*' This subsidy programme for deliveries and emergency obstetric care was initiated across the country before technical management was ready and a full communication strategy related to implementation of the policy was developed. The health workers are caught in the middle. They represent the Ministry and are supposed to implement the new policy, but with insufficient medicines or kits, they cannot perform as expected and run the risk of being blamed by the patients when they are dissatisfied with the services.

Professional constraints

As mentioned above, the standard equipment at the dispensaries is very limited, and they rarely have running water or electricity. Solar panels are becoming more widespread, but not yet to the extent

that dispensaries can rely on this type of supply. All our interlocutors were very concerned about the absence of basic equipment for diagnosis and treatment. One nurse at a dispensary in the district of Tenkodogo said:

Seriously, the equipment available at our level does not allow us to work well. For example, one single tension-meter for the whole maternity service! That is not interesting. The maternity service has several sections. We have the planning section, the delivery section and the CPN [ante-natal consultation]. If one single piece of equipment has to rotate between all these units, that will seriously not facilitate the work. The working conditions are not at all up to standard.

A chief nurse at a CSPS in Tenkodogo district said: ‘The working material is insufficient, even tables and chairs are insufficient. We do not have an “aspirateur”, that’s a problem. The mattresses, the beds, all this is insufficient’.

Health workers at the district hospitals also voiced their discontent with the equipment at their level. A pediatric nurse said:

The equipment is not enough. For example, currently, at the neonatal services, we have no oxygen for the newborns. It is necessary to transfer them to another department to provide them with oxygen. The hoovers do not work well. They are insufficient and the quality is low; the scales are also defective.

It was very clear from the interviews that these shortages cause general disappointment and frustration among the front-line health workers:

There is a difference between the working equipment we have today and the ones we thought of, when we left school. We had thought to use all the knowledge we had learnt at school, in the field. But we realize that this is not possible because you do not always have the equipment that you need in order to make some types of deliveries that seem to be a little complicated, but for which you have the skill. (Midwife at Dandé district hospital)

Thus, while the majority of the front-line health workers whom we interviewed were proud to work in the health sector and to represent the Ministry of Health, they also expressed great frustration about their working conditions. They were particularly worried and frustrated about the general shortage of medico-technical equipment.

Seeking pragmatic solutions

Faced with equipment and personnel constraints, health providers have initiated various strategies to perform their duties, as is expressed by the head of the dispensary of the Tenkodogo health district: *If you work on the front line, you have to develop strategies to ensure patients’ satisfaction.*

Many of our interlocutors act like bricoleurs in the sense that they mobilise other resources than their theoretical knowledge acquired at medical school (Levi-Strauss, 1966; Livingston, 2012). As formulated by Levi-Strauss:

for the bricoleur, the first practical step is retrospective. He has to turn back to an already existent set made up tools and materials, to consider and reconsider what it contains and, finally and above all, to engage in a sort of dialogue with it and, before choosing between them, to index the possible answers which the whole set can offer to this problem. (Levi-Strauss, 1966, p. 18).

With improvisations and ‘bricolaging’ the front-line health workers in Burkina Faso sometimes perform procedures, they are not qualified for, and at other times, they have to refer cases up to the next level of the health care system, which they would have been qualified to treat, had they had the required equipment and medicine. According to a nurse at a dispensary (Tenkodogo district): *It is always said that there is shortage of equipment. It is insufficient. But, we manage with that, as we are a poor country with few resources. So, it is logical that the health services have the same environment [of shortage]. The means are not enough? And you try to adapt.* They take many discretionary decisions about which treatment is most appropriate and what medicine to prescribe without having the possibility of making an evidence-based diagnosis. They use their professional autonomy while feeling that they are not in control

of the technical aspects of their work. A nurse, now working at a Tenkodogo district hospital (CMA), explained about his experiences as chief nurse at a dispensary close to the Ghanaian border:

We were only two, I did five years there without a midwife. It was me who took care of the maternity cases. Six years without leave and without authorized absence. I don't give flowers to myself [je ne me jette pas des fleurs], but I know that I was useful. The state owes us a lot, even the community owes us a lot. Care was provided, we managed to do something. We saved lives.

