

Utilization of HIV services and burnout amongst healthcare workers in Lusaka District, Zambia.

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Abstract

Background: Well-documented shortages of health care workers in sub-Saharan Africa are exacerbated by the increased human resource demands of rapidly expanding HIV care and treatment programs. The successful continuation of existing programs is threatened by health care worker burnout and HIV-related illness.

Methods: From March to June 2007, we studied occupational burnout and utilization of HIV services among health providers in the Lusaka public health sector. Providers from 13 public clinics were given a 36-item self-administered questionnaire and invited for focus group discussions and key informant interviews.

Findings: 483 active clinical staff completed the questionnaire (84% response rate), 50 staff participated in 6 focus groups, and 4 individuals gave interviews. Focus group participants described burnout as feeling overworked, stressed, and tired. In the survey, 51% reported occupational burnout. Risk factors were having another job (relative risk [RR]: 1.4, 95% confidence interval [CI]: 1.2-1.6) and knowing a co-worker who left in the last year (RR: 1.6, 95% CI: 1.3-2.2). Reasons for co-worker attrition included: better pay (40%), feeling overworked or stressed (21%), moving away (16%), death (8%), and illness (5%). When asked about HIV testing, 370 of 456 (81%) reported having tested; 240 (50%) tested in the last year. In contrast, discussion groups perceived low testing rates. Both discussion groups and survey respondents identified confidentiality as the prime reason for not testing.

Interpretation: In Lusaka primary care clinics, overwork, illness, and death were common reasons for attrition. Programs to improve access, acceptability, and confidentiality of health care services for clinical providers and to reduce workplace stress could substantially impact workforce stability.

INTRODUCTION

Over the past decade, access to antiretroviral therapy (ART) has grown at an unprecedented rate in sub-Saharan Africa, with tremendous health gains observed among those utilizing these services (1-3). As programs have expanded, availability of trained health personnel has become an important limiting factor in the provision of services (4-6). Nowhere is the shortage more noticeable than sub-Saharan Africa, where patient-to-provider ratios fall significantly below World Health Organization recommendations. In 2006, for example, an estimated 2.3 health care workers served every 1,000 people in the region. This figure is below the worldwide average of 9.3 per 1,000 and below the level defined as a critical shortage: 2.5 per 1,000, at which populations fail to achieve 80% coverage of services like deliveries and vaccinations (7).

Numerous approaches have been implemented to compensate for the shortage. These include task-shifting (8, 9) employment of lay health workers (10, 11), and use of technology (e.g. mobile phones, internet) to facilitate care and consultation (11, 12). Few strategies, however, have focused on maintaining the well-being of *existing* workers (13). It is critical that this human resource foundation be kept intact if service provision is to continue in these resource-constrained settings.

In settings with high HIV prevalence, related morbidity and mortality is responsible for health provider absenteeism and attrition. In Zambia, mortality rates are high and death is the most common cause of attrition among district health care workers (14, 15). A recent South African survey measured HIV prevalence among health care workers at 12% (16). In Malawi, the death rate among health care workers was 2%, the most common causes were TB and chronic illness attributable to AIDS (17). Perhaps more overlooked is the issue of occupational burnout among health personnel, a phenomenon characterized by exhaustion, depersonalization, and inefficacy (18). The emotional intensity of caring for HIV-infected patients, along with the high patient volumes seen at many ART centers may place health providers at particular risk for burnout (19). The consequences can be severe and include exhaustion, reduced productivity, decreased empathy for patients, absenteeism, and desire to search out other occupations (20, 21).

METHODS

We designed a two-part study to describe occupational burnout and utilization of HIV services among providers in the primary care centers of the Lusaka, Zambia public health sector, where services for HIV care and treatment have rapidly expanded since 2004 (3). We recruited physicians, clinical officers (equivalent of physician assistants in the U.S. and Europe), nurses, midwives, and pharmacy staff employed at government clinics. Thirteen sites were chosen, all providing care for long-term HIV care and treatment. At each facility, other primary care services are provided, including general outpatient care, antenatal services, child health services, and tuberculosis treatment. Characteristics of each facility and catchment size are shown in Table 1.

