

Phenomenological Experience and Determinants of Professional Identity Loss Among Nurses in a Deprived Hospital Setting: The Case of Wangata General Reference Hospital in Mbandaka, Democratic Republic of Congo

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ABSTRACT

Introduction: Nursing identity is suffering from a global crisis of meaning driven by new public management. In the Democratic Republic of Congo, and particularly at the Wangata General Reference Hospital in Mbandaka, this situation is exacerbated by extreme material deprivation and the cost-recovery system, forcing nurses into continuous financial negotiations that conflict with their professional ethics.

Objective: This study aimed to analyze the phenomenological experience of nurses at the Wangata General Reference Hospital to understand the internal mechanisms and structural determinants driving the loss of their professional identity.

Methodology: This qualitative study adopted Husserl's descriptive phenomenology based on the concept of epochē. Seven nurses (A0, A1, A2 levels) with at least two years of tenure were interviewed using in-depth semi-structured interviews. Verbatim transcriptions underwent thematic content analysis using ATLAS.ti software, while maintaining strict anonymity.

Results: The analysis revealed an entry into the profession often by default, total stagnation in career advancement, and a systematic reliance on "sacrificial care." Faced with a lack of

biosecurity supplies and unpaid 36-hour shifts, staff endured medical authoritarianism, severe wage insufficiency, and the trauma of successive epidemics (Ebola, Mpox).

Discussion: Career inertia illustrated the stifling centralization of Kinshasa. The shortage of basic inputs forced reliance on makeshift solutions (système D), generating a profound ethical conflict. Furthermore, symbolic violence from physicians triggered professional aphasia, while material wretchedness drove staff toward silent resignation.

Conclusion: Nurses oscillated between spiritual withdrawal and sacrifice. Urgent reforms are critical: standardizing local risk allowances, decentralizing continuous professional development, and ensuring a continuous supply of personal protective equipment.

Keywords: Phenomenological experience, Determinants, Loss, Professional identity, Nurses, Deprived hospital setting.

1. INTRODUCTION

1.1 Background and Problem Statement

The very essence of nursing identity, traditionally carried by values of clinical care and solicitude, is currently confronting a profound crisis of meaning induced by the weakening of healthcare structures globally. Worldwide, the rise of new public management and cost rationalization strips care of its relational dimension (Molinier, 2018), provoking a form of dehumanizing bureaucratization (Dejours, 2012) where professionals struggle to link their self-image from training with recognition from their institution (Dubar, 2015; Hughes, 2020).

In sub-Saharan Africa, this phenomenon is aggravated by chronic material deprivation (World Health Organization [WHO], 2022). Healthcare workers face a violent ethical paradox: the obligation to provide care in the midst of absolute destitution (Blaise et al., 2019). This daily powerlessness generates a deficit of institutional recognition (Honneth, 2006), transforming personnel into managers of scarcity.

This malaise takes a systemic turn in the Democratic Republic of Congo (DRC), where the health system relies on cost recovery from impoverished populations (Ministry of Public Health of the DRC, 2021). Between dilapidated infrastructure and delayed remuneration for "new units" (Maindo & Malemba, 2020), the Congolese nurse is forced to adopt a posture of financial negotiator, in complete rupture with professional ethics (Mukwege, 2018).

This observation crystallizes locally at the Wangata General Reference Hospital in Mbandaka, a territory marked by isolation and supply disruptions (Provincial Health Division of Équateur, 2024). The central problem of this research lies in the permanent fracture between the nursing ideal of Wangata GRH nurses and the extreme precariousness of their daily lives. This dissonance generates a major professional identity loss. The challenge is to explore the phenomenological experience of this alienation—the intimate suffering and psychological defense mechanisms of caregivers—a blind spot that quantitative literature has thus far neglected.

1.2 Research Question

The main research question was formulated as follows: How do nurses at the Wangata General Reference Hospital in Mbandaka (DRC) perceive and theorize their phenomenological experience of deteriorating working conditions, and what are the structural determinants that precipitate the loss of their professional identity in this deprived hospital setting?

1.3 Study Objective

This study aimed to analyze the phenomenological experience of nurses at the Wangata General Reference Hospital in Mbandaka (DRC) in order to understand the internal mechanisms and structural determinants governing the process of professional identity loss in a deprived hospital setting.

2. METHODS

2.1 Study Design

The choice of a qualitative design was essential to grasp the deep meaning that actors attribute to their experience. This study adopted descriptive phenomenology, an ideal framework for exploring the subjectivity of caregivers. Inspired by Husserl (1913/2018), this approach advocates a return to things themselves, capturing the daily reality of care before any statistical reduction. To operationalize it, Giorgi (2009), Moustakas (1994), and Paillé and Mucchielli (2021) recommended epochē—a bracketing of the researcher's prejudices to reveal the raw essence of the identity crisis. In nursing sciences, this rigor allows analysis of the psychological conflict born of precariousness. Following Benner (1984), Streubert and Carpenter (2011), Van Manen (2016), and Dépelteau (2020), suffering identity is revealed through the free narration of Erlebnis (fully conscious experience).

2.2 Study Setting

The Wangata General Reference Hospital is located in the eponymous commune of Mbandaka, capital of Équateur Province, DRC. Established during the colonial era on the banks of the Congo River, the institution suffered from the political and economic crises of the country. Monographs by Bifuko (2015), Tshilombo (2019), Lututala (2020), and Mumbere (2022) illustrate how post-independence lack of investment transformed this health hub into a reflection of local distress, marked by isolation and chronic shortages. Managed by a standardized committee, the hospital oversees Medical Direction, Nursing, and Financial Administration. This field site embodies the Congolese hospital paradox. Kasongo (2021), Malemba (2018), Yuma and Mpala (2023), and Ngoy (2022) confirm that it brings together the causes of the nursing identity crisis: lack of inputs, patient poverty, coexistence of unpaid caregivers, and the obligation to demand payment before care.

2.3 Population and Sampling

The target population encompassed all nursing staff in the hospitalization services of Wangata GRH, including state-certified nurses (A2), graduate nurses (A1), and licensed nurses (A0). The

study used non-probabilistic purposive sampling. Far from statistical representativeness, Pires (1997), Morse (2015), Hamel (2020), and Flick (2022) recall that this method prioritizes the richness of experience of subjects confronting the degradation of their practice. Inclusion criteria required practicing direct care and having at least two years of tenure, a duration necessary to imbibe institutional routines and testify freely. Strictly administrative staff were excluded to preserve the authenticity of bedside experience. Sample size depended on empirical and semantic saturation theorized by Glaser and Strauss (2017), Guest et al. (2006), Saunders et al. (2018), and Hennink et al. (2020). This level was reached when new narratives revealed no thematic novelty, often stabilizing between twelve and fifteen interviews.

2.4 Data Collection Method, Technique, and Instrument

Empirical data collection rested on the descriptive phenomenological method, supported by the technique of in-depth semi-structured interviews. This technique offered a space for free and flexible expression while maintaining a rigorous thematic direction through a primary instrument: the thematic interview guide. This instrument was designed based on the international literature on workplace suffering. It was structured around four major axes: professional trajectory and initial nursing ideal, concrete experience of material scarcity, ethical dissonance related to self-erosion, and coping strategies developed by staff. In qualitative research, traditional notions of validity and reliability are translated into criteria of credibility, transferability, dependability, and confirmability, following paradigms established by Guba and Lincoln (1985), Yardley (2000), Creswell (2013), and Noble and Smith (2015). Credibility was ensured here through member checking, which involved submitting transcripts and preliminary analyses to the interviewed nurses to validate the accuracy of the interpretation of their statements. Confirmability was guaranteed by maintaining a methodological logbook and peer triangulation during the textual coding stage.

2.5 Data Collection Process

The deployment of data collection unfolded in several well-defined chronological and relational phases. The first phase involved negotiating institutional access by presenting official

authorizations to the Medical Direction and Nursing Direction of Wangata GRH, while conducting passive immersion to adapt to the rhythm of services. The second phase was dedicated to individual recruitment of nurses meeting the inclusion criteria. This was the moment when study objectives were explained before scheduling appointments outside peak clinical activity hours. The third phase was the conduct of phenomenological interviews, which took place in an isolated office within the hospital to guarantee total confidentiality from the administrative hierarchy. Drawing on the precepts of Savoie-Zajc (2011), Kvale (2007), Van Kaam (2016), and Colaizzi (1978), the researcher practiced active listening, using non-directive prompts to avoid inducing responses. Finally, the fourth phase encompassed the complete transcription of audio recordings immediately after each encounter, enriched by field notes documenting non-verbal expressions, silences, and emotional manifestations of participants facing their ethical suffering.

2.6 Data Analysis Technique

The processing of textual data from verbatim transcriptions was carried out through thematic content analysis assisted by computer using ATLAS.ti software. Analytical rigor was maintained by following the systematic procedure documented by Friese (2019), Silver and Lewins (2014), Rambaree (2021), and Hwang (2023). The process began with the open coding phase where textual documents were read line by line to assign conceptual codes. Primary importance was given to in vivo codes that reproduced the exact expressions of caregivers to describe their alienation. Subsequently, axial coding grouped these isolated codes into broader categories, called code families. This step thus linked structural determinants of precariousness to corresponding subjective experiences. Finally, the conceptualization phase used ATLAS.ti's network view to map logical relationships, contradictions, and causalities between different themes, allowing transparent and traceable modeling of the overall structure of the identity loss phenomenon specific to these staff members.

2.7 Ethical Considerations

Conducting research on professional distress within a sensitive state institution required absolute ethical vigilance, rigorously adhering to the great principles of universal bioethics theorized by Beauchamp and Childress (2019), Guillemin and Gillam (2004), Iphofen (2020), and Mainard (2021). The first imperative concerned obtaining free and informed consent, materialized by the signing of a written form after a clear explanation of the right to withdraw from the research at any time without any professional prejudice. The second imperative imposed strict anonymity and complete de-identification of textual data to protect participants from possible hierarchical sanctions, translated by the use of neutral alphanumeric codes instead of names and the smoothing of overly specific biographical details. Finally, the third ethical imperative encompassed the principle of beneficence and the management of emotional countertransference. The researcher committed to maintaining a posture of caring listening and offering a space for psychological debriefing at the end of each interview, mitigating the emotional charge potentially reactivated by the narrative of workplace suffering.

3. RESULTS

3.1 Sociodemographic and Professional Characteristics

Table 1. Individual encoding matrix of respondent characteristics (N=7)

Code	Sex	Age (years)	Education level	Clinical tenure	Monthly total income	Home-hospital distance
INF-01	Female	46	Licensed (L2)	14 years	85 USD	>1 km
INF-02	Female	42	Licensed (L2)	11 years	90 USD	>1 km
INF-03	Female	51	Graduate (A1)	18 years	80 USD	>1 km
INF-04	Male	38	Licensed (L2)	8 years	95 USD	<1 km
INF-05	Female	49	Graduate (A1)	15 years	85 USD	>1 km

Code	Sex	Age (years)	Education level	Clinical tenure	Monthly total income	Home-hospital distance
INF-06	Female	45	Licensed (L2)	12 years	90 USD	>1 km
INF-07	Female	34	State-certified (A2)	5 years	75 USD	>1 km

This table serves as a key for discourse analysis. Codes from INF-01 to INF-07 were systematically attached to verbatim presented in the text to guarantee scientific traceability of data while preserving strict participant anonymity.

3.2 Thematic Analysis of Interviews: Nurses' Lived Experience at Wangata GRH

Theme 1: Professional Trajectory and Motivations

Subtheme 1.1: Entry into the profession through intrinsic vocation or default choice

Nursing commitment married altruism and educational constraints related to limited university offerings in Mbandaka.

"I started wanting to help people, but also because there weren't many other schools here in Mbandaka" (5 out of 7 nurses).

This motivational ambivalence revealed early identity fragility, where initial altruism collided with educational determinism in Équateur Province. Choosing the profession by default, for lack of diversified university alternatives, weakened the nurses' psychological contract from the start. Faced with harsh clinical realities at Wangata GRH, this lack of initial options accentuated feelings of professional entrapment and precipitated identity loss.

Subtheme 1.2: Temporal anchoring and tenure at Wangata GRH

Professional trajectories revealed prolonged urban sedentarization, following initial clinical practice in rural or peripheral zones of the province.

"I have been at this hospital for 9 years. Before, I was in a health center in Bikoro" (4 out of 7 nurses).

Wangata GRH attracted personnel from the hinterland, but this decade-long stability without social improvement reflected a blockage of health mobility, generating professional wear and tear.

Subtheme 1.3: Professional stagnation and horizontal compartmentalization

Career advancement dynamics within the hospital institution were characterized by an absence of vertical progression. Changes in assignment were limited to transfers from one clinical department to another, maintaining staff in an unchanging status despite accumulated years of service.

"I am still a state-certified nurse, never promoted. We just rotate through services" (6 out of 7 nurses).

This stagnation revealed a rigid provincial glass ceiling in Congo. Inter-service rotation did not enrich competencies but constituted a managerial palliative masking the absence of internal promotions. This sterile circularity devalued diplomas and installed a feeling of administrative uselessness that destroyed professional development.

Theme 2: Perception of Professional Identity

Subtheme 2.1: Sacralization of care through the notion of personal sacrifice

The construction of meaning in the profession among Wangata GRH nurses operated in a context of global material destitution. Discourses highlighted a strong internalization of the sacerdotal dimension of care, where persistence in patient assistance was erected as an absolute moral imperative surpassing material contingencies.

"Being a nurse means accepting lack of everything, but not abandoning patients" (all 7 nurses).

"Sacrificial care" redefined nursing identity through tolerance of scarcity rather than technical mastery. This paradoxical defense mechanism sacralized collective endurance to avoid feelings

of professional failure. While this ethics ensured service survival, it absolved the institution of its logistical obligations.

Subtheme 2.2: Feeling of invisibility and deficit of social recognition

Interactions within the hospital arena revealed clear demarcation lines regarding attribution of professional prestige. Participants reported a marked asymmetry in the capture of public recognition, with clinical successes systematically associated with the physician figure.

"Doctors take all the credit. We remain in the shadows" (6 out of 7 nurses).

Symbolic spoliation generated violent social invisibility for the Mbandaka nurse, who nonetheless ensured care continuity. By confiscating recognition, the hospital maintained the nursing corps in alienating dependence, relegating the profession to the shadows and reinforcing the stereotype of the subordinate executor.

Subtheme 2.3: Proximity cohesion and service solidarity

Faced with lack of institutional recognition, nursing staff developed dynamics of horizontal alliance within care units. These mutual assistance relations constituted a daily bulwark, although they did not translate into effective voice during formal management meetings.

"Among ourselves, we support each other. But in meetings, we don't have a voice" (5 out of 7 nurses).

Nursing cohesion at Wangata GRH functioned in a defensive and informal mode. While this proximity solidarity helped endure daily life, it created no political counter-power. Trapped in a culture of submission, mutual assistance confined itself to corridors, abandoning decision-making space to doctors and administration.

Theme 3: Working Conditions and Environment

Subtheme 3.1: Chronic shortage of inputs and infrastructure destitution

The practice environment at Wangata GRH was characterized by a structural lack of basic medical consumables and personal protective equipment. Caregivers described recurrent situations where absence of materials forced them to improvise to maintain care continuity.

"No gloves, no alcohol, sometimes even no gauze. We manage with washed cloths" (all 7 nurses).

Logistical shortages forced nurses into a tragic arbitration between therapeutic abstention and high-risk care. This permanent improvisation altered their technical identity, generating guilt and depersonalization when faced with scientifically non-conforming acts dictated by destitution.

Subtheme 3.2: Work overload and unpaid night shifts

Work time organization at this general reference hospital relied on particularly extended duty schedules. These prolonged service periods were performed without adequate salary compensation and under precarious rest conditions.

"We do 36-hour shifts without extra pay. Sometimes we sleep on a stretcher" (6 out of 7 nurses).

These 36-hour shifts imposed on stressed staff constituted institutionalized exploitation and a breach of care safety. The absence of decent dormitories materialized hospital contempt. This chronic exhaustion altered nurses' cognitive capacities and precipitated their affective disengagement from the profession.

Subtheme 3.3: Impact of climatic realities and local sanitary vulnerability

Mbandaka's geographical situation, subject to a rigorous equatorial climate, directly influenced the attendance and health of hospital staff. Deficiencies in the urban road network transformed caregiver travel into major constraints during heavy rainfall episodes.

"Many nurses fall ill. Going to work in the rain in Mbandaka, the roads are impassable" (4 out of 7 participants).

Environmental equatorial factors, such as torrential rains, multiplied hospital hardship by causing isolation and resurgence of malaria. Without logistical support for transport or medical care for

staff, the hospital aggravated survival absenteeism, leaving the nurse doubly abandoned by nature and employer.

Theme 4: Factors of Identity Loss

Subtheme 4.1: Economic pauperization and salary insufficiency

The financial dimension constituted a central stumbling block in the professional experience of Wangata GRH staff. The level of remuneration received was described as largely inferior to essential subsistence needs, altering the worker's social status.

"My monthly salary doesn't even cover transport. We feel like volunteers" (all 7 nurses).

Salary insufficiency and delays in risk allowances in DRC destroyed the professional dignity of caregivers. Lacking economic emancipation, they went into debt to work, perceiving themselves as captive volunteers. This pauperization dissolved self-esteem and imposed extra-professional survival strategies detrimental to care quality.

Subtheme 4.2: Relational asymmetry and contempt from medical-administrative staff

The managerial climate within the institution was marked by highly hierarchical interprofessional relations. Participants reported attitudes of disregard from medical authorities, translating into denial of their status as collaborators.

"The head physician speaks to us like servants. He doesn't even know our names" (5 out of 7 participants).

Anchored in hospital culture, paternalism and medical authoritarianism imposed servile subordination assimilated to domesticity. This dehumanization through denial of nominal identity and daily humiliation destroyed nurses' clinical confidence, annihilating any autonomous therapeutic initiative in favor of passivity destructive to their identity.

Subtheme 4.3: Trauma related to public health emergencies and successive epidemic crises

Équateur Province experienced several major health crises in recent years. Direct exposure to these deadly pathologies, without assurance of adequate biological protection, left deep psychological traces among front-line personnel.

"During Ebola, they sent us sometimes without necessary equipment. I wanted to resign" (3 out of 7 nurses).

Ebola, COVID-19, and Mpox crises revealed Wangata GRH's vulnerability. Sending nurses to the front without protection broke the employer's moral contract. Faced with risk of death and abandonment by Kinshasa, professional identity collapsed before the survival instinct, making resignation the only rational exit.

Theme 5: Preservation Strategies and Recommendations

Subtheme 5.1: Spiritual transcendence as psychological defense mechanism

To compensate for lack of institutional support and degradation of their work environment, nurses mobilized spiritual resources. Resort to Christian faith intervened as an indispensable emotional regulator before taking service.

"I pray every morning before entering. Without God, I would have already left" (6 out of 7 nurses).

Caregiver resilience in Mbandaka rested on collective adherence to a metaphysics of suffering. Morning prayer served as a psychological shield against the hospital environment by displacing recognition toward the divine. However, this religiosity induced fatalistic resignation that slowed active claiming of social rights.

Subtheme 5.2: Informal sharing economy and resource pooling

Operational survival of different hospital services was guaranteed by the establishment of a solidarity micro-economy. Staff daily shared their food resources and the rare protective tools available within the institution.

"We share our meals and our rare gloves. Otherwise, we wouldn't hold up" (all 7 nurses).

The gift economy and resource sharing formed the last rampart against the collapse of care at Wangata. This act of ethical co-survival and organic solidarity compensated for the failures of the Congolese state. The nursing group substituted for failing logistics, keeping the institution afloat by socializing material misery.

Subtheme 5.3: Demand for decentralized training and securing of risk allowance

In terms of future perspectives, proposals formulated by nursing staff oriented toward pragmatic proximity solutions. They demanded equitable access to on-site skills reinforcement and regularization of their basic financial incentives.

"Let them train us here in Mbandaka, without going to Kinshasa. And let them pay us a modest risk allowance" (5 out of 7 nurses).

Participants denounced the stifling centralism of Kinshasa, which monopolized professional development. By demanding decentralized training in Mbandaka, they aimed for local scientific rehabilitation. Their modest financial demand illustrated their economic pragmatism: they did not seek opulence but minimal contractual security guaranteeing their daily survival.

4. DISCUSSION

4.1 Career Inertia and Mobility Paralysis in Provincial Settings

The advancement of nurses in Mbandaka suffered total blockage, illustrating the excessive centralization of Kinshasa denounced by Mukendi et al. (2021). Deprived of career prospects, they faced a feeling of administrative uselessness described by Maluwa et al. (2012), which reduced them to simple executors. The only changes consisted of mandatory horizontal transfers between services. Far from being enriching, these rotations masked a lack of local managerial management (Mayombo, 2022) and confined caregivers to trajectories of relegation according to Dubar's (2015) concept, ruining their clinical confidence and any chance of specialization.

4.2 Ethical Conflict Between Care Mission and Structural Destitution

The acute shortage of inputs forced nurses into constant improvisation at the expense of biosecurity. This predominance of the "système D" (makeshift solutions), analyzed by Nsambanzilu (2023) in DRC, echoed the work of Roets et al. (2018) in South Africa on risks of nosocomial infections. This routine degraded the scientific dimension of evidence-based care and generated profound ethical dissonance. To overcome this destitution, caregivers took refuge in spiritual overinvestment, reactivating the sacrificial care model (Roets et al., 2018). However, as De Gasquet (2019) emphasized, this logic of charity slowed professionalization. This mystical devotion proved alienating, pushing nurses to assume responsibility for the hospital system's failure.

4.3 Power Asymmetry and Interprofessional Symbolic Violence

Physicians displayed marked condescension, using infantilizing terms that illustrated Bourdieu's (1984) symbolic violence and the feudal system described by Mayombo (2022) in Équateur. This contempt, which broke self-esteem as observed by Awooda et al. (2020) in Sudan, dehumanized caregivers. This denial of their identity disqualified them before patients and stifled any professional affirmation. Excluded from decisions, their clinical observations remained ignored, marking the failure of interprofessional collaboration theorized by d'Amour et al. (2008). Reduced to simple executors of prescriptions, they lost their intellectual substance (Maluwa et al., 2012). This systematic marginalization provoked professional aphasia, pushing nurses to feel useless in their own expertise.

4.4 Biological and Economic Vulnerability During Health Crises

Sent to confront Ebola or Mpox without protection or training, caregivers experienced a profound feeling of abandonment. This trauma echoed the ethical rupture described by Kabamba (2020) in Équateur and the findings of Awooda et al. (2020), where medical duty became forced sacrifice. This deliberate endangerment broke attachment to the institution, transforming professional pride into painful existential regret. Simultaneously, salary misery and delays in risk allowances illustrated the failure of Herzberg's (1966) hygiene factors. This pauperization sometimes pushed toward the financial deviations denounced by Mukendi et al. (2021). The state

thus broke the work contract by demanding everything without counterpart, transforming care into imposed volunteerism and leading to silent resignation.

4.5 Study Limitations

Several limitations should be acknowledged. First, the sample size (n=7) was modest, although qualitative saturation was reached. Second, the single-site design limits generalizability to other hospitals in the DRC. Third, the cross-sectional nature of data collection captured experiences at one point in time, which may not reflect evolving conditions. Fourth, social desirability bias may have influenced participant responses regarding sensitive topics such as salary and hierarchical relations. Despite these limitations, the study provides rich phenomenological insight into the lived experience of nurses in a resource-limited Congolese hospital.

5. CONCLUSION

This descriptive phenomenological research highlighted a severe professional identity loss among nurses at Wangata GRH in Mbandaka, trapped between chronic logistical shortages, administrative stagnation, and violent medical paternalism. To survive this ethical and biological suffering, caregivers took refuge in a sacrificial model or silent resignation. Faced with this crisis, this study recommends urgent reforms: regularize local risk allowances, decentralize continuing professional development to bypass the centralism of Kinshasa, institute participatory governance that values nursing diagnosis, and guarantee the permanent distribution of personal protective equipment against epidemics.

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