Conscious of the shortage of appropriate equipment for their duties, front-line health workers – in particular, the physicians – put the emphasis on their listening skills, their patience and their ability to give advice based on knowledge of individual case studies. Rather than emphasising their technical skills, they highlight their direct relationship with the patients, as expressed by a physician in Dandé district: *'We, the district doctors ... the success of our work is not based on equipment, but on proximity to the patient. We do not have the medical equipment necessary to make a very specific diagnosis, like our doctor colleagues at the hospitals. But we are closer to the patients, we take more time to listen and learn the history of their illnesses (...). That creates a confidence between the patients and us.'* Another physician said: *'We only have proximity to offer our patients, we are accessible and that relieves them a little. Other than this, we do not have enough equipment to diagnose the diseases and treat them.'*

Sometimes the health workers paid for their patients' medications in order to build a trusting relationship:

You face a patient who can't pay for his medication. He regrets attending the health centre (...) You know, the last time I paid for one lady because I understood from our exchange that she doesn't want to come to the health centre again because she does not have the money to pay. In her view, it is better to stay at home with the disease and try to find an alternative such as self-medication or a traditional healer. I paid for her to encourage her to come back for health services. (Nurse working at a dispensary in Tenkodogo district)

Our interlocutors expressed a strong concern for the importance of establishing a trustful relationship with the rural citizens. In some cases, they perform services that they are not particularly qualified for, in other cases they use their local knowledge and proximity to the patients, which even includes occasionally paying for the patients' medicine.

Erosion of competencies

Although front-line health workers developed strategies to carry out their duties, they recognised that the difficult working conditions did impact negatively on their daily work. This was mainly expressed by the physicians.

The main consequence of equipment shortage is what front-line physicians call 'unfounded referral'; that is, the referral of a patient whom they could have treated if the appropriate equipment had been available. Such situations lead to feelings of intense frustration and inferiority:

Sometimes you receive a patient, and since you don't have appropriate equipment to make a proper diagnosis, you treat on the basis of a clinical examination; you are not confident with your prescription. After one or two days, if you don't see an improvement, you decide to evacuate the patient. You don't take time to see the effect of the medicine. You are not confident in your own diagnosis, you don't want to take risks, so you evacuate the patient to the health facility, where there is better diagnostic equipment (...), but the problem with that is that your patient will be treated properly in the hospital by your physician colleague, who has the same skills as you, but the availability of equipment makes his performance better than yours, since he made a good diagnosis, thanks to the examination equipment and laboratory tests, so he prescribes the proper medicines. Often, that leads to frustration because your colleague at the upper level of the health services is considered better than you; however, that is not true, it is just an equipment issue. (Physician at Dandé district hospital)

The problem of unfounded referral due to the equipment shortage was expressed primarily by the physicians. This highlights the fact that some categories of health providers are more dependent of specific equipment to perform their tasks, than others. Medical equipment is part of the physicians' examination process and not having the basic equipment impact the diagnostic and treatment skill of front-line physicians negatively.

These types of referrals lead health workers to feel a loss of competency. They express frustration about having to refer patients to the next level of the health care system, often staffed with colleagues who have the same qualifications as themselves. Such experiences make the health workers feel that their professional authority is undermined and their skills have depreciated.

Many interviewees also noted that by not being ‘allowed’ to use their skills in everyday practice, they risk losing touch and they were concerned that their accuracy in diagnostics would wane. This is clearly expressed by a doctor of the district of Dandé

... by referring patients to other health centres, you end up not acquiring experience with regards to the management of some diseases. So as not to take risks (since you do not have adequate equipment to make accurate diagnoses), you decide to refer the patient without exhausting whatever in your opinion may be done to treat the patient.

Following the patients from their arrival to the clinic to their discharge gives the health provider the opportunity to go through all the steps of the disease evolution and make choices for adequate treatment to achieve healing. He or she gains experience and knowledge in managing diseases by taking into account the variability of the patients’ responses to the same disease. On top of that, not being able to practice the academic knowledge predisposes to forgetfulness. Hence, the unfounded referral is perceived as a problem by our interlocutors as their knowledge building is disrupted and they are left with feelings of incompetency.

Discussion

The front-line health workers depend on the state as their employer and the state depends on them to deliver health care services to the population. Our interlocutors are clearly conscious of their ambiguous position as mediators between the health system and the users, as well as of the shortcomings of a fragile health care system. In this paper, we use a distinction between *professional autonomy* and *professional authority* in order to examine how they see and manage their ambiguous role in the ‘street-level bureaucracy’.