This study included qualitative and quantitative study components. Our qualitative methods consisted of six focus group discussions and four key informant interviews. One group session was held for each of the followings: midwives, physicians, clinical officers, and pharmacy staff. Two groups of nurses were convened as they comprise the vast majority of health care workers. Participants were stratified according to clinic of employment and professional cadre, and then randomly selected. Overall, 13 invitations were sent out for each group (i.e. one representative per clinic). Discussions were held in a private conference room at a local non-government organization and each lasted approximately 90 minutes. Trained study staff served as facilitators, written notes and tape recordings were transcribed. Key informants were identified by physicians based at the study clinics and were recruited to participate in one-on-one interviews. The four interviews included two providers living with HIV, one HIV negative, and one with unknown HIV status. Each lasted approximately 60 minutes. Data were analyzed by manually compiling common themes and matrices and discussing these data between investigators, study staff, and representatives from the Lusaka District Health Management Team.

In parallel, we surveyed active health care providers across the 13 clinics to quantify their perceptions of occupational burnout and HIV service utilization. All staff reporting to work over a three-week window were asked to complete a 36-question survey by their supervising nurse managers. Each questionnaire had a statement of consent attached; completion of this consent was necessary for inclusion in the analysis. Drop boxes were provided so that participants could return their questionnaires anonymously. In the survey, prevalence of occupational burnout was based on a single question that has been validated against a full occupational burnout scale (22). Respondents were asked to quantify their level of burnout from a five-item scale: (1) 'I have no symptoms of burnout,' (2) 'Sometimes I am under stress, but I don't feel burned out,' (3) 'I am definitely burned out and have occasional symptoms of burnout,' (4) 'The symptoms of burnout I'm experiencing won't go away,' and (5) 'I feel completely burned out and I am at the point where I need to make some changes or seek some sort of help.' If respondents selected (3), (4), or (5) from the scale they were categorized as having occupational burnout. We also asked numerous supporting questions to better understand types of burnout in this population.

To determine utilization of HIV services, we relied primarily on use of HIV testing services over the past 12 months. Information regarding demographic characteristics, employment history, and HIV knowledge and perceptions were also collected. In our statistical analysis, we calculated unadjusted and adjusted relative risks (RR) with 95% confidence intervals (95% CI) to identify predictors of occupational burnout and HIV service utilization (23). We adjusted for individual and clinic level variation in hierarchical logistic models using the SAS GLIMMIX Procedure (24). Covariates included demographics and other independent variables associated with the outcome at $p < 0.10$ in unadjusted models. All analyses were performed using SAS version 9.1.3 for Windows (Cary, North Carolina, USA). All participants provided written informed consent to participate. This study was approved by the University of Zambia Research

Ethics Committee and the University of Alabama at Birmingham Institutional Review Board.

RESULTS

In May 2007, 78 individuals were invited for focus group discussions. Fifty (64%) participated: 18 nurses, eight midwives, nine clinical officers, five medical officers, and 10 pharmacy staff. Key informants comprised two registered nurses, one nurse manager, and one clinical officer. From March to July 2007, 483 of 573 active health care providers in the 13 clinics completed the study questionnaire (84% response rate). Demographic characteristics are shown in Table 2. The vast majority was female (87%) and the overall median age was 37 (IQR: 31-45 years). The median time spent in the district service was 10 years (IQR: 4-17 years).

Occupational burnout

In our qualitative work, participating health providers related occupational burnout to feelings of being overworked, stressed and tired. Key informants characterized occupational burnout as having low energy levels, being irritable, providing poor treatment, acting rude towards patients, being more prone to mistakes, and getting physically sick. Focus group participants attributed their burnout to poor working conditions. They noted long hours and heavy workload: clinical officers reported seeing over 100 patients in a day. Low salaries and benefits were a consistent source of frustration. Participants found their salary difficult to survive on and many took on additional jobs which further exacerbated feelings of burnout. One key informant, reported owning a small shop in addition to working nights at the general clinic and mornings at the ART clinic. These feelings led many government workers to seek “greener pastures,” such as private facilities, non-government organizations, or other countries where conditions were perceived to be better. It was noted that most health care workers stayed only one to three years before moving on. It was noted that when people leave, more work falls on those remaining.

