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Logics of Actors in the Resilience Trajectory of People Living with HIV/Type 2 Diabetes Comorbidity

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Abstract: The person living with HIV/diabetes a type 2 comorbidity (PLHIV/DT2) faces adversities from the moment the diagnosis is announced, such as uncertainty about the course of the pathology, chronicity and the management of complex recommendations. Different professional and social actors intervene in his different environments to support him. In spite of this, PLWHIV/AIDS oscillate between improvement and relapse, acceptance and denial, stability and instability, autonomy and dependence. This reflects a fluctuating trajectory of resilience. The aim of this article is to analyse the logics of the actors in the trajectory of resilience of PLWHA/DT2. In order to answer this question, we have opted for a phenomenological qualitative research. The biographical writings of 05 PLWHA/DT2, who attend the National Obesity Centre and the Cameroonian Association of Diabetics, and in-depth interviews with 20 social and professional actors were carried out and were the subject of a content analysis. The results showed that the characteristics of the actors are diversified and their action strategies are complex. The logics of positioning (power games, confrontation of scientific and secular knowledge), standardisation (respect for deontology, ethics and institutional culture) and complementarities (négociations, intégration, interactions) were identified. Interdisciplinarity is suggested.

Keywords: Stakeholders' Logics, Trajectory of Resilience, PLWHIV/DT2, Diabetes, HIV

1. Introduction

The use of certain antiretroviral drugs increases the risk of developing certain chronic comorbidities including type 2 diabetes (T2D) worldwide [1-3]. In France, the prevalence of T2DM in HIV patient cohorts was 6.8% in 2005 and 15.1% in 2015 [4]. In Cameroon, as in most Sub-Saharan African countries, the prevalence of HIV remains very high. It is 3.4%, and that of type 2 diabetes is 6% [5, 6]. The management policy for HIV/DT2 co-morbidity is 'test and treat', which will increase the estimate to 4 times higher in the PLHIV population compared to the general population [2]. Supporting these PLHIV/DT2 requires several actors, as these patients face adversities from the moment of diagnosis (such as shock, trauma), uncertainty of disease progression, chronicity, disease management and complex recommendations. Furthermore, PHAs/DT2 oscillate between improvement and relapse, acceptance and denial, stability and instability, autonomy and dependence. This fluctuation in the resilience trajectory is permanent in these people. The objective of this study is to analyse the logic of actors in the resilience trajectory of people living with HIV/DT2 co-morbidity.

2. Methodology

This study took place at the National Obesity Centre (CNO), located within the Yaoundé Central Hospital (HCY), during the period from January to December 2018. It is a qualitative phenomenological descriptive study on a population of PLWHA/DT2 consulting the CNO, and the care actors in service in the said unit including social actors. The selection of the participants was made according to a reasoned choice. Based on the principle of saturation, 05 PLWHA/DT2, 02 social actors and 14 professionals were interviewed. The data collected was transcribed manually (organised into units of analysis, then categorised) and

processed by content analysis. In order to understand this work, we relied on Max Weber's theory of actor logics, which states that the individual is the product of social structures and cannot be neglected in the analysis of an action.

3. Results

Our results are organised according to the identification and roles of actors, the conceptual approach to the resilience trajectory among actors, and finally the empowerment strategies in the resilience trajectory.

Identification and roles of the actors: Three groups of actors collaborate in the care of PLWHA/DT2: the care professionals (two diabetes/endocrinology doctors, one general practitioner, six nurses, two nurses, two care assistants and one dietician). They have extensive experience in caring for PLWHA/DT2. They have taken part in several ongoing training and refresher courses. In particular, they have participated in conferences and symposia on care. This is what emerges from the statement of a P1 informant in the following terms: "..... I participated last year in the training organised by the technical partners of the Ministry of Health (GIZ) in Mbalmayo.....". The doctors were the biomedical actors in charge of the consultation. The nurses were for some in hospitalization, and for others at the reception, and finally at the service of care of diabetic feet. The nurses' aides were responsible for therapeutic education. Several categories were represented among the people living with HIV/DT2: patients consulting for the first time, those for routine appointments, hospitalized patients, and finally the dressings. The associations (ACADIA, ACAFEM) are the social actors responsible for the accompaniment and psychosocial care of PLHIV/DT2, through therapeutic education and counselling.