We find that they all reflect carefully about ‘the problem of the gap’ or the divergence between the professional norms and their everyday practices at the health facilities. They are very conscious about their professional autonomy, in the sense that they rely on their own clinical judgement and their discretion as decision makers and gatekeepers. However, the lack of diagnostic tools and technical equipment challenge their professional autonomy.

Likewise, their professional authority is constantly challenged when working as front-line health workers at the margin of a fragile state. Taking ‘the oath’ as a nurse, midwife or medical doctor is a very important moment in many health workers’ careers, as we have also seen in studies by Wendland (2010) and Østergaard (2016). This ritual of becoming a professional contributes to the shaping of their professional authority and identity. Likewise, their uniform and the status as government employee with pension rights also support their professional authority. However, in order to mitigate the shortcomings of the system and to balance their professional authority, the health workers in our study deploy a number of different strategies. Some take autonomous decisions, like the dispensary nurse who took charge of deliveries without being qualified; others referred patients to a higher level, not because they were not qualified to diagnose the patients themselves, but because they were short of equipment. Others took advantage of their ‘proximity to the patient’ in order to compensate for their ‘injured’ professional authority. These findings correspond well with the findings of Magadzire et al., from South Africa, where front-line health workers act as ‘brokers’ when securing patients’ access to medicine despite logistical bottlenecks (Magadzire et al., 2014). Similarly, we find resonance with the notion of *workhood* as described by Gross, Pfeiffer and Obrist (2012), which highlights that health workers in Tanzania mobilise social, cultural and symbolic capitals when coping with working situations where health infrastructures are weak and they lack equipment and medicines.

Furthermore, the front-line health workers in our study all express concern about losing their professional skills while posted at the peripheral health facilities. As noted by Wendland in her

study of doctors going through medical school in Malawi, ‘in a medical world where “routine” medical technologies were rarely available, good doctors had to use flexibility and creativity to make do with inadequate resources’ (Wendland, 2010, p. 173).

During the last decade, health professionals in Burkina Faso have struck work on several occasions, protesting against their employer, the state, for launching new policies without providing the necessary means for their implementation by the health workers, and for providing poor working conditions and salaries (Østergaard, 2016). With the increasing *fragilization* of the state (Hagberg et al., 2015; XX, 2020) due to political turmoil and escalating insecurity in the country, the prospects for improved working conditions are meagre. This may further demotivate the front-line health workers and reduce the quality of health services at the peripheral level.

Conclusion

We know from many studies that infrastructure constraints, scarcity of essential drugs, lack of clean water and electricity as well as demotivation among health staff, all affect the ability of the health services to provide good quality care (Mbindyo, Blaauw, et al., 2009; Mbindyo, Gilson, et al., 2009; Mkoka et al., 2015; Thu et al., 2015). The current paper goes beyond this representation and highlights how health workers at the front line cope with these difficult working conditions to perform their duties. Inspired by Grimen’s work on power in modern health care systems, we have suggested an analytical distinction between professional autonomy and professional authority in order to get a more nuanced picture of how front-line health workers themselves navigate their roles as professionals. The interlocutors of our study apply different technologies of power to compensate for the many shortcomings and challenges that they encounter in their everyday professional life, displaying a great deal of autonomy in their effort to live up to their role. Being able to make discretionary decisions is of course important in a context where health workers have to respond to acute cases of illness, but without having control over the technical aspects of their work, their professional authority is challenged. We also found that many of them worry a lot about how to sustain and defend their professional identity. As Bierschenk and Olivier de Sardan have noted in their analysis of bureaucracies in Africa, street-level bureaucrats

do not only implement policy, they make policy. Policy is not what is written in policy papers and organizational regulations, but what street-level bureaucrats do: they, and not the administrators and politicians, make the everyday decisions about what really constitutes policy in the field. (Bierschenk & Olivier de Sardan, 2014, p. 36)

So, if the ‘front-line’ health workers actually *make* the health policy through their everyday decisions, then massive strengthening of their professional capacity is imperative.

Notes

1. The assistant-doctors are trained nurses with a further specialisation.
2. The ‘Fragile Future’ project was funded by a grant from the Consultative Research Committee/DANIDA (11-014KU) during 2013–2018, Data for this article was collected as part of a work-package focusing on the health care system.

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