In the quantitative survey, occupational burnout was noted across numerous metrics. Approximately half of respondents met our definition for occupational burnout. Nearly one quarter of respondents reported feeling too burnt out to go for work at least once per week. When asked why their co-workers left their positions, the most common reasons were better pay (40%) and because they felt constantly overworked or stressed in their current position (21%), a manifestation of occupational burnout (Table 3). In hierarchical models, significant risk factors for occupational burnout are shown in Table 4.

Utilization of HIV services

In qualitative discussions, focus group participants believed that few health care workers had tested for HIV. When asked to try to quantify this, participants estimated between 25 to 50% of their colleagues were aware of their HIV status. There was widespread belief

that staff members do not test at their clinic of employment, but instead go elsewhere to seek services (e.g. private clinics and non-government organizations). A few participants also reported self-testing for HIV among health care providers, without recommended pre- and post-test counseling. According to focus group participants, the main reason health providers fail to undergo HIV testing was concern over confidentiality. Every focus group acknowledged a perceived or actual lack of confidentiality by co-workers. One key informant, overheard nurses discussing the circumstances surrounding her decision to seek HIV testing (i.e. her husband's illness). A medical officer observed, "*in the clinic the whole staff are confidential with a patient's history, but when it comes to a clinical officer, the whole staff would be interested.*" Focus group participants also reported that if a health care provider was known to be living with HIV, he or she would lose the confidence of patients and their future employment prospects would be compromised.

Focus group participants were afraid of getting HIV at work through activities like injections, blood collection, intravenous infusions, and deliveries. Despite this concern, many felt obligated to put themselves at risk during procedures for the sake of the patient. As one nurse explained, "*If you do it you risk your life and if you do not, the patient dies.*" However, every discussion group believed most HIV infected health care workers acquired the disease through their personal life rather than occupational exposure.

Focus group participants reported significant stigma associated with HIV. In one case, a staff member with known HIV infection used another staff member's cup. When the owner of the cup discovered this, she broke it rather than re-using it. Participants believed that stigmatization contributes to staff avoiding or delaying HIV testing. Despite these examples, many insisted that stigma was decreasing and supported disclosure of one's status as the best way to cope with a diagnosis of HIV. Participants reported that colleagues who were open with their HIV positive status were treated equally. However, many agreed that HIV-infected staff members were more likely to be perceived as ill and therefore given lighter work assignments. The subsequent increase in workload for others was sometimes resented.

In our survey of health providers, 52% reported undergoing HIV testing in the last 12 months. Of these, more than half (54%) reported testing in their clinic of employment (Table 5). When respondents who had not undergone HIV testing were asked why not, confidentiality was cited as the chief concern among 28 of 60 (47%) respondents. Most respondents (87%) worried about getting HIV during their work as a health care provider. In contrast to our focus groups, more than one-third of our respondents believed that most HIV-positive health care workers were infected at work. There were fears regarding unlikely modes of transmission, including through sweat (14%) and saliva (25%).

Most survey respondents (87%) reporting knowing at least one health worker infected with HIV, usually after the colleague directly disclosed their HIV status. However, other modes of disclosure were reported that involved breaches of confidentiality (Table 5). 195 of 474 (41%) had personally witnessed health providers gossiping about a patient's HIV status. In multivariate models, work in the ART clinic (RR = 1.4, 95%CI = 1.0 -

1.6) and worry about getting HIV during their work (RR = 1.8, 95%CI 1.2 - 2.2) were significantly associated with HIV testing (Table 6).

DISCUSSION

In this study, we found surprisingly a high prevalence of occupational burnout among district health staff. Over half met our screening definition, with most reporting numerous symptoms. Conditions of service were the most commonly cited causes of occupational burnout and attrition. Only half of our respondents reported testing for HIV in the past 12 months, despite the widespread availability of such services in the clinic of employment and “stand-alone” testing sites in the community. Stigma remained a significant reason why health care workers avoided HIV testing and continued to serve as a barrier to widespread HIV testing among providers.