The relationship between the three actors mentioned above was generally not harmonious. It was sometimes conflictual, with a lack of synergy in the care of PLWHA/DT2. The health professionals very often reprimanded the social actors and the patients. And sometimes they did not accept any collaboration or a point of view other than their own. Health professionals always positioned themselves as undeniable referents. An attitude that often embarrassed patients and social actors "...it is desirable that the patient comes to see this with us, instead of going to the diversionists (associations), who do the real nonsense, and make the situation worse. In the end, patients only come to us when the situation is very serious, as if our job is to solve the problems that others are organising left and right..... On the other hand, the associations complained about the real lack of collaboration and recognition of health professionals, regarding their work, their participation in the care of PLWHIV ".... really the doctors, they think they are gods here at the NOC. They think they know everything, even visiting the patient at home, they do that too..., the patient is still an actor in his care at home, in the neighbourhood, everywhere....". In this war, the patients are frustrated, lost, afraid and indexed as scapegoats. This actually leads them to abandon follow-up and to the optional choice of letting go towards chronicity.

Conceptual approach to the trajectory of resilience among the actors: the verbatim reports revealed that this concept was difficult to define for most of the actors. Everyone gave their own definition and understanding of the concept. Some gave it the meaning of adaptation ".... From now on, I have to see how to review my way of life, of eating, and I have to stop drinking...", others the meaning of enduring and accepting ".... I will do what I can, life must go on and I must accept and endure...", and others the meaning of support ".... We are here to give you the weapons so that you can delay your evolution towards chronicity....". The concept of resilience has been in use in the scientific community for several decades. In Anglo-Saxon countries, work on resilience has been going on for some thirty years and has given rise to recognised scientific publications for over 25 years. In French-speaking countries, resilience has been gaining momentum especially since the 1990s. Resilience in the literature refers to normal development under difficult conditions, a process by which an individual interacts with his or her environment to produce a given outcome. It is a capacity for successful insertion into society despite adversity that carries the serious risk of a negative outcome, an exceptional adaptation despite exposure to significant stressors [6, 7, 8]. According to various disciplines, resilience is essentially, and in a nutshell, the capacity of a person or a system to recover from a shock and remain relatively stable despite a turbulent environment. The trajectory here is none other than the line described by any point of a moving object, and in particular by its centre of gravity. Or the life course, the succession with age of an individual's passage from one state or social position to another. The trajectory of resilience fluctuates in a PLWHA/DT2. It is either positive, leading to maintenance, stability and satisfaction with follow-up and care, or negative, leading to a relapse and a rapid evolution of the co-morbidity towards chronicity.

Conceptual approach to the resilience trajectory among the actors: the verbatim reports revealed that this concept was difficult to grasp for most actors. Everyone gave their own definition and understanding of the concept. Some gave it the meaning of adaptation "....From now on, I have to see how to review my way of life, of eating, and I have to stop drinking...", others the meaning of enduring and accepting "....I'm going to do what I have to do, life has to go on and I have to accept and endure...", and others the meaning of accompaniment "....We are here to give you the weapons so that you can postpone your evolution towards chronicity....".

The concept of resilience has been under discussion in the scientific community for several decades. In Anglo-Saxon countries, work on resilience has been going on for some thirty years and has given rise to recognised scientific publications for more than 25 years. In French-speaking countries, resilience has been gaining momentum especially since the 1990s. Resilience in the literature refers to normal development under difficult conditions, a process by which an individual interacts with his or her environment to produce a given outcome. It is a capacity for successful integration into society despite adversity that carries

the serious risk of a negative outcome, an exceptional adaptation despite exposure to significant stressors [6, 7, 8]. According to various disciplines, resilience is essentially, and in summary, the ability of a person or system to recover from a shock and remain relatively stable despite a turbulent environment. The trajectory here is none other than the line described by any point of a moving object, and in particular by its centre of gravity. Or the life course, the succession with age of an individual's passage from one state or social position to another. The trajectory of resilience fluctuates in a PLWHA/DT2. It is either positive, leading to maintenance, stability and satisfaction with follow-up and care, or negative, leading to a relapse and a rapid evolution of the co-morbidity towards chronicity.

Management strategies in the resilience trajectory: five types of adversity were identified in this study. Adversities linked to the announcement of the diagnosis (ad1): shock, trauma; those linked to the uncertainty of the evolution of pathologies (ad2); those linked to the management of illnesses (ad3); to the management of complex recommendations (ad4) and finally to chronicity (ad5). Faced with these different adversities, the strategies mobilised by the actors were different, as were the trajectories of resilience.

1) Strategies linked to ad1: each of the actors here mobilised a strategy specific to his or her role, activity and action in care. The professionals adopted a strategy of lecturing and moralising, while the social actors adopted a strategy of listening and empathy. The patients themselves adopted a strategy of self-flagellation.
2) Strategies related to ad2: health professionals used the conditioning strategy the most, social actors the psychosocial support strategy, while patients used the violence and nervousness strategy.
3) Strategies related to ad3: professionals developed the classical medical care strategy (biomedical). The social actors developed the intercultural care strategy, while the patients developed the medical pluralism strategy (biopsychosocial).
4) Strategies related to ad4: three strategies were mobilised by the three groups of actors. The health professionals mobilised the message modelling strategy, the social actors mobilised the pragmatism strategy, while the patients mobilised the self-normativity strategy.
5) Strategies related to ad5: in the face of chronicity, professionals developed routinisation strategies, while social actors developed permanent adaptation strategies, while patients were in survival strategies.

A resilience strategy determines the capacity of a community to mobilise action in response to a threatening situation when it occurs [13]. Of all these strategies, some in our study favoured rebound and maintenance of the patient, while others made PLHIV/DT2 more vulnerable.

4. Discussion

Our synthesis is grouped into positioning, standardisation and complementarity logics.

Logics of positioning: various results have enabled us to identify the power games, the power games, the confrontation of lay knowledge with scientific knowledge. With regard to power games, the health professionals felt that they were experts compared to the other actors. This is in line with Max Weber's concept of domination [9]. Indeed, this concept is essential in Weber's comprehensive sociology. It can be broken down into legal, traditional and charismatic. In our case, the professionals have a legal domination based on their scientific knowledge and their administrative position. These actors create a gap between the social actors and the patients, and prevent the expression of the other actors involved. This attitude on the part of health professionals reinforces the vulnerability of PLWHA/DT2 in their resilience trajectory. While social actors are much closer to the patients, these attitudes favour reaching the turning point for a rebound. The social actors are the anchor points on which the deployment and maintenance of a resilient trajectory can be based; the former weaken this trajectory. The poor understanding of the concept of resilience and the lack of awareness on the part of the actors make the PLWHA/DT2 vulnerable.

The logic of standardisation: Standardisation is the rule that tends to reduce the manufacturing models [10]. It is a standardisation of models (modelling the care of people living with HIV/DT2). Health personnel then act from the perspective of respecting deontology; ethics; institutional culture assimilated to road maps (normative documents). The sick person, being part of a complex diversity, sees his or her trajectory disturbed and even weakened.

The logic of complementarities: In this field of care, the patient is informed from new technologies, family relatives and the society in which they live. They then have a mass of information to analyse, integrate and make decisions about implementing. Several problems may arise such as the level of understanding and analysis, interpretation and integration skills for decision making may further weaken it. This can disrupt the achievement of the resilience trajectory. This attitude of the ill person is supported by the logic of complementarity. In the background, there are many hidden actors with divergent interests who influence the resilience trajectory. The patient finds it difficult to define his ideal type according to Max Weber, i.e. to clarify the meaning, the actions and the coherence that he gives himself as a category of conduct.

Negotiation is a process of communication and exchange between at least two parties whose object is to organise a relationship or to resolve a problem between them [11, 12]. The negotiation process is then part of a cooperative relationship between the parties in action, or a relationship of complementarity. Three structural configurations take shape in different negotiation contexts. They do not have the same objectives and use specific techniques. Interpersonal negotiations emphasise the negotiators' dispositions, their persuasiveness and their experience in face-to-face situations. Intra-organisational negotiations show us how they manage to bring together individuals who cooperate so that the organisation

is built and functions. Here the question of the representativeness of the negotiators is clearly raised. And finally, inter-organisational negotiations question the efficient methods for regulating contemporary conflicts [13, 14, 15]. During a negotiation, it is common to alternate between the three types of structural configuration. In contrast to the traditional hierarchical relationship between health professionals and people living with HIV/DT2. Negotiation is one of the modalities by which the patient's participation in the decision-making process concerning his or her health is truly expressed and health and social professionals accompany him or her towards achieving his or her objectives [11].

Negotiation is not the best shared thing in the management of a Co-infected patient with two chronic pathologies [16]. The health professional must balance the endogenous scientific culture and the institutional culture. While the social actors in their social culture of risk sharing and mutual aid maintain the resilience trajectory. This is not always the case for health personnel, who observe a fluctuating trajectory between maintenance and relapse. Here, the educational relationship is very complex since we are dealing with the combination of two chronic pathologies, which require specific and particular skills on the part of health professionals. Therapeutic education in cases of this comorbidity and chronicity is complex, as each of the diseases requires a specific lifestyle, associated with a specific diet.

5. Conclusion

In order to achieve the objective of this study, which was to analyse the logic of the actors in the resilience trajectory of people living with HIV/DT2 co-morbidity, a qualitative phenomenological descriptive study was carried out. Using an interview grid, 05 PLWHA/DT2 consulting the CNO/HCY, 14 care actors in service in the said unit including 02 social actors were interviewed. The data collected was transcribed manually and processed by content analysis. Max Weber's theory of actor logics enabled us to identify the logics of positioning (power games, confrontation of scientific and lay knowledge), standardisation (respect for deontology, ethics and institutional culture) and complementarities (negotiations, integration, interactions). Interculturality associated with interdisciplinarity is suggested in holistic care, in order to maintain the resilience trajectory of people living with HIV/DT2 co-morbidity.

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