

Creating Incentives to Work in Ghana: Results from a Qualitative Health Worker Study

Tomas Lievens, Pieter Serneels, Sabine Garabino, Peter Quartey, Ebenezer Appiah, Christopher H. Herbst, Christophe Lemièrre, Agnes Soucat, Laura Rose, Karima Saleh

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Health, Nutrition and Population (HNP) Discussion Paper

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Creating Incentives to Work in Ghana: *Results from a Qualitative Health Worker Study*

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Abstract: The Ministry of Health, Ghana, is engaged in developing a new Human Resources for Health (HRH) Strategy (2001–15); one that tries to draw on some of the evidence pertaining to the dynamics of the health labor market. This study is one of several efforts by the World Bank to support the Ministry of Health in its endeavor to develop a new evidence-based HRH strategy. Using qualitative research (focus group discussions), this study carries out a microeconomic labor analysis of health worker¹ career choice and of job behavior. The study shows how common problems related to distribution or performance of HRH are driven by the behavior of health workers themselves and are determined largely by select monetary and nonmonetary compensation. Such findings generate insights that provide a starting point for further analysis and a basis for the development of effective human resources for health policies.

Keywords: Health Workers, Ghana, HRH, Health Labor Market, MDGs

Disclaimer: The findings, interpretations, and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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Table of Contents

ABBREVIATIONS	6
PREFACE	7
AUTHORS AND ACKNOWLEDGMENTS	8
EXECUTIVE SUMMARY	9
CHAPTER 1. INTRODUCTION	13
METHODOLOGY	14
<i>Summary</i>	14
<i>Focus Groups</i>	14
CHAPTER 2. CHOOSING A CAREER IN THE HEALTH SECTOR	18
<i>Summary</i>	18
<i>The Role of Earnings</i>	19
CHAPTER 3. WHICH JOBS ARE ATTRACTIVE TO HEALTH WORKERS: IDENTIFYING THE RELEVANT JOB ATTRIBUTES	21
<i>Summary</i>	21
<i>Salary and Remuneration</i>	22
<i>Allowances and Bonuses</i>	24
<i>Workload and Hours Worked</i>	25
<i>Access to Equipment</i>	26
<i>Access to Training</i>	27
<i>Social Recognition</i>	29
<i>Exposure to HIV and AIDS</i>	29
CHAPTER 4. WHICH JOBS ARE AVAILABLE FOR HEALTH WORKERS?	31
IDENTIFYING THE DIFFERENT OPTIONS	31
<i>Summary</i>	31
<i>Working in the Public Sector</i>	33
<i>Working in the Private Sector</i>	34
<i>Working in the NGO Sector</i>	35
<i>Locum and Dual Practice</i>	36
<i>Changing Sectors</i>	38
<i>Rural and Urban Posting</i>	38
<i>Working in Public Health</i>	40
<i>Migrating Abroad</i>	40
<i>The Ideal Career</i>	42
<i>Informal Health Care</i>	42
CHAPTER 5. HEALTH WORKER PERFORMANCE	44
<i>Summary</i>	44
<i>Absenteeism</i>	44
<i>Shirking and Malingering</i>	46
<i>Informal Fees and Other Forms of Petty Corruption</i>	46
<i>Drug Embezzlement and Pilfering</i>	47

CHAPTER 6. MONITORING AND EVALUATION.....	50
<i>Summary</i>	50
<i>Performance Evaluation</i>	50
<i>Promotion</i>	51
<i>Patient’s Voice</i>	51
CHAPTER 7. CONCLUSION.....	53
APPENDIX. PARTICIPANT SELECTION CRITERIA.....	55
<i>Overview of the Eight Focus Group Discussions</i>	55
<i>FGD U1 & R1—Doctors</i>	55
<i>FGD U2 & R2—Senior Nurses</i>	55
<i>FGD U3 & R3—Auxiliary Nurses</i>	56
<i>FGD U4 & R4—Users</i>	56
REFERENCES.....	57

ABBREVIATIONS

ADHA: Additional Duty Hour Allowance

FGD: Focus Group Discussion

HRH: Human Resources for Health

ISSER: Institute of Statistical Social and Economic Research

MOH: Ministry of Health

NHIS: National Health Insurance Scheme

OPM: Oxford Policy Management

PREFACE

Ghana has made significant progress in some health outcomes, but lags behind in others: infant mortality has decreased (from 77 per 1000 live births in 1988 to 50 in 2008), and fertility rates have come down (from 6.4 percent in 1988 to 4 percent in 2008). However, much targeted effort is required to ensure that maternal health outcomes, in particular, and nutrition status are improved. Maternal mortality remains high and has declined very slowly in the past two decades from 740 per 100,000 live births in 1990 to 451 in 2008. Immunization coverage is improving (79 percent in 2008), although neonatal death is still high (30 per 1,000 live births in 2008). Institutional delivery remains low (57 percent in 2008).

The Government of Ghana recognizes that further improvement of health outcomes and in particular maternal and neonatal mortality requires further improvement in access to health services, currently hampered by remaining health systems weaknesses. One such weakness concerns the health workforce; there is general consensus that intervention to increase and improve health worker stock, distribution, and performance is critical to further improve access to health services and thus health outcomes. Regional evidence on Africa suggests a strong correlation between the number of health workers and assisted deliveries.

So far, the government has demonstrated strong commitment to addressing the country's so-called Human Resources for Health (HRH) crisis, which is well reflected in Ghana's Human Resources for Health Strategic Plan 2007–2011. The plan, drawing on some basic evidence and data on HRH, aims at ensuring an adequate and equitable distribution of an appropriately skilled and motivated health workforce through effective HRH planning, increased workforce production, improved productivity and performance management, and strengthened overall HRH management. It fits into the broader health sector plan, which prioritizes general health systems development, and is also consistent with the government's vision to bring the country to middle-income status by 2015—a goal that requires a healthy population.

The Ministry of Health is now engaged in developing a new Human Resources for Health Strategy (for 2011 and beyond), one that tries to draw on some of the evidence pertaining to the dynamics of the health labor market. This study is one of several efforts by the World Bank to support the Ministry of Health in its endeavor to develop a new evidence-based HRH strategy. Using qualitative research (focus group discussions), this study carries out a microeconomic labor analysis of health worker² career choice and of job behavior and generates insights that provide a starting point for further analysis and a basis for the development of effective human resources for health policies.

2. Only doctors, nurses/midwives were interviewed for this research. The term “health worker,” frequently used in the text, indicates only those three cadres of staff.

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The lead authors of this report are Tomas Lievens, Pieter Serneels, Sabine Garabino, and Peter Quartey. Contributors are Ebenezer Appiah, Christopher H. Herbst, Christophe Lemiere, Agnes Soucat, Laura Rose, and Karima Saleh.

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EXECUTIVE SUMMARY

To explore, identify, and describe explanatory factors and their interrelationships in health worker performance and labor market choice, this study uses focus group interviews, which elicit and contrast a multitude of views of health workers and also allow for the collection of a large quantity of data in a relatively short time. Participants were purposively selected to represent a range of profiles, and interviews were recorded, transcribed, and analyzed with text software.

The research interviewed sixty-three doctors, nurses, and patients in eight separate groups; four in the capital and four in a provincial town, although the health workers' facilities were (with a few exceptions) in the rural areas around the provincial town. Due to the small-scale nature of this qualitative study, the results are suggestive rather than generalizable.

The findings suggest that health workers in Ghana enter the health sector both because they are motivated to care for sick people and because the sector, for the cadres interviewed in this work, pays well, "guarantees" a job, and offers opportunities for international migration. The relatively good material prospects of the sector are believed to have contributed to attracting less dedicated health workers, who are less empathetic and compassionate and have a lesser drive to serve and care for patients. On the other hand, there are instances where dedication has been eroded because material incentives are too low. This indicates there is a need for further fine-tuning of the incentive structure to elicit each worker's best performance.

Job attributes that predominantly drive health worker labor market choice are salary, benefits and allowances, and access to training; while issues like workload, the availability of medical equipment, and social recognition also play a role. Salary is by far the most important job attribute, with the private sector offering the highest payments in comparable jobs. The NGO sector, while offering the same salary as the public sector, offers additional financial benefits. Overall, basic remuneration in the health sector is seen as too low given the workload and compared to other sectors. Allowances and bonuses are strongly associated with the NGO sector and seem to succeed at better addressing workers' preferences and elicit better performance. The public sector has also tried out various incentives schemes, which were generally appreciated but were subject to high levels of uncertainty as to how they could be accessed and to whom they applied, suggesting that their potential to impact health worker behavior was not fully realized. Rural incentives were tried as well but were not seen as effective by either the ministry or the health workers. There is considerable variation across sectors and locations in the number of hours health workers are expected to work and in workload management practice. In general, the workload is considered high or too high, especially in the public sector, and seems to be increasing over time. Patients also complain that they are not given sufficient quality time during consultations. This is associated with the high workload and the lack of medical equipment. Health workers indicate that lack of equipment can also lead to job dissatisfaction and even international migration. Rural facilities are generally poorly equipped, and health workers who spend a long time in these facilities are perceived as delivering poor quality care. These factors further contribute to making rural service unattractive. Having access to training is also seen as important, and the public sector provides the most opportunities for further training and specialization. However, senior management may select or allocate training opportunities based on the attendance fee they yield rather than on professional need. While rural jobs provide lower access to training, they provide thorough first job experience, which is strongly appreciated

by some health workers. Access to postgraduate training has improved since the Ghana College was set up.

The major career choices for health workers in Ghana are the choices between jobs in the public, private, and NGO sectors; between rural or urban practice; and for possible migration abroad. From the individual health worker's perspective, each choice has advantages and disadvantages that match his or her preferences. Health workers typically enter the public sector after subsidized training, and see the obligation to work for the public sector as a guaranteed first job. Users argue that health workers in the public sector put in little effort and that waiting times are too long, but at the same time they often perceive workers to be more competent than those in the private sector. Most commonly, workers in the private sector are paid by the hour; but while pay may be good, opportunities for further training are poor. Private sector workers are perceived as putting in more effort, a phenomenon often attributed to the higher level of remuneration. Their attitude toward patients is also perceived to be better compared to public sector workers'. Users of health services confirm that more staff is available and waiting times shorter. At the same time, the quality of staff is not guaranteed. An important though small segment of Ghana's health care providers are NGO institutions. Since most NGOs are faith-based organizations, health workers usually need to be church members to be considered for a job in a NGO facility. NGO health workers typically live on the premises of the facility and have a comparatively heavy workload. Performance expectations are high, and supervision and workplace norms are strict. Health workers are unanimous that workers in the NGO sector provide patient-centered care. The quality of care is judged higher, waiting times are generally shorter, and staff is less absent.

Health workers also have clear preferences between rural and urban posts. They identify a number of disadvantages associated with rural postings. An important factor is isolation, which includes absence of quality schooling for children, limited social life, and for single people, the lack of opportunities to meet a partner. Professionally, rural facilities are often ill equipped and have high workloads, with many off-hour obligations, including night duties. For doctors, there are also limited opportunities to top up their salary through dual practice. On the other hand, health workers also cite a number of positive aspects: on-the-job clinical as well as managerial experience, especially for young staff; and the chance to help poor and sick people, which is especially attractive for committed health workers. Social recognition also tends to be high and the cost of living low. The discussions suggest that rural jobs could be made more attractive by introducing a rural premium, better equipment, and improved career prospects (for instance, a credible commitment to limited tenure of rural service and an offer of promotion to health workers after rural service). Access to adequate schooling for children and transport to visit family in urban areas are also seen as important.

Migration abroad is predominantly motivated by financial reasons. Among the key factors that push Ghanaian health workers to migrate are the poor access to postgraduate training and the lack of a performance-based promotion system and of regular pay rises. Family pressure to take up a well-paid job abroad and send remittances home can also play a role. But moving abroad is not straightforward and has become more difficult over time. Recent salary increases also seem to have slowed down emigration for nurses, but it is unclear what the effect is for doctors.

Turning to on-the-job performance, the most common performance problems among Ghanaian health workers are absenteeism, shirking, petty corruption, and drug pilfering. Absenteeism among health workers occurs frequently and seems to increase with the level of

position. Absenteeism among public sector doctors and senior nurses seems most closely linked to locum or moonlighting in the private sector, and appears to be most prevalent in urban areas. In general, dual work creates a number of difficulties. Working two jobs tends to be exhausting for the health worker and may lead to lower efficiency and quality of service, including poor attitudes to patients. Absenteeism is usually not sanctioned in the public sector, in contrast to the private sector. Shirking,³ although not endemic, is also commonly observed and seems more noticeable in urban facilities. Health workers do not seem to be frequently involved in petty corruption or in charging informal fees. When there is corruption, it mostly seems to involve administrators (like accountants, money collectors, and cashiers), and it seems to occur more frequently in the public and rural facilities. Drug embezzlement seems similarly to be carried out mainly by drug administrators and pharmacists, since health workers typically do not have direct access to drugs. Regarding their own attitude toward patients, health workers say they try to have a positive attitude and show respect to the patients, but admit to being rude at times, often as a consequence of a high workload. Patients confirm that health workers are easily angered. The attitudes of health workers toward patients seem roughly similar across sectors, although they may be better in NGO and rural sector facilities.

The discussions confirm that monitoring is a powerful tool to impact health worker behavior in conjunction with external and internal incentives and workplace norms. Three monitoring devices are commonly used in Ghana: performance evaluation, promotion, and patient voice. All three seem to be functioning at a suboptimal level. Although a number of performance appraisal mechanisms are in place, they do not seem to be used to elicit high performance and penalize low performance. Promotion is generally granted on the basis of the number of years of service and not on performance. Patients also lack ways in which to express complaints about health worker behavior, for instance. A culture of linking performance to reward is more prevalent in the NGO sector.

These findings provide some direction for further research and for policy making. Further research is needed to inform improved policy making; quantitative research should test more formally some of the hypotheses generated by this work. When changes to HRH policy are implemented, they would greatly benefit from rigorous impact evaluation. At the policy level, the findings suggest both practical changes and new directions. Jobs in the public sector, especially in rural areas, can be made more attractive to health workers relatively easily by fine-tuning existing incentive schemes and clarifying and adapting existing regulation. Allowance schemes in the public sector, especially for rural posts, should be made more transparent and should aim to match workers' preferences. Even relatively small changes that could be put in practice quickly, such as a commitment to limiting the period of rural service, deserve attention. Existing schemes for monitoring and performance evaluation and promotion as well as giving patients voice need to be further optimized to elicit better performance and penalize poor performance, absenteeism, and shirking.

The direction of future human resource policies is to focus more on matching health worker preferences with the jobs available. To address this, job attributes must correspond more closely to health worker preferences and the job market, better organized. Measures such as organizing information to improve market transparency, setting up a specialized employment agency for the health sector, and organizing the market to improve matching need to be actively explored.

3. Shirking means that a worker avoids working hard while at work.

Overall, the study findings indicate that more effective and purposeful human resource policies are not only needed but also are within reach of the Ministry of Health and will help improve health service delivery in Ghana.

CHAPTER 1. INTRODUCTION

It is increasingly recognized that health workers are a key input for health service delivery. The mix of their numbers and their skills have been the traditional policy focus, but recently attention has also focused on their job choice and their on-the-job performance, which are both important drivers of health system outputs.⁴

In recognition of the importance of HRH, the Ministry of Health in Ghana is currently working on developing a new HRH Strategic Plan, covering 2011–15, which is to form the basis for intervention on HRH. The plan aims to address key concerns related to the availability of health workers, particularly in rural areas, as well as to their performance. To achieve results, effective HRH policies must include interventions that increase the size of the workforce, improve urban-rural distribution of health workers, and manage their performance.

Geographical maldistribution, low productivity levels, and dual practice are three often discussed examples of contemporary HRH challenges in Ghana. They are the consequence of individual health worker choices. Indeed, health workers, even with limited options, make informed choices about where to be based, how hard to work, and in which sector to work; these individual choices then culminate into sector-wide health workforce challenges.

This paper is one of several efforts by the World Bank to support the Ministry of Health in its endeavor to develop its new evidence-based HRH strategy. Currently there is little understanding about the microeconomics of health worker career choice and performance. What are the factors that determine rural versus urban choice? Why do some health workers prefer a career in a rural facility? Why does productivity, as measured by patient-days-equivalent per health worker, vary so dramatically between individuals with the same wage? To help fill this gap in understanding, this study carries out qualitative research on the career choice and performance of health workers in Ghana.

Concerned with understanding key questions of labor market choice and on-the-job behavior of health workers, this study uses a qualitative approach to explore the drivers of health worker choice and behavior and the interaction among these. It generates preliminary insights and perhaps is best seen as a preparatory phase for complementary quantitative research that can test more formally some of the hypotheses generated by this work. Its ultimate aim is to provide further inputs to more effective human resources for health policies. This paper is one of several papers produced by the World Bank to analyze specific components of the health labor market in Ghana.

Crucially, this study is premised on the notion that health workers are not passive actors in the health system, but make choices about where, when, and how to work that are governed by their preferences and by the institutional and organizational environment in which they operate. The study focuses on individuals with formal training in allopathic medicine. In recognition of the interdependencies between different parts of the health sector, it includes health workers active in the public, private, and NGO sectors as well as those working in hospitals, clinics, and primary health care units. Similar research in Ethiopia and Rwanda

4. Hongoro, and Normand. "Health Workers: Building and Motivating the Workforce." (2006); JLI (Joint Learning Initiative). *Human Resources for Health: Overcoming the Crisis*. (2004).

provides a framework and methodology for this study and allows a comparison across countries.⁵

The remainder of the text is organized as follows: In the subsequent section of this chapter, we provide details on the study method. Chapter 2 highlights the reasons that health workers enter the health sector, while chapter 3 analyzes the attractions of jobs in health, and chapter 4 assesses the different career paths available. Chapter 5 discusses health worker performance, and chapter 6 reports findings on human resource management, focusing on monitoring and evaluation. Chapter 7 provides a conclusion.

METHODOLOGY

Summary

Because health worker career and performance choices are poorly understood, this research uses qualitative methods to explore, identify, and describe explanatory factors and their interrelations. To elicit and contrast a multitude of views of health workers and to collect a large quantity of data in a relatively short time, the research used focus group interviews. Participants were purposively selected to represent different profiles, and interviews were recorded, transcribed, and analyzed with text software. The research interviewed sixty-three doctors, nurses, and patients in eight separate groups; four in the capital and four in a provincial town to capture the rural reality. Due to the small-scale nature of the study, its findings are not generalizable to the entire population of doctors, nurses/midwives.

This section briefly describes the study method. It explains why focus group discussions were chosen, how the participants in the groups were identified, and how the data were registered and analyzed.

Focus Groups

Qualitative methods are well suited to building first insights and exploring issues that are poorly understood and complex in nature. This is also the case for health worker career and performance choices. The choice for certain jobs with specific characteristics as well as the prevalence of issues like absenteeism, shirking, or pilfering of drugs and small medical equipment are receiving increased attention, but their foundations are still poorly understood. Qualitative research, as applied in this study, can shed light on these issues and generate hypotheses for future quantitative research. It also reveals the vocabulary used by health workers, which is useful for follow-up quantitative research.

Group interviews elicit a multitude of views on a range of topics and allow the exploration and contrasting of different opinions. These interviews allow for the collection of a large amount of data in a relatively short timespan (in contrast to individual interviews). Following the same method as did previous research in Rwanda and Ethiopia, the study used semistructured group discussions with a preset interview guide. The interviews took place in June 2007. Participants of a similar socioprofessional status were brought together in the same groups to minimize inhibitions caused by differences in social and professional status.

5. See Lindelow, and Serneels, "The Performance of Health Workers in Ethiopia: Results from Qualitative Research" (2006); and Lievens, and Serneels, Synthesis of Focus Group Discussions with Health Workers in Rwanda (2006).

Given the wide variety in formal cadre definitions (the number of nurse cadres easily exceeds ten, for example), it was a challenge to divide the health workers into a limited number of sufficiently homogenous groups that corresponded with different health career choices. With help from the Ministry of Health and the Ghana Health Service, we categorized all cadres into three groups: doctors, senior nurses, and auxiliary nurses. We also interviewed users of health services. To guarantee variation within each group, participants were purposively selected using criteria that affect career and performance choice, such as gender, age, childbearing, sector of work (public, private, NGO⁶), and engagement in a second job for health workers and socioeconomic background for users. Health workers from the same facility who were previously acquainted were not allowed in the study. Appendix 1 shows the participant selection sheet, which was adhered to except in four instances due to the challenge of identifying female doctors, male nurses, health workers in the private sector in rural areas, and doctors who do not know each other at all. All groups counted eight participants except the group with auxiliary nurses in Accra, which proceeded with seven participants (as one had transport problems due to heavy rains).

Focus Group Discussions: Location, and Number of Participants

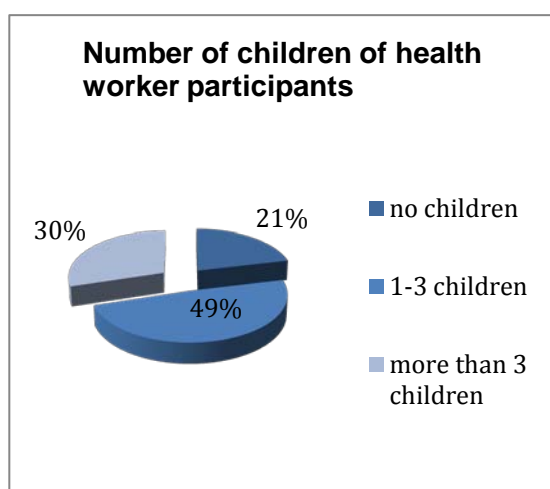
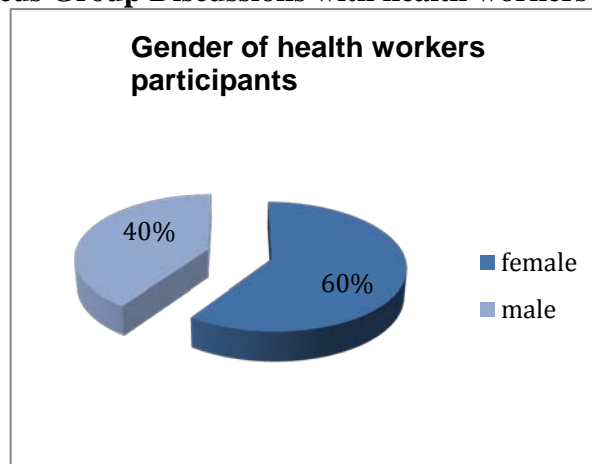
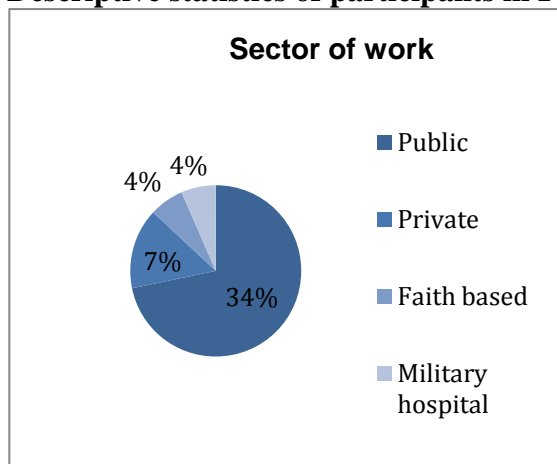
Code	Participants	Location	Number of participants	Length of discussion
U1	Doctors	Urban (Accra)	8	1h 49min
U2	Senior nurses	Urban (Accra)	8	2h 22min
U3	Auxiliary nurses	Urban (Accra)	7	1h 55min
U4	Users	Urban (Accra)	8	1h 52min
R1	Doctors	Rural (Sunyani)	8	1h 42min
R2	Senior nurses	Rural (Sunyani)	8	2h 06min
R3	Auxiliary nurses	Rural (Sunyani)	8	1h 55min
R4	Users	Rural (Sunyani)	8	1h 59min

To capture the differences between rural and urban settings, interviews were undertaken in the capital (Accra) and in a provincial town (Sunyani, northwest of Kumasi), bringing the group discussions to a total of eight in which a total of sixty-three persons participated. The table below gives an overview of the different focus group discussions (FGD), their location, and the number of participants.

The descriptive statistics below relate to the six health worker groups with doctors, senior nurses, and auxiliary nurses in urban and rural areas. Of all participants, 60% were female, reflecting that the majority of nurses in Ghana are female.

6. The most important segment within the nongovernmental health sector in Ghana is composed of faith-based institutions.

Descriptive statistics of participants in Focus Group Discussions with health workers



Average age of FGD participants

	Rural	Urban	Total
Doctors	39	44	42
Senior nurses	50	47	48
Auxiliary nurses	36	39	38

The interviews were conducted using semistructured interview scripts, which were based on scripts used in similar studies in Ethiopia and Rwanda, and further enriched with insights from both expert interviews in Ghana as well as from existing work on health worker career and performance. Each script focused on a number of issues and provided prompts or trigger questions to guide the discussion, where needed. Two separate interview guides were developed for users and health workers, although they mostly addressed the same issues. All discussions took place in a meeting room in a hospital either at the Legon hospital in Accra or at the district hospital of Sunyani. Interviews lasted just under two hours on average (1 hour and 58 minutes).

At the beginning of the discussion, participants were informed about the objectives of the study; its independent academic character was emphasized to avoid perceptions of linkages with the Ministry of Health, possibly triggering inhibition among the participants. Full confidentiality and anonymity were guaranteed. Participants filled out an information sheet and were reimbursed for transport and time cost.

The discussions were held in English except for the discussion with users in Sunyani, which was partly in Twi. The recorded discussions generated one audio file per group interview; these were then transcribed in English. The analysis (and coding) was carried out using QSR NVivo 7.0. A total of fifty-four codes have been used reflecting the diversity of the issues of interest in this study. Different codes can be applied to a single quotation in case the quote refers simultaneously to different topics. When this occurs, association between quotes can be investigated. In total 1,812 quotes have been examined. Throughout the remainder of this paper, participant quotes illustrate the topics discussed. These quotes are selected for their salience or because they reflect a recurrent or important theme in the discussions; no other filter has been applied. As is common with results from qualitative research, these quotes do not provide a representative view; rather they reflect health workers' and users' views on health worker careers and performance.

CHAPTER 2. CHOOSING A CAREER IN THE HEALTH SECTOR

Summary

Certainly, those who enter the health sector are motivated to care for sick people, but they are also drawn by the comparatively higher levels of income, lower unemployment, and better prospects for international migration. High levels of social recognition as well as a family example are also often cited as motivations to join the health sector. The public and NGO sectors also provide highly subsidized education in return for the obligation to work some years in a public or NGO health facility. Health workers do not perceive this kind of bonding scheme as negative as it guarantees a job immediately after training.

However, according to health workers themselves, dedication or commitment plays an important role in choosing the health sector. Dedication is variably described as being empathetic and compassionate, and as the drive to help and serve patients. Highly dedicated workers are less absent, more available for emergencies, and more willing to improvise to help patients when equipment is lacking. Not all workers are equally dedicated. Commitment levels of health workers may also change over time. Generally, health professionals today seem less dedicated than in the past, possibly because the increasingly good financial prospects of the sector have attracted less committed individuals. Dedication is often seen as independent from external incentives, but external incentives as well as monitoring can enhance commitment; and dedication may erode when incentives are too low. Dedication levels are highest in the NGO hospitals.

The Role of Dedication and Commitment, and its Diversity

When asked, “Why do people enter the health sector?” health workers state that dedication plays an important role. Dedication is variably described as being empathetic and compassionate, and as the drive to help and serve patients. Religious vocabulary is sometimes used. Dedication is seen to transpire in health workers’ on-the-job behavior, with highly dedicated workers being less absent, more available for emergencies, and more willing to improvise to help patients when equipment is lacking. The satisfaction that is derived from dedication may also compensate for suboptimal working conditions and low salaries.

I had wanted to be a lawyer but realized that the medical sector was the only way to serve mankind. I always advise people to go into nursing and tell them it is a God-given talent to do the job well, and if you are not born with it and you enter this profession, you will find yourself in a lot of trouble.

Senior nurse, rural area

It is also recognized that not all health workers are equally dedicated, and both users and health workers indicate that health professionals seem less dedicated than in the past. Reasons for the change might include the higher wages, the prospects for international migration, and the comparatively lower chance of unemployment—all attractions also for those who are less intrinsically motivated to care for patients. Medical schools have also expanded to train growing

numbers of students, and this may also contribute to less dedicated candidates entering into the profession.

The undedicated ones are those who were forced or pulled into the profession because of money, but not because they love it.

Senior nurse, rural area

The undedicated ones are those who take up the job in order to go to London.

Senior nurse, rural area

If you call me and I am not on duty, I will not be available.

Doctor, Accra

While health worker dedication is often seen as independent from external incentives, health workers recognize that both external incentives and monitoring can enhance commitment, and that dedication may erode when incentives are too low. Health workers believe that dedication is higher in those who work in NGO hospitals, also because monitoring and sanctions are in place and because health workers have “fear of God.”

Sometimes the problems are so big that the dedication ebbs away. Most of us in the public sector are doing the work because we have to, not necessarily because we love the work. We have to because we need our daily bread. I sometimes think it is like hell, there is apathy and the feelings for human beings are almost gone.

Doctor, Accra

The Role of Earnings

Apart from dedication, good financial prospects are an important reason to choose a career in health. Even if health workers do not earn as much as workers in finance or accountancy, they earn more than teachers, for example. Compared to other sectors, there is less unemployment in the health sector; additionally, the better prospects for international migration are especially attractive.

When I completed school, I decided to train as a nurse so that I could get a job.

Auxiliary nurse, rural area

It is better than some, but other sectors are a lot better than the health sector, such as banking and finance.

Doctor, Accra

Low-Cost Graduate Education and Guaranteed Employment through “Bonding” or Free Choice

Choosing employment in the health sector may also bring low-cost education and guaranteed employment whereas those who prefer greater freedom of choice must pay for their own education. Those receiving subsidized training in a public or NGO institution enter a bonding scheme, which obliges them to work for some years in the public sector, where the first assignment is typically in the geographical vicinity of the training institution; or the NGO sector, where the first job is not necessarily in the area of the training institution. Health workers tend to see the bonding practice in a positive light as it guarantees employment immediately after training. Privately trained health workers must find their own jobs; however, this is not perceived to be a problem, in general.

There are two options, either you will allow the hospital to sponsor you, or you will pay for [the training] yourself. If the hospital sponsors you, when you finish, you will work for them. So getting a job afterwards is easy, if they like the way you serve, they can just pick you at where you served. But if you sponsor yourself, you will choose your own way.

Auxiliary nurse, rural area

Both the public sector and NGOs provide this type of subsidized education for health workers. While they offer the same degree course, these may differ in content. Public schools in the south of the country tend to be more popular because they are in or close to Accra, but also because they are believed to be better equipped. Admission is awarded based on grades, and institutions in the south of Ghana, especially Korle Bu in Accra, are believed to attract better students. Mission training hospitals are also said to instil discipline in students. However, the labor market does not seem to place a premium on the training institution when looking for recruits.

CHAPTER 3. WHICH JOBS ARE ATTRACTIVE TO HEALTH WORKERS

IDENTIFYING THE RELEVANT JOB ATTRIBUTES

Summary

Salary is by far the most important job attribute. A comparison of similar jobs across sectors shows that the private sector offers the highest payment while the NGO and the public sector offer the same base salary. The NGO sector, however, also offers additional incentives and benefits while the public sector provides access to training, specialization, and job security. The public sector base salary is the same for urban and rural areas. However, the opportunities for savings and additional income differ: the urban centers offer opportunities for dual practice, but the rural sectors have significantly lower living costs. Lower-level health workers, especially, are able to save more in rural areas. The basic remuneration in the health sector is generally deemed too low given the workload and in comparison with other sectors.

Allowances and bonuses are strongly associated with the NGO sector, and a wide variety of schemes exist across dioceses. The public sector has tried its hand at various incentive schemes such as Additional Duty Hour Allowance (ADHA), deprived area allowances, a postgraduate scheme, and car incentives. While these schemes were generally appreciated, they were all subject to high levels of uncertainty as to how they could be accessed and to whom they applied. As a consequence, most health workers were unclear whether these schemes were still in place. This suggests that their potential to impact health worker behavior was not fully realized.

There is considerable variation across sectors and locations in the number of hours health workers are expected to work as well as in workload management practice. Most doctors in the public sector organize their own time, but nurses are more at the mercy of patients and colleagues. Duty rosters are often meaningless in rural areas where health workers are seen as permanently on call. The NGO hospitals often require health workers to live on the premises so that they are permanently available. Working hours in the private sector are more strictly regulated; and employees are paid for overtime. The workload, especially in the public sector, is considered high or too high, and is increasing over time. Patients complain that they are not given sufficient quality time by health workers during consultations.

Both users and health workers said quality of care was related to the availability of medical equipment. The lack of equipment can also lead to job dissatisfaction and even international migration. For lower levels of care, public facilities seem to be worst equipped and private facilities best equipped. But the opposite seems true for higher levels of care. Rural facilities seem poorly equipped in general, and health workers who spend long periods of time in these facilities are said to deliver poor quality of care. It is for these reasons that the majority of health workers find rural service unappealing.

Having access to training is seen as an important job attribute. The public sector provides the most opportunities for further training and specialization. Workers in the NGO sector may also have access to some training opportunities in the public sector. The private sector does not provide easy access to further education. Training is organized mostly through workshops with

participation based on specialization. However, senior management may choose to attend the “best” training or training that pays best, as many workshops provide attendance stipends. Lower ranked staff seems to have consistently less access to training, as do those in rural jobs. Rural service is, on the other hand, associated with acquiring thorough first job experience. Access to postgraduate training seems to have improved since the Ghana College was set up, although many health workers express frustration with the conditions for gaining access.

Social recognition is another important job attribute. It is highest in rural areas but has generally decreased over the years due to the strikes and because of workplace drinking, shirking, and corrupt behavior.

Availability of protective materials to prevent on-the-job HIV infection is generally good, as is health worker confidence in treating HIV-positive patients. Discrimination is low and confidentiality generally respected, but fear of infection remains and seems to explain some health workers’ on-the-job behavior and career choice.

Salary and Remuneration

There is substantial variation in financial remuneration in the health sector, both across sectors and across geographical locations. Generally, health workers have lost track of which sector pays best for comparable qualification and workload, although there is a consensus that the private sector offers the highest payment for health workers who are permanent staff. Second jobs in the private sector, also called “locums” in Ghana, are paid per hour and very popular among public sector workers in urban centers.

While in the past NGO sector health workers did not receive the Additional Duty Hour Allowance (ADHA), resulting in lower earnings than their public sector colleagues, today the NGO and the public sector offer the same base salary. The NGO sector often offers additional incentives and benefits such as a performance-based end-of-year bonus, presents and gifts for religious holidays, diocesan allowance, and so on; while the public sector offers other advantages like access to training, specialization, and job security. This explains, to some extent, the observed flow of workers from the NGO and the private sector to the public sector.

In Accra, depending on your rotation, you were able to close around 2 pm if you are in the outpatient department and do a four-hour job in a private clinic and go home by 6 or 7 pm. We also arranged with colleagues to stand in for us, and we would later make up the time lost. We did this to supplement our income. I am being told that things have now improved, and this may no longer be necessary.

Doctor, rural area

There is no difference between the public and faith-based sector when it comes to salary, but the mission hospital offers some additional allowances to their workers, like, for example, a monthly diocesan health allowance, which is structured according to the grade of the health worker. We also receive gifts during festive occasions like Christmas and Easter.

Senior nurse, rural area

The public sector base salary is also the same for urban and rural areas. However, the opportunities for savings and additional income tend to differ. While the urban areas offers opportunities to do a second job (locum work) in the private sector, the living costs in the rural areas are substantially lower, and health workers often get free housing accommodation; they are also more likely to receive presents from patients. Some health workers, therefore, save more in rural areas. Health workers believe that additional allowances for rural postings will attract more health workers to these postings. But these additional financial benefits would not compensate for other drawbacks of rural sector jobs such as the lack of equipment, limited promotion opportunities, less access to schooling for children, and poor living conditions in general.

The basic remuneration in the health sector is seen as too low given the workload and in comparison with other sectors such as banking, finance, and accountancy. Some health professionals therefore suggested that the basic remuneration should be further increased beyond the ADHA received in 1998 and consolidated into the salary in 2006.⁷ However, the industrial action that preceded this pay rise is seen by some as having damaged health workers' reputation. The pay rise salary levels are perceived to be more in line with the job responsibilities and requirements such as the need for night duties. The increased nurse salary may encourage nurses who migrated abroad to move back. Health workers in the private sector did not participate in the strikes, possibly because their salary levels are adequate, but they may also feel less secure about their jobs when they strike. Health workers believe an unintended effect of the salary increase to be that the sector now attracts more undedicated health workers who enter the profession for its rosy financial prospects and the chances it offers to migrate abroad.

Across the board, health workers feel they earn less than workers with comparable educational levels or social status. Although teaching is often seen as a similar profession, it comes with a lighter workload and more holidays. Workers in the banking sector and accountancy have substantially higher salaries yet are often seen as peers. While doctors have identical social status to other liberal professions like lawyers, they earn less.

If you are only entering the profession for the money, you will find that the sacrifice is not compensated for by the money you will get. If your friend starts working in the banking sector and you enter the nursing profession, you will see that she will quickly be ahead of you.

Senior nurse, Accra

To me, health workers are just greedy because they receive all the things needed to motivate them, like housing, for instance doctors' flats and nurses' quarters, car loans, etc., but they are still not satisfied.

User of health services, rural area

Perhaps unique to the sector is that health workers frequently receive (cash or in-kind) presents from patients, especially in rural areas.

7. Ministry of Health, "Analysing Health Labour Market Outcomes and Determinants in Ghana: A Status Report on Human Resources for Health," (January 2010).

Sometimes you get a reward from your patient that is more than your salary. You will serve the person nicely, and he will give you a check or buy you a phone or something, a nice reward that might be ten times your pay.

Auxiliary nurse, Accra

Allowances and Bonuses

Allowances and bonuses are strongly associated with the NGO sector. There is a substantial variation across dioceses, and a wide variety of schemes are in place including housing allowance, end-of-year bonus, performance-based bonus, diocesan car allowance, gifts and financial rewards for religious events, and transport and telephone allowance. These types of incentives are far less common in the private and public sector.

The mission hospitals have diocesan arrangements so the Eastern Regional Diocese may have different schemes than those in other regions. The missions also provide a housing allowance to keep workers in their district.

Doctor, rural area

Health workers were appreciative of ADHA in general but saw the shortcomings in the scheme, particularly the lack of information about the scheme, the unexplained differences between benefits for nurses and doctors, and the preferential treatment of administrators and accountants over clinical workers. ADHA was eventually consolidated as a permanent part of the salary. Most viewed this as positive even if it came with the contractual obligation to work more hours per day for some. Initially, the NGO sector did not benefit from ADHA, which seems to have caused some health workers to join the public sector. Since the consolidation, the basic remuneration levels are again similar across sectors.

The new system is preferred to the ADHA, but those opposing it could likely be people who benefited when they weren't supposed to. For example, those in the accounts and administrative sections did not perform any additional duty but benefited.

Doctor, rural area

The deprived area allowance, while appreciated in general is also criticized. It is a very small allowance, it is paid irregularly, and it is unclear whether it is still in place,⁸ and if it is, who is entitled to what. Because a so-called deprived area is not well defined, most health workers see this scheme as a political tool.

I know in one they were given five hundred thousand cedis in addition to their salary. But this was only once, and it never happened again.

Senior nurse, rural area

8. It no longer existed at the time of the study.

The determination of what qualifies as a deprived area is purely political.

Senior nurse, rural area

I have worked in the rural area, but I didn't receive that benefit.

Auxiliary nurse, rural area

Doctors in the public sector also have access to a car incentive scheme, which allows them to import certain car types and brands free of tax, and is sometimes linked to a bank loan where monthly installments are taken from their salary. There is general uncertainty about the scheme, and health workers think the system is not transparent. It is, for instance, unclear whether the scheme applies only to those working in deprived areas or whether the loan is obtained by the Ministry of Health or privately. While some argue that the scheme is attractive, others point out that it is unfair since it is only accessible to those earning above a certain threshold, and this excludes most auxiliary nurses. Some participants also claim the scheme is suspended.

It is there but we don't know. They will not make it transparent unless you know somebody there.

Auxiliary nurse, Accra

Workload and Hours Worked

There is considerable variation across sectors and locations in the number of hours health workers are expected to work. In general, the workload is felt to be high or too high, especially in the public sector. There is often no time to take a break, and many health workers often put in more hours than they are contractually obligated. Hours worked are often patient-driven, since all patients need to be attended, leading to unpredictable schedules. Working hours may also be irregular because they are, paradoxically, organized in workshifts, which require health workers to stay at the workplace until the following shift shows up. In the public sector extra hours are not normally compensated. The duty roster determines who's on duty; however, especially in rural areas, health workers tend to be permanently on duty as the health facility calls them in case of emergency. Some health workers, especially in urban areas, may refuse to go to the facility when not on duty.

A doctor does not have a clock-in or clock-out system. You schedule your time according to the number of patients, and often you don't know when you will finish once you have started. It is difficult to calculate how much we work because you can pass three full days without being called or you can pass one full week without having a break.

Doctor, rural area

We are short staffed at work, and we suffer from this. Six people are supposed to be on duty in the morning, but because there are not enough nurses, only two, at times only one, nurse is serving about twenty-five patients or even more. You cannot provide quality health care this way; by the end of the day you are exhausted.

Auxiliary nurse, Accra

Patients often find health workers absent and wonder if they put in the additional hours they claim to have worked. Others argue they know health workers are overworked. Most patients complain that they are not given sufficient quality time by health workers during consultations, and do not find health workers very dedicated. Health workers admit that high work volumes can lead them to treat patients disrespectfully. They are frustrated that they cannot provide a higher quality of care.

I know one nurse who works at the mission hospital. She arrives in the morning and sometimes stops at 9 pm, and the following morning she is there again.

Senior nurse, Accra

The other day I heard a doctor complaining that he takes care of two hundred people or more in one hour; this is not normal. For patients to receive good quality health care, doctors should see fewer patients, so they can take the time to understand the patient's problem.

User of health services, Accra

On the whole, workloads seem to be increasing for several reasons. Population growth does not seem to be matched with a corresponding increase in the number of health workers. This is exacerbated by migration abroad, which further increases the workload of those who remain. HIV/AIDS has also increased the workload because the National Health Insurance Scheme (NHIS) requests patients to be tested, and additional counseling is needed. Last, the NHIS itself has boosted the demand for care by lowering financing barriers to access care, leading to an increase in demand.

Workload management also varies across sector and type of job. While most doctors in the public sector organize their own time, nurses in the public sector are more at the mercy of patients and colleagues since they are expected to see all patients who are waiting and must remain at the facility until the staff for the next shift arrives. Private health jobs, on the other hand, do not require staff to be on duty and have regular hours, and second jobs in the private sector are typically well defined in terms of time. Working for a NGO hospital often requires health workers to live on the premises to be permanently available for emergencies. The ADHA has drawn workers' attention to the issue of extra hours but initially suffered from shortcomings regarding the remuneration of extra working time. There have been cases where clinical staff put in extra hours but did not receive ADHA while administrative staff unduly received ADHA. In some cases the scheme also limited the ability of public sector workers to do extra work in the private sector. This was the case when it was implemented jointly with formal increases in working hours, which were designed to increase the proportion of health services delivered through the public sector to make access to health care more equitable. While the scheme was mostly seen as positive in its ambition, it also led to considerable frustration and dissatisfaction among health workers.

Access to Equipment

Both users and health workers note a connection between the type of medical equipment available and the quality of care. Health workers also link equipment to job satisfaction and see it

as a potential for migrating abroad. Most health workers, especially the higher- educated ones, prefer more and better equipment. Only especially dedicated health workers find satisfaction in improvising when there is a lack of equipment.

Rural facilities in particular are associated with a lack of equipment; health workers who have worked in a rural facility for a long time often gain the reputation of “village nurse,” which is a health worker who is able to provide care without proper equipment. Such an arrangement is often disparaged as the quality of care provided is perceived to be lower. Not surprisingly health workers signal they are willing to take up rural posts if they are adequately compensated and only if the issue of medical equipment is addressed.

Where equipment is available, you will be satisfied; but where you have to improvise, satisfaction will be absent.

Senior nurse, rural area

Many lives are being saved purely because of the dedication of health staff. If you would not be dedicated, you would say there is a lack of equipment in the hospital, and that you cannot help it, but we never do that. If someone's life is in your hands, we do all we can.

Doctor, Accra

The availability of equipment already varies between training facilities. Teaching hospitals in Accra are best equipped, while rural training facilities have the poorest provision. Health workers trained in the latter are therefore perceived as providing lower quality care. NGO training institutions are generally better equipped than public institutions, and lower-level private sector facilities are generally better equipped than public facilities, although the opposite is often true for higher-level facilities, which require more expensive equipment. At the same time the level of equipment may vary substantially between private sector facilities themselves.

The private sector has more equipment than the public sector.

User, Accra

Access to Training

Having access to training is important for health workers. Once working, access to training can be in two ways. Some jobs provide on-the-job training; others provide health workers access to specialized training or funding for further specialization.

The public sector provides most opportunities for further training and specialization. Workers in the NGO sector may also have access to training opportunities in the public sector. The private sector does not provide easy access to further education, although some individual private employers may organize workshops.

I will advise the person to be in the public sector. I don't think there are structured programs in the private sector where they can train you and give you postgraduate

training, for instance. So, if you are not careful and you move to the private sector, you will not be able to progress from your current level.

Doctor, rural area

In the private hospitals personal development does not come in at all.

Doctor, Accra

Training is mostly organized through workshops. The allocation of staff to training is ideally based on area of specialization. However, with many workshops providing attendance stipends, senior management may choose to attend the training that pays the best, regardless of whether it is in their area of specialization. Lower ranked staff has consistently less access to training. Opportunities to attend workshops are not always availed of because health workers cannot leave high workload jobs even though some feel they lack skills in, for instance, relatively new disease areas such as HIV/AIDS.

Sometimes the opportunity will come, but because of the shortage of nurses on the ward you wouldn't be told, and if you are told, you wouldn't be allowed to go because there is no one to take over. If the attendance fees are important, then the boss will go and wouldn't let anyone know.

Senior nurse, rural area

Some of us have received little training about HIV/AIDS. I think most health workers are not fully at ease when dealing with an HIV/AIDS patient. So I wouldn't be surprised if a colleague wouldn't operate on an HIV/AIDS patient.

Doctor, rural area

Rural jobs have less access to further training opportunities. They are, on the other hand, associated with acquiring thorough first job experience because of the lack of equipment in rural facilities (requiring improvisation), the absence of seniors (allowing juniors to do clinical work they could not normally do in better-staffed urban facilities), and the seriousness of the diseases. Relationships at work are often better than in urban areas, allowing for more and easier learning. The drawback of rural service is that the exposure to technological developments is less available.

Access to postgraduate training has improved since the Ghana College was set up. In the past health workers needed to go abroad to get a postgraduate degree; this was one of the driving forces for migrating abroad. However, many health workers express frustration with the conditions for access to Ghana College courses—some years of professional experience, (including in rural service) and a release by the employer, which is problematic given that staffing levels are generally low. Consequently, some health workers still seek migration for easier access to postgraduate training. Doctors are eager to get access to postgraduate training and the national postgraduate incentive scheme enabled doctors to go abroad for postgraduate training, operating a bonding clause in return. Doctors knew about this scheme and some have benefited. However, there is confusion whether it is still in place—or was abolished with the start of the Ghana College—and how one can access it.

After you [pointing to one of the other participants], I don't think anyone has benefited from the scheme. And it is over three years now since you came back.

Doctor, rural area

Social Recognition

Health workers are generally well respected in Ghana. They seem to be ranked below priests but above lawyers and teachers in the social hierarchy. In rural areas they are even more respected. Still, social recognition has decreased over the years; this may be attributed in part to the strikes, which portrayed health workers as driven by financial motivations and may have prevented some patients from receiving medical attention. Health workers also seem to have lost respect because of the inappropriate way they treat patients and because of unacceptable behavior at work such as drinking, absenteeism, and engaging in corrupt activities. Patients do show appreciation and recognition, for instance by offering gifts. In rural areas health workers may occasionally even receive a plot of land or free labor to build a house. They are also often invited as guest of honor, and may receive preferential treatment (for example, jump the queue) in certain instances. Health workers, for their part, appreciate this recognition and find it motivating.

We show appreciation either verbally or through gifts when we are treated well or receive warm reception from them.

User of health services, rural area

Personally, I think I enjoy the recognition, for instance when someone visits you for treatment, and the person recovers later. Not the money but the respect and satisfaction you derive.

Doctor, rural area

Exposure to HIV and AIDS

As health workers elsewhere, health workers in Ghana are exposed to the risk of infection on the job, although HIV/AIDS is comparatively low in Ghana, compared to some other countries in Africa (Ghana has an estimated HIV prevalence rate of 2.3 percent (UNAIDS 2007). Most health workers feel sufficiently informed about HIV/AIDS, both in terms of protecting themselves and in treating HIV-positive patients. This seems to be the result of the extensive training and information on HIV and AIDS that health workers have received. Most health workers support the view that HIV-positive patients should receive the same treatment as any other patient. Workplace norms regarding discrimination and confidentiality seem to be in place, but fear of infection remains. Protective materials are generally available, although in some cases there is a lack of specialized material. Increases in the workload are mostly due to NHIS requirements to consistently test and counsel patients.

We treat everyone equally and make basic protection a priority.

Auxiliary nurse, rural area

Some will violate the ethics of the profession. Instead of just mentioning, “the patient is in bed 88,” they will just say, “the AIDS patient.”

Auxiliary nurse, Accra

Protection kits are always available although some specialized protective material, not always.

Doctor, rural area

HIV/AIDS hasn't really increased the workload. It is only that we do more counseling because of the NHIS.

Senior nurse, rural area

CHAPTER 4. WHICH JOBS ARE AVAILABLE FOR HEALTH WORKERS?

IDENTIFYING THE DIFFERENT OPTIONS

Summary

Health workers in Ghana can choose between jobs in the public, private, and NGO sectors; for rural or urban practice; or they may choose to migrate abroad. They may switch sectors, but more commonly, public sector workers top up salaries through dual practice in urban centers. Each opportunity has pros and cons depending on the preferences of the individual health worker.

Workers typically enter the public sector after receiving subsidized training. They see the obligation to work for the public sector as a guaranteed first job. Although public sector wage is at par with NGO sector wage, allowances and incentives in the NGO sector are meant to elicit performance whereas public sector incentives seem to be less effective; and workers' attitudes toward patients seem to be more problematic. Users argue that health workers in the public sector put in little effort and that waiting times are too long; at the same time they often perceive workers to be more competent than private sector workers.

Permanent staff in the private sector has the highest earnings; more commonly, workers may have a second job in the private sector (locum workers), which is paid by the hour. Career development and access to postgraduate and other training are generally weak in the private for-profit sector. Private sector workers are perceived as expending greater effort, which is often attributed to the higher level of remuneration they receive. Their attitude toward patients is also generally better compared to the health workers in the public sector. Users of health services confirm that more staff is available and waiting times shorter. At the same time the quality of staff is not guaranteed, and there are high fluctuations in the quality of care from one facility to another. Setting up a private clinic is capital intensive and competition in Accra is high. Nurses frequently start their own drug shops, which are far less capital intensive. However, obtaining a license from the Pharmacy Board may be a lengthy process.

A small though important segment of Ghana's health care providers is formed by NGOs. Because they are dominated by faith-based institutions, a health worker must typically be a member of the church to be considered for a job in a NGO facility. While basic salaries are the same as in the public sector, allowances are more common. Health workers usually live on the premises of the facility and have a comparatively heavy workload. Performance expectations are high, and supervision and workplace norms are strict. Health workers are unanimous that workers in the NGO sector are the most committed and are very patient-centered. The quality of care is judged higher in NGO facilities by both users and health workers. Waiting times are generally shorter and staff is less absent.

Dual practice or moonlighting—holding a second job in addition to one's main job— occurs frequently among health workers. The main reason is financial. Higher-level health workers tend to be more involved in locum work or moonlighting. Frequently, junior and auxiliary nurses are asked to take over while the senior nurse is moonlighting. While dual work is very common, it is

associated with a number of difficulties, such as worker exhaustion, which may, in turn, lead to lower efficiency and quality of service, including worsened attitudes to patients. It is also associated with absence from the primary, mostly public, job.

Mobility across the public, NGO, and private sectors seems to be frequent in only one direction: leaving the public sector is easy—one just resigns—but re-entering is difficult as the administrative procedure to reapply takes a long time. Some health workers who do not manage to get transferred from a rural to an urban job resign from the public sector and join the military or police hospitals in bigger urban areas.

Health workers identify a number of disadvantages to rural postings. The absence of quality schooling for children is seen as an important negative aspect of rural areas. Moreover, there is limited social life, and single health workers lack opportunities to meet a partner. From a professional perspective, rural facilities are often ill equipped, the workload is high with more off-hour obligations, including night duties. For doctors, there are, at best, limited opportunities to top up salaries through dual practice. Still, health workers also point to a number of positive aspects: there are good opportunities for first on-the-job clinical as well as managerial experience, and committed health workers have the chance to help poor and sick people. Social recognition also tends to be high and the cost of living low. Rural jobs could be made more attractive by introducing a rural premium, better equipment, and a credible commitment to limit the period of rural service and to promote health workers after that service. Access to adequate schooling for children or transport facilities to visit the family in urban areas are also deemed important.

Turning to the choice to emigrate, the most important factor in that decision is the prospect of higher earnings. Some add that a job abroad offers the prospect of practicing quality care; others are attracted to foreign cultures. Among the key factors that push health workers to emigrate are poor access to postgraduate training and the lack of a performance-based promotion system and pay rise in Ghana. Family pressure to take up a well-paid job abroad and send remittances home can also play a role. But migrating abroad is not easy, and has become more difficult over time. Obtaining a visa and work permit are the largest barriers. Recent salary increases seem to have slowed down emigration for nurses, but it is unclear what the effect is for doctors.

Health workers are also able to describe their view of the ideal career: A health worker's career may start in a rural area, where clinical experience is acquired, and the general population is served. He or she can then move to an urban job and continue, for instance, in the public sector, which provides access to further training and specialization for career development. Going abroad is also warranted for specialization or further training. Doctors seem to prefer specialization above general practice. An ideal career ends in the private sector, after having acquired skills, experience, capital, and a solid client base in the public sector. The early stages of this "ideal career path" correspond with what is offered in bonding schemes of public and NGO sectors, where most students are trained. These bonding schemes provide a first job in a rural area and later allow a move to the public sector in an urban area.

In this section we review the career options and jobs available to health workers, and compare the attributes described in the previous section across careers.

Working in the Public Sector

Many health workers have their first job in the public sector as part of a bonding scheme. In exchange for subsidized education, they are obliged to work for some years in the public sector, with the first assignments typically in the vicinity of the training institution. Health workers tend to see the bonding practice as a positive as it guarantees employment immediately after training. They disagree about the length of the required service and whether it should include an obligation to work in a rural area. When an urban public sector job is difficult to find, police and military hospitals may be attractive alternatives, even though they may not receive the same allowances (for example, ADHA). Military hospitals also offer some of their staff the opportunity to go abroad.

When comparing remuneration levels, health workers argue that the basic salary is the same in the public and the NGO sector, but that public sector jobs come with less allowances. Public sector allowances, (for instance, the deprived area allowance and the car allowance) are also seen as politically motivated rather than actually addressing health worker needs.

Salaries in the public sector in Ghana are paid regularly, and a public sector job guarantees a pension at the end of a worker's career. Extra hours are, on the other hand, not reimbursed. With the recent increase in public salary, health workers from the private and NGO sectors have tried to join the public sector, but this trend may now have stabilized again.

Working in the public sector seems less stressful compared to the private sector because in the latter, health workers assume final responsibility for their job. Health workers' attitudes toward patients seem to be more problematic in the public sector. Patients report that they are regularly abused or shouted at in public facilities and that nurses may look down on them. Public sector workers agree that patients can be treated disrespectfully in the public sector, and some argue that public sector health workers are less motivated because of their meager salaries. Users also argue that health workers in the public sector put in little effort, that waiting times are too long, and that there is limited equipment. The public sector also has a referral system that is not functioning well, where the patient has to buy medical support materials and wait a long time for test results, which are sometimes lost. Private sector workers complain about the inadequate treatment received by patients referred from the public sector.

I was not feeling well so I went to a polyclinic (public clinic), and they told me I should do some tests, but they did not have the machine. I had to go to a private clinic.

User of health services, Accra

At the same time, patients often perceive health workers in the public sector as well as those in the NGO sector to be more competent than private sector workers. Some health workers share this perception and argue that this is a direct consequence of the public sector investing more in continuous training.

Working in the Private Sector

Health workers make a distinction between permanent staff and staff working in a second job (or locum work). Permanent staff tend to be well paid and often receive additional allowances (such as car loans or petrol.). They typically do not receive a pension. Locum workers are paid by the hour.

Career development and access to postgraduate and other training is generally weak, if not absent, in the private sector. Working hours are not significantly different than in the public sector. Extra hours are normally paid, and health workers take far less sick leave compared to public sector workers. However, permanent contracts are not common, and the private sector employs many part-time workers in, what is for them, a second job. For some older health workers who want to “phase-out” and work less, this is very attractive. Those working in the private sector as a second job have two salaries: one salary from their public sector job and a top up from private practice, a combination that typically provides them with good earnings.

In some ways, private sector workers are perceived as more committed to their work than public sector workers both by patients and their colleagues. They are seen to put in more effort, which is often attributed to the higher level of remuneration (including benefit package); and they did not participate in recent strikes. Their attitude toward patients is generally better than in the public sector. Users of health services confirm that more staff is available in the private sector, waiting times are shorter, and there is no complicated referral system like the one in the public sector. Private sector facilities are generally better equipped and furnished with, for instance, fridges (and even carpets and flowers). At the same time, the quality of staff is not guaranteed in the private sector, and in some instances ward staff⁹ may act as medical staff to cut costs. Both users and health workers themselves indicate that there can be high fluctuations in the quality of care from one private facility to another. Some users argue that reputed specialists are more available in the public sector. The private sector is also said to be relatively inaccessible because of high health care costs and the tendency to refer patients with a health profile that yields no profit to the public sector.

The government and private hospitals have different ways of approaching the patients. So, if the prognosis is not good in the private hospitals, they are not interested in keeping you for a long time. They will send the patient to a government hospital. But the patient may not feel comfortable because of the way they do this.

Doctor, Accra

In private facilities they usually do not employ many permanent nurses, most of the nurses work there as a second job. They don't go every day, maybe twice a week.

Senior nurse, Accra

Private-sector facilities have more equipment than public-sector ones.

User of health services, Accra

9. Staff active at the ward can be from different clinical levels.

In Korle Bu, for instance, there are more specialists than in any private facility. In the private sector doctors are only looking for money.

User of health services, Accra

Setting up your own private clinic requires substantial amounts of capital as well as a good client base, experience, and knowledge of equipment. Obtaining the required capital is the main challenge. Most health workers finance the investment from their own savings, often accumulated while working abroad and complemented by a commercial loan. Partnerships between health workers are not common. Competition among private providers is already high in Accra, and most new private clinics are set up in smaller towns.

I have plans to undergo the medical assistant training so that I could establish a clinic in my village. But there is no money or assistance from anyone, so I would want to go outside the country and work so I could raise some money to start the health center in my village and in fact, that is my vision.

Senior nurse, rural area

Nurses frequently start their own drug shop, and this is far less capital intensive than setting up a private clinic. They can get a loan, which allows them to buy an initial stock of drugs. It can, however, take a long time to obtain a license from the Pharmacy Board, and some health workers simply register a pharmacy, open it, and then wait for the license to arrive. A license in itself is also expensive and some drug shops use others' licenses. In general nurses tend to recruit staff to manage the drug shop on their behalf and only monitor after working hours.

The money here is not sufficient so if I get some money, I will consider a private business to support the scanty salary received from the health sector.

Auxiliary nurse, rural area

For the license [to open a pharmacy], you write to the Pharmacy Board, but you will be tossed over and again until you are fed up.

Auxiliary nurse, rural area

Working in the NGO Sector

An important though small segment of Ghana's health care providers are NGO institutions, which are linked to local churches and for which hospitals are located mostly in rural towns.

NGO training institutions also operate bonding schemes that subsidize health education and in return require the health worker to serve a number of years in their clinic or hospital. In contrast to the public sector, these jobs are not necessarily in the vicinity of the training institution.

The sector also employs workers outside its bonding scheme, but in general, a health worker needs to be a member of the church to be considered for employment, in, say, a mission hospital. Health workers usually live on the premises of the facility, and have a comparatively heavy workload. Performance expectations are high, and supervision and workplace norms are strict,

with many restrictions imposed by the management. For some this may lead to frustration that impels them to leave the sector. Health workers are unanimous that NGO sector workers are the most committed and patient-centered. They are seen to work for God and not for financial reward. While basic salaries are the same as in the public sector, allowances are more common in the NGO sector. They are not applied in a uniform way but decided at the diocesan level. There are many different types of allowances, including individual performance bonus, end-of-year bonus, housing allowance, monthly diocesan allowance, gifts for religious holidays, and allowance for rural service.

The quality of care is judged to be generally higher in NGO facilities by both users and health workers. Transport for outreach activities is often available; staff is competent, has a positive attitude, and is respectful toward patients. Waiting times are generally shorter, and staff is less absent. Additionally, most NGO workers did not participate in recent strikes.

If you are working in a religious facility with so much work, but for the same salary, eventually you will end up leaving and move to a place where you have peace. There are too many restrictions and that frustrates people.

Senior nurse, Accra

I prefer to go to the mission hospital because the nurses in the public hospital in this area abuse me whenever I visit the facility. When you go to a mission hospital, the nurses are fine and don't abuse you. They also still attend to patients when nurses or doctors are on strike.

User of health services, rural area

Locum and Dual Practice

Locum, dual practice, or moonlighting—holding a second job in addition to one's main job—occurs frequently among health workers, and is sometimes referred to as locum work in Ghana. We focus on secondary activities within the health sector. Locum typically takes place outside the working hours of the main job. It is most common in urban areas and among workers who have their primary job in the public sector. Some workers from NGOs also moonlight. Higher-educated health workers, like doctors and senior nurses tend to be more involved in locum work. The main reason is financial. Sometimes the work is only for a limited time, for instance only while children are in school to cover the cost of education. Remuneration in the second job is per hour worked, and typically does not come with benefits. Moonlighters are usually supervised by permanent staff, especially for clinically challenging tasks.

When it comes to extra income, in some rural areas there are private clinics where you can do locum work, but there are not too many. Therefore many doctors will stay in the city.

Doctor, Accra

It is very widespread, especially in the cities.

User, Rural area

The most frequent process is that public sector health workers will receive their work schedule, contact a private facility, and communicate the days they can take up extra work. They are then penciled in the private facility's roster. An alternative approach is that public sector workers take annual leave to work in a private facility, sometimes up to a month. Some public sector workers also use their days off, received as compensation for night duty, to work in a private facility.

Most health workers will not moonlight on a daily basis; twice a week seems more common. Because absenteeism and tardiness are not tolerated in private facilities, dual work is often associated with absence from the primary job. Health workers at well-staffed public facilities may cover for each other, so that each in turn can take up extra work in the private sector, if that partially overlaps with working hours of their main job. Frequently junior and auxiliary nurses are asked to take over while the senior nurse is moonlighting. Public sector health workers may also refuse to accept after-hours duty so they can take up extra work in the private sector.

In Accra, depending on your rotation, you can close around 2 pm if you are in the outpatient department and do four hours extra work in a private clinic and then go home by 6 or 7 pm. That is an easy one to sort out. There is also the tacit arrangement with colleagues to stand in for us; so when we come back we make up the time lost.

Doctor, rural area

We do this to supplement our income.

Doctor, rural area

Where I work, they will use all their leave to do extra work in a private facility.

Senior nurse, rural area

In the private sector they usually do not employ many nurses permanently; most of the nurses work there part time. They don't come everyday, but only when they are free in their main job.

Senior nurse, Accra

Even if they are supposed to close at 2 pm, they will leave by 12 pm because they have to start at 2 pm in the other place. The authorities are aware and allow them to go. We stay behind doing the donkey work.

Auxiliary nurse, Accra

While dual work is very common, it is associated with a number of difficulties. The combination of two jobs tends to be exhausting for the health worker, and this may lead to lower efficiency and quality of service, including worsened attitudes to patients. For these reasons, some health workers scale down their main activity in the public sector to be fitter for the secondary activity in the private sector. Some health workers have seen their official working hours increased since ADHA has been incorporated in the salary, making the uptake of a second job more challenging.

While the vast majority of second jobs seem to be in the health sector, lower level health workers in rural areas seem especially to be engaging in activities outside the health sector, including farming, running a shop, and baking and selling bread.

I am a farmer. But I do it after work or when I am off duty.

Senior nurse, rural area

Changing Sectors

Changing jobs often involves changing sector, but mobility across sectors seems to work only in one direction. Leaving the public sector is easy—one just resigns—but re-entering is difficult, since the administrative procedure to reapply takes a long time. Typically one also has to take up a job similar to the one just left or even at a lower level. Health workers also argue that the public sector limits the intake from the NGO sector because the latter has many facilities in rural areas, where health workers are more in need. Reapplying to a public sector job is also more difficult if the health worker did not resign properly and, for instance, just “left” his job. In general, it is easier for doctors than for nurses to reintegrate into the public sector. Some health workers who do not manage to get transferred from a rural to an urban job, resign from the public sector and join the military or police hospitals in bigger urban centers. The recent increase in public sector salaries has made these jobs more attractive and seems to have stemmed the flow of workers from the public to the private sector.

Transfer from a mission or private hospital to a government hospital is very difficult. You need to apply to the Ministry of Health in Accra, and then you are invited for an interview in Accra. It takes at least six months before you can start in the new position, and after you have been transferred, it usually takes a year or two before you receive your salary.

Senior nurse, rural area

Rural and Urban Posting

Health workers identify a number of disadvantages associated with rural postings. The absence of quality schooling for their children is seen as an important negative aspect of rural areas. Female health workers also argue that it is generally difficult to convince their husbands to join them in rural areas, which often lack even the most basic amenities, such as piped water. They also often lack mobile phone coverage and a social or night life..” For single health workers, opportunities to meet a partner and engage in a serious relationship, which may lead to marriage, are also limited.

I think social amenities like schools for the kids and mobile phone reception and even night clubs as well as professional experience are the main reasons why people stick to Accra and Kumasi or if they are sent to the regions, wouldn't want to go beyond Sunyani.

Doctor, rural area

From a professional perspective there is a lack of exposure to technological advancement in medical equipment. Equipment is often absent, which makes it virtually impossible for specialists to practice in rural areas. The workload in rural areas is also often higher because there are more night and weekend duties because of the limited staff, and the work often requires outreach activities involving rough travel. Some health workers argue that many villagers do not understand modern health care and visit traditional healers instead; thus, treating this type of patient population can be frustrating. Doctors also point out the lack of opportunities to earn additional income in the health sector in rural areas.

There is no adequate education for the children. That is one major problem that prevents people from going to work outside the city. The children are their future. If you sacrifice them and go and live somewhere, they will also suffer.

Doctor, Accra

I trained at Korle Bu and when I finished, I told them that I wanted to work in the Volta Region. I sent a letter, and it was approved immediately.

Senior nurse, Accra

I was trained in the rural area, Jasikan area [Volta Region]. It was my first posting and it was not easy. We had to go around to so many villages with the bus whilst carrying our things. When I got married, I moved to Accra.

Senior nurse, Accra

There is also the fear of “getting stuck in a rural area,” since the procedure to be moved to an urban post is cumbersome and lengthy, although there seem to be shortcuts if one has contacts high up in the Ministry of Health or in politics. In contrast, requests to be moved to a rural posting are granted almost immediately. Willingly accepting the first rural posting, immediately after finishing one’s studies also seems to make it easier to get a transfer to an urban area later, while a refusal to accept a rural post may be interpreted as misconduct and invite a sanction.

I was posted to Brong Ahafo Region. I pursued the matter for some time because I did not want to go there. The person in charge of human resources told me that there was no way that I am going to Accra or the Western Region. But I was lucky, he was my wife’s cousin so I could persuade him and they sent me to a government hospital in Accra.

Doctor, Accra

If every village in Ghana is well equipped, we can work anywhere.

Senior nurse, Accra

But health workers also point out a number of positive aspects of rural postings. Most importantly, rural service comes with exposure to a wide range of pathologies. In practice, many health workers perform duties that are above their skill level; perhaps the best proof is that they are called “doctor” by the local population, independent of their grade. Moreover, the bonding between staff is generally higher in rural facilities. This facilitates on-the-job learning so that

health workers acquire in-depth clinical experience, including surgery in a relatively short time span. Similarly, since health workers receive opportunities to manage teams they would not have in better-staffed urban centers, rural service fosters leadership and management skills. Also, health workers point out that rural service allows them to satisfy their commitment and dedication to the profession. Social recognition also tends to be high. Health workers are often praised and receive cash or in-kind presents, for instance, food, money, a plot of land, free labor to build a house, or free rent. This also helps to lower the cost of living. Combined with the lack of opportunities to consume and spend, health workers can save a substantial part of their income when working in rural areas, even if public salaries for rural and urban postings are the same. Some health workers prefer a rural posting; especially those who want to be community health nurses may have an active interest in serving in rural areas—at least at the beginning of their careers. Those born in rural areas are also more likely to want to serve in rural areas.

If you are looking at experience and training, it is better in the rural areas. That is where you pick up your skills. Your colleagues there will take you through a lot of things that you will never get the opportunity to get close to in the city. If you go to the rural areas, you learn a lot of surgeries and all those things. When it comes to extra income, in some rural areas there are some private clinics where you can do extra work, but there are not many; therefore many doctors will want to stay in the city.

Doctor, Accra

Is there a way to make rural postings more attractive? Among the reforms suggested were a salary increase or rural premium, better equipment, a credible commitment to limiting the period of rural service, and promotion for health workers after their rural service. Allowances such as a good car for visits to family in the city and access to adequate schooling for children are also mentioned.

Working in Public Health

A job in public health has a number of advantages compared to a job in clinical care, for instance, no night and weekend work and quicker promotions. Some health workers enroll in training to earn a degree that will give access to posts in public health.

Today many health workers are shifting to public health because they prefer it above working along the bedside, and they don't get to see so many nasty things.

Senior nurse, Accra

In public health one is promoted faster than in a clinical job. That is why most of them run to that side.

Senior nurse, Accra

Migrating Abroad

The most important reason health workers migrate abroad is the prospect of earning more money. Some argue that health workers emigrate to be able to enjoy the nursing profession “as

they have been taught,” which implies higher quality of care. Some report that it is to access further education more easily or to enjoy and learn about another culture. Migration abroad is generally seen as an opportunity, and is deemed sufficient reason for some to choose a career in health.

I have been in the system for six years and still collecting the same salary, and so, if I get a visa, I would definitely go abroad where better conditions exist.

Auxiliary nurse, rural area

The Ghana College is there, but you enter and you don't know when you will finish. I have colleagues in the Ghana College who have been struggling to finish for years. In fact it is very frustrating. I am a specialist now, but if I were to be a general practitioner and had the chance to specialize abroad, I would go for it.

Doctor, rural area

Among the key factors that push health workers to emigrate are the poor access to postgraduate training, now centralized in the Ghana College. Its rigid entry system, which requires a health worker to fulfill a number of conditions, including rural service, contrasts starkly with the ease of entering US-based postgraduate training. Others are frustrated with the promotion system in Ghana, which is not sufficiently performance-based and lacks regular salary increases. There is also family pressure to take up a well- paid job abroad and send remittances home. The extended family often provides support in the form of information, pooling money to pay off the bonding fee, or finance the travel or the initial accommodation abroad. Most health workers who work abroad send remittances, although not necessarily regularly.

But migrating abroad is not easy and has become more difficult over time, especially to Europe. Obtaining a visa and work permit are the most difficult barriers. Although not all health workers who want to, manage to leave, and health workers are aware that it is not always easy to find a job as a doctor or nurse abroad. There are also strict administrative requirements, and doctors are said to end up working as nurses or even taxi drivers, while nurses may work as ward assistants. Many Ghanaian health workers abroad are said to be frustrated. Recent salary increases seem to have slowed down migration abroad for nurses, but it is unclear what the effect is for doctors. Many health workers who have migrated abroad seem to return to Ghana. Some come back because they cannot find work or because the work abroad is too tedious. Most come back to retire or to open a clinic or pharmacy with their savings, but some do not return.

If they want to work abroad after school, I would advise youngsters to join the health sector.

Doctor, Accra

The government has recently increased the salary of doctors to prevent them from going abroad, but the response is still meager. However the exodus of nurses was very high before, and with the increase in salary levels, it has gone down.

User of health services, rural area

Health workers who have migrated abroad are not always perceived positively by those who stay. They may be accused by health workers and users of misusing tax money—with which they funded their training—and some argue they should be brought to court. They may be seen as money-oriented and lacking dedication.

The Ideal Career

Health workers also have a view of what an ideal career might be. A health worker's career may start in a rural area, where clinical experience is acquired and the general population is served. He or she can then move to an urban job and continue, for instance, in the public sector, which provides access to further training and specialization for career advancement. Going abroad is also warranted for specialization or further training. Doctors seem to prefer specialization above general practice. An ideal career ends in the private sector, after having acquired skills, experience, capital, and a solid client base in the public sector. The early stages of this “ideal career path” correspond with what is offered in bonding schemes in the public and NGO sectors, where most students are trained. These bonding schemes provide a first job in a rural area and later allow a move to the public sector in an urban area.

If you are looking at experience and training, it is better in the rural areas. That is where you pick up your skills. Your colleagues there will take you through a lot of things that you will never get the opportunity to get close to in the city. If you go to the rural areas, you learn a lot of surgeries and all those things. When it comes to extra income, in some rural areas there are some private clinics where you can do locum, but they are not too many. Therefore many of doctors will stay in the city.

Doctor, Accra

I think the private sector is often for people who are nearing the tail end of their service. Such people become consultants after having served the public for years so they can minimize their activities and have some rest.

Doctor, rural area

Informal Health Care

When people, rich and poor, know someone is a health worker, they feel free to ask medical advice. This type of informal care is generally provided for free; in rare instances it is paid for, typically in kind; this is more frequent in rural areas. Informal care is said to be part of the Ghanaian culture and refusing to help patients would be difficult. But apart from reluctance to damage one's reputation, dedication also plays a role. The fact that traditional healers work at different locations reinforces patient habits of requesting informal care from modern health workers outside the health facility. Questions for informal care may indeed occur at any place and time—after church, at market days, or at funerals. However, there is a growing tendency to send patients to a health facility or to inform them about the existence of health insurance.

They consult you everywhere, and so you must put a prescription form in your car. [...] I think that informal healthcare is part of our culture or social norms and so cannot be avoided.

Doctor, rural area

It is free. They don't have money to pay.

Senior nurse, rural area

It is cheaper for the people, but it could be expensive for you. If you give advice or medication and something happens, they will blame you.

Doctor, Accra

CHAPTER 5. HEALTH WORKER PERFORMANCE

Summary

Absenteeism among health workers is relatively commonplace and increases with the health worker's level of education: doctors are more absent than senior nurses, who in turn are more absent than auxiliary nurses. Whether observed absenteeism occurs for legitimate reasons is less clear to both facility managers and patients. Based on our limited sample, absenteeism among public sector doctors and senior nurses is linked mostly to moonlighting in the private sector, and is most prevalent in urban areas. Absenteeism is usually not sanctioned in the public sector, as it may be in the private sector.

Shirking, although not endemic, is also frequently observed, especially in the form of sleeping during office hours and chatting on the phone or with colleagues. Shirking is more frequent in urban facilities.

Health workers neither engage in petty corruption nor do they frequently charge informal fees. When there is corruption, it mostly involves administrators as accountants; money collectors and cashiers may collude to forge accounts. Corruption occurs more frequently in public and rural facilities.

Similarly, health workers do not easily access drugs in most facilities. Consequently, when drug embezzlement occurs, it usually involves drug administrators and pharmacists.

Health workers try to maintain a positive attitude and show respect to patients, but admit to being rude sometimes. This is, they say, a consequence of high workload levels or noncollaborative patient attitudes. Patients confirm that health workers often get angry following an inquiry, question, or remark from users. There seem to be a general lack of feedback and complaint mechanisms, and repercussions for health workers are rare. The attitudes of health workers toward patients seem similar across sectors, although they may be better in NGO and rural sector facilities.

In this section we review the evidence on performance problems, including absenteeism, dual practice and moonlighting, malingering or shirking, pilfering drugs, informal fees, and other forms of financial corruption and suboptimal attitudes toward patients. This study finds limited evidence for systematic and large-scale performance problems but also finds significant scope for improvement.

Absenteeism

Both health workers and users of health services offer several examples of worker absenteeism. There is general agreement that absenteeism increases in the higher echelons of the profession: doctors are more absent than senior nurses, who in turn are more absent than auxiliary nurses. But they also affirm the ambiguity of what qualifies as illicit absenteeism; there is a grey area of

activities where absenteeism may be justified, such as having to deal with an emergency situation, attending an obligatory social event, or being stuck in traffic (especially in Accra). In rural areas health workers face irregular demands for their services, which leads to an irregular presence at the facility. Because of this grey area and the difficulty of verification of the reason for absence, employers sometimes resort to extreme measures, such as asking health workers to use their holidays when they say they are ill.

Doctors are few so when one is out to eat, it is difficult to get another to replace him, and that becomes the reason given for their absence.

User of health services, rural area

When I went to the government hospital Accra [name omitted], we knew that the doctor was supposed to be there at 8 am, so we got there around 6 am. We sat down from 6 am and the doctor arrived at 1 pm, although he was supposed to be there at 8 am. So I waited for my turn and when I was leaving, it was 8 pm.

User of health services, Accra

Absenteeism among public sector doctors and senior nurses is linked mostly to moonlighting in the private sector, and is most prevalent in urban areas. Although, for the most part, the second job is done outside working hours of the first job, it often starts at the same time as the first job ends, compelling health workers to leave their first job, usually in the public sector, early to be on time for the second job, usually in the private sector, where late arrival is not tolerated. Absenteeism of doctors is usually not sanctioned in the public sector; it is not tolerated in the private sector.

Absenteeism among nurses is contained as they generally cannot leave service before the nurses of the next shift have arrived, imposing some kind of implicit monitoring on nursing staff. The consequence is that latecomers must at least apologize to colleagues or pay out-of-pocket for the time colleagues covered their shifts. Absenteeism in the private sector is not tolerated and is typically sanctioned.

I finished my night shift in the morning, and my colleague did not come to start their shift, and I was told that she was sick. We were only three nurses, so two of us worked until 2 pm. I once had to work both Saturday and Sunday.

Auxiliary nurse, Accra

Ideally, the second job is carried out while one is on leave. But some try to combine the second job with their first main job and that becomes difficult, and so they have to cheat by stealing a bit of time from their main work. A few of our colleagues are doing that.

Doctor, rural area

Shirking and Malingering

In Ghana, shirking is more commonly referred to as malingering. Well-staffed facilities in urban areas provide more opportunities for shirking compared to understaffed rural facilities. Most frequent forms of shirking are sleeping during office hours, and chatting with colleagues or on the phone. Users are upset with the long waiting times caused by malingering. Health workers counter that the workload generally does not allow them to shirk. Patients often categorize all those working at a health facility as health workers, and judge the quality of care, including waiting times and shirking, by the attitude of nonclinical personnel like lab technicians and other support staff.

Yes, I have encountered it a lot. Sometimes when you are asked to go to the lab, you realize the technicians ignore the patients and concentrate on their phone call.

User of health services, rural area

Once I was in the consulting room with the doctor at a hospital in Accra [name omitted], and a patient knocked on the door. The doctor asked to excuse himself and started talking to the person. They wanted the conversation to be secret so they started speaking another language and unfortunately that was my mother tongue, and so I understood the conversation. They were talking about the university. They could have had the conversation at home, so that twenty minutes could be used to take care of somebody.

User of health services, Accra

While some argue that shirking has decreased over time and may now be the exception rather than the rule, older health workers argue that shirking is more prevalent among younger colleagues because the norms to enter the profession have relaxed.

Some of my colleagues will come and walk around and then disappear. [...] When I was there it was the exception rather than the rule.

Doctor, rural area

Gone are those days that work was done in pairs, and that one would be working while the other one would be sitting around. Now I am doing everything alone, and I can't finish my work. I don't even have time to eat.

Senior nurse, Accra

Informal Fees and Other Forms of Petty Corruption

The discussions suggest that health workers are not involved on a large scale in petty corruption and in charging informal fees in Ghana. The financial management systems that are in place ensure that health workers do not handle finance themselves. Typically, health workers only dispense care and write a bill, which is then given to the cashier (or money collector or accountant), who receives payment from the patient; the patient then receives a receipt in return.

Sometimes patients give a token of gratitude to the health worker, but that is on their own initiative, and typically happens after treatment.

At the hospital [name omitted], when a patient is discharged, we prepare the bill but we don't handle the money. After we prepare the bill we give the folder to the cashier because we have a twenty-four-hour cashier. The patient then pays everything to the cashier and collects the final receipt from him.

Auxiliary nurse, Accra

It doesn't happen. If people give something to the doctors to show their appreciation, this happens usually after the treatment.

User of health services, rural area

As a result, when there is corruption, it mostly involves administrators. Accountants, money collectors, and cashiers may collude and forge the accounts. On some occasions health workers may be involved, but these seem to be exceptions. In other instances, namely when the administrator is absent, health workers may collect the revenue from patients; this creates an occasion to embezzle part of the revenue. If corruption occurs, it seems more frequent in the public than in the private sector and more frequent in rural than in urban facilities. Today, patients often proactively request a receipt when settling their final bill; this seems to help limit corrupt practices and payment of informal fees.

As for the revenue, the accountants and administrators are still siphoning of a lot of money.

Doctor, Accra

Recently I had a problem on a Saturday. I went to the outpatient department and there were over twenty patients who had paid and had received no receipt. I called the administrator and told him what was happening. He told me that there is no evidence. The following day I collected all the patients without receipt, and I told the administrator to come and see. I showed him the evidence. I have seen it everywhere. The accountants and administrators are in league with the revenue collectors. The accountant will never punish any revenue collector involved in this thing; they will always cover them.

Doctor, Accra

Drug Embezzlement and Pilfering

As with payment of bills, the management systems in place prevent health worker access to drugs. Only pharmacists and drug administrators have direct access to drug stocks. This holds even for emergency drugs on the wards. Health workers, like patients, now only obtain drugs against prescriptions. And in the rare cases where health workers administer drugs, they are generally required to make use of a drug sheet that reports quantities and prices. Often, but not always, health workers also need a prescription from another health worker to obtain drugs for themselves. This drug management system seems to contain drug pilfering and embezzlement

among health workers, although some suggest that embezzlement of drugs happens more frequently in rural areas.

Now you can't have the drugs unless you have prescription for them. Even as a nurse if you have a headache while on duty, you have to go to the dispensary before you will be given one or two tablets of paracetamol. Even that depends on the decision of the person at the dispensary because you don't have a prescription.

Senior nurse, rural area

Even doctors don't have access to drugs; it is the pharmacist who manages the drugs.

Doctor, rural area

In contrast, pharmacists and drug administrators can provide drugs to health workers with or without prescription, even if this is for personal use, creating the potential for drug administrators to embezzle drugs. There have been cases where drug administrators transfer drugs bit by bit from the workplace to their private drug shop in town. There are also anecdotes of health workers involved in pilfering drugs to sell them on market days. While health workers and users indicate that this is generally rare, it remains difficult to detect and only seems to be discovered by chance. Drug pilfering is not normally tolerated and typically results in dismissal.

They buy the drugs and, let's say in another village on a market day, they go and sell it there. I knew one male nurse who was doing this. He would go around the community and write prescriptions for people, so they would come to the hospital. He paid lab technicians to write a prescription, and went to the pharmacy to get drugs pretending that it was for his family. Then he would sell them. So they started calling him "doctor." It came to the ears of the management and they called him in and warned him, but he kept on doing it, and was eventually dismissed.

Senior nurse, Accra

Health workers state they try to have a positive attitude toward patients and to show respect for the patient. They recognize the need to respect the patient's wishes but admit to being rude sometimes. Health workers admit they become impatient with patients at times and tell them off, lose their temper, and insult them. Health worker response to patients is attributed to high workload. Patients also do not do as they are told and seem to need authority or firm instructions. They may, for instance, not take drugs as prescribed or refuse to sit down when they are asked to; they may also refuse to pay. Patients confirm that health workers often get angry following an inquiry, question, or remark from users.

I look out for health workers who have good attitudes toward their patients. Because even if I go to a hospital without good equipment but with a doctor with good relationships with his patients, I can be referred or rushed to another hospital if they cannot take care of me

User, rural area

I was bleeding seriously, and I was rushed to Ridge Hospital [government Accra]. I got there around 6 am, and by the time they attended to me, it was 12 noon, and meanwhile I was bleeding seriously. I called one of the nurses and she told me to wait, and she started shouting at me.

User, Accra

I also noticed one thing when I was working at the mission and came to work at Korle Bu. I noticed that the nurses there were a bit disrespectful. But later when I also worked there for some time, I learned to appreciate their behavior. The workload was so high.

Senior nurse, Accra

We have a positive attitude, but in a situation where you give drugs to a patient and he refuses and he becomes more ill, we are sometimes forced to shout a bit at them to make them do the right thing. I wouldn't call this a negative attitude.

Auxiliary nurse, rural area

Users report many instances of negative attitudes among health workers. At the same time they are aware that a good relationship with health workers may pay off in terms of referrals or preferential care.

The attitudes of health workers toward patients seem similar across sectors, although they may be better in NGO and rural sector facilities. Negative attitudes can lead to a negative assessment, but this seems to apply mostly to trainees, who may face difficulties in obtaining final registration. It is more likely that health workers acquire a negative reputation with the population because of their bad behavior, especially in rural areas, and that people, as a consequence, stop visiting the facility, if they have the choice.

My sister was pregnant and she just lost her baby. While she was in pain and the baby was coming she was shouting to the nurses that the baby was coming and they were chatting. She was not taken to the labor ward. But the baby was overdue so they should have helped her. The baby's head was coming; she physically held it before they took her to the labor ward. The nurses said, "You soldier wives you have had too many babies."

User of health services, Accra

CHAPTER 6. MONITORING AND EVALUATION

Summary

Monitoring serves as a powerful tool to impact health worker behavior, in conjunction with external and internal incentives (and norms). Although a number of performance appraisal mechanisms are in place, they are not used in a way to elicit high performance or penalize poor performance. Promotion is mostly granted on the number of years of service, not on the basis of good performance. Patients also lack ways in which to complain about health worker behavior. A culture of linking performance to reward is more prevalent in the NGO sector. In this section we discuss three common mechanisms that are part of the health worker–monitoring environment in Ghana: performance evaluation, promotion, and patients’ voice.

Performance Evaluation

Health workers seem very familiar with the notion of performance evaluation. They refer to the self appraisal and the general appraisal, the logbook system for those in training and, less frequently, for visits from a monitoring team from headquarters to appraise them. In the public sector the appraisal is linked to promotion and is typically carried out when the health worker applies for promotion. The health worker then has a face-to-face meeting with his manager, using the appraisal form. They discuss and fill out the form together. At the end the form is read aloud and signed by both parties. If they do not agree on some sections, a panel can be called to hear the respective arguments. There is also a part for recommendations to be filled out by the manager.

But the system is not applied as regularly as it should be, and negative critique is not always put down in writing. Doctors and managers argue they cannot evaluate all their staff because the numbers are too large. Performance evaluation appears to be more rigorous in the NGO compared to the public sector.

Since not everybody is trained to appraise the workers below them, I am obliged to do that myself. I can't imagine myself appraising about hundred people. It will be difficult and so I will take a lot of shortcuts.

Doctor, rural area

We have the performance appraisal. I used to appraise the young ones when I was in the mission hospital and there, we used to do it religiously, often every year. But in the public sector, if someone wants to be promoted, he brings the form and you will have to appraise the person five years back. I think it is not optimal because it will be difficult to remember how the person performed five years back. They should do it properly.

Doctor, rural area

\Some health workers point to the large number of undedicated and poorly performing health workers to argue that the appraisal system does not function well. Users of health services are in favor of introducing performance evaluation if this could help remove under- or nonperforming health workers.

No one wants to be the bad person and so usually what happens is, those in charge only quarrel with the person verbally and that will be it. He will then allow the person to go through. That is why you find a lot of undedicated or nonperforming nurses rising through the ranks.

Senior nurse, rural area

Promotion

There are various routes to promotion. Most commonly, promotion happens semiautomatically after a certain number of years in the same job, or after a positive appraisal. Promotion based on seniority means that certain health worker categories, especially doctors and senior nurses, tend to get promoted automatically after a number of years. When the time has come, they either receive an invitation for an interview or contact the ministry themselves and are invited for an interview, after which they typically receive their promotion. Some health workers are promoted after having completed rural service, but this seems rare. Auxiliary nurses seldom get promoted.

Promotion is generally associated with higher pay and therefore important to health workers. But it is also seen as important in itself, since it is a sign of recognition. Absence of promotion is also cited as a reason to migrate abroad. Health workers do not rate the promotion system very highly. Auxiliary nurses complain about the lack of transparency and unfairness of the system. Other health workers argue that the system relies too heavily on colleagues and superiors, allowing for abuse of power. The actual system where promotion is based on seniority rather than on performance is also perceived negatively.

Promotion is as important as remuneration because you cannot stay in one place forever.

Doctor, Accra

Since I came to my district, it's been almost six years and I haven't been promoted and am still receiving the same salary. I don't even know the procedure.

Auxiliary nurse, rural area

Patient's Voice

While health care issues are sometimes discussed with friends, including health worker friends, they are not the subject of frequent debate according to patients. There is also no system to channel complaints. While some patients have talked to health workers, this is not seen to have led to change. Calling in to radio programs seems the most common way of airing disapproval, but this may not reach health workers.

Yes, shirking happens. I went to a hospital in Accra [name omitted] and experienced it firsthand. I approached the doctor and complained about it. He said they would do something, but nothing has happened.

User of health services, Accra

We complain to friends who are nurses or doctors and also during radio stations phone-in programs.

User of health services, rural area

We call to a radio station, but the people who should hear the information don't. They are in their office working, and it is not the time for them to be listening to the radio.

User of health services, Accra

CHAPTER 7. CONCLUSION

The Ministry of Health in Ghana is increasingly cognizant of the importance of health workers in achieving its sector goals. But policy making is hindered by the absence of evidence, as little is known about the microeconomic foundations of health worker career choice and about on-the-job behavior. This qualitative study helps fill this gap.

Using qualitative research with health workers and users of health services in urban and rural areas, we explore a range of issues related to career choice and on-the-job behavior. We find that health workers in Ghana enter the health sector both because they are motivated to care for sick people and because the sector pays well, guarantees employment, and yields opportunities for international migration. Increased extrinsic incentives are believed to have attracted less intrinsically motivated workers over time.

The major career choices of health workers in Ghana are the options between a job in the public, private, or NGO sector, between rural and urban practice, and for migration abroad or staying in Ghana. Health workers compare jobs across these sectors and locations by assessing salary, benefits, allowances, and access to training, while issues such as workload, the availability of medical equipment, and social recognition also play a role. From the individual health worker's perspective, each choice has advantages and disadvantages that match his or her preferences; these can be substantially different across individual workers.

We also find evidence for persistent performance problems such as absenteeism and shirking, but less so for corruption. Health worker attitudes toward patients often remain problematic, especially in the public sector. These findings provide some inputs for policy making. At a practical level, the evidence suggests that jobs in the public sector, especially in rural areas, can be made more attractive to health workers relatively easily. The public sector, for example, has put in place a number of allowance schemes and incentives, but these are ambiguous as to whom they apply to and what they want to achieve, and are not always aimed at matching workers' existing preferences. Rural jobs can be made more attractive by introducing a rural premium, providing better equipment, and improving career prospects for those who take up a rural post, for instance by offering a credible commitment to a limitation of the period of rural service, and by offering promotion to health workers after that service. We find suggestive evidence that incentives help to modify health worker behavior: increases in nurses' salaries seem to have stemmed their migration abroad. The discussions also confirm that monitoring can be a powerful tool to impact health worker behavior, especially when used in conjunction with incentives and workplace norms. At the same time there is much room to optimize the use of the available monitoring systems—performance evaluation, promotion, and patient voice—to elicit high performance and penalize low performance. This may in turn lead to progress on a number of job performance issues identified in this study, most importantly, absenteeism and shirking.

While qualitative research is good at identifying problems and generating hypotheses, it is weak at showing the extent of these problems and in testing hypotheses. The findings of this work generate hypotheses for further research on a range of issues. We see scope for further research

at two levels. First, quantitative