A strength of this study was its combination of qualitative and quantitative methods. This allowed us to “triangulate” data from multiple sources and provide comprehensive descriptions of our topics of interest. Our primary limitation is external validity. We do not know the degree to which our findings are specific to the primary care clinics of the Lusaka public health sector; however, we believe the themes are applicable to other urban African settings. We are also aware of potential reporting bias, particularly in descriptions of occupational burnout. Focus group participants were familiar with the phenomenon of burnout, likely due to prior district sponsored workshops on the topic. In addition, all participants were informed that this study was designed to inform district policy. These conditions may have provided incentives for staff to overestimate burnout prevalence.

Occupational burnout was prevalent in this population of government health workers in these Lusaka primary care facilities. One significant predictor for occupational burnout was knowing a co-worker who left government service. Those who remain are left with more stressful conditions putting them at risk for burnout. This is a cycle that deserves further investigation, given its potential for exacerbating the burnout phenomenon in settings where health staff are limited. Furthermore, patients may suffer in this process as both occupational burnout and low staffing levels have been associated with a decline in quality of care (21, 25). Measuring the effect of health care provider burnout on patient outcomes is an important area for future research with powerful implications for maintaining HIV care and treatment programs.

More than half of our survey respondents had tested for HIV over the past 12 months. Although this figure is higher than other reports in the region (26, 27), it was below our expectations. Nearly one quarter said they had “not had the opportunity to test” for HIV despite the availability of services across numerous different testing venues (e.g. public clinics, private facilities, stand-alone testing centers). Participants in both study components conveyed worry over accidental disclosure of HIV infection. Ironically, this fear of disclosure has made utilization of HIV services more difficult for these Ministry employees, since their familiarity with clinic staff may make them vulnerable to breaches

in confidentiality, speculation, and gossip. Confidentiality and gossip have been recognized as deterrents to HIV testing among general populations (28). Clinic staff working to provide ART were more likely to test for HIV when compared to those from other departments. This may be related to reduced stigma within this department or greater concern over HIV transmission from infected patients.

The role of occupational exposure in HIV acquisition was inconsistent between our qualitative and quantitative components. Focus groups attributed HIV infection among providers to non-work-related risk factors (75-90%) while about 40% of survey respondents believed that occupational exposure was the major route of transmission. This discrepancy may be partially attributed to misconceptions by survey respondents that HIV could be transmitted by sweat or saliva. If health care workers perceive themselves to be at high risk for HIV infection based on these misconceptions it could adversely affect their likelihood of testing. A study among Zambian women found women reporting high personal risk for infection were less likely to accept testing at antenatal facilities (29).

Despite their roles in providing care for HIV-infected patients, health staff may have persistent misinformation and misconceptions about the disease (30). In our survey, for example, nearly all respondents stated that HIV-infected individuals should be treated with the same respect as those who are not infected. At the same time, large proportions blamed promiscuous men or prostitutes for spreading the epidemic. While the opposing nature of these views may be subtle, they do speak to underlying and persistent stigma – even among health providers.

The overall goal of this study was to further inform district policy regarding workplace conditions. These results have been formally presented to clinic nurse managers and the Lusaka District Health Management Team. The ensuing discussion resulted in numerous recommendations that are currently being considered at the district level. To combat occupational burnout, district staff suggested workshops to teach individuals to identify burnout and develop coping mechanisms. To improve utilization of HIV-related health services, staff emphasized the need for multiple options, since one approach was unlikely to meet the needs of all. Possibilities included: (1) parallel systems within clinics where staff could get care from a trusted provider, (2) a central HIV/AIDS clinic for staff, or (3) a central comprehensive health care clinic for staff offering both ART and general care. Peer support groups for HIV-infected health care providers were functioning in one clinic, this was seen as a success and it was suggested that other clinics implement this strategy. Ongoing initiatives to combat confidentiality breaches and HIV-associated stigma were promoted. Formal workplace HIV policies were recommended to address the unique challenges of confidentiality and stigma faced by health care workers accessing HIV services.

As new initiatives are implemented to increase health personnel capacity in sub-Saharan Africa, existing health providers must not be overlooked. The burden of providing HIV services to large numbers of extremely ill patients is substantial and may lead to high levels of occupational burnout. Work conditions should be regularly evaluated and where

possible improved, to prevent the attrition related to occupational burnout. Initiatives must also focus on improving uptake of HIV testing, care, and treatment services among health providers. This may require investments into locally appropriate clinical care options that will ensure confidentiality and formal workplace policies to protect those who disclose their status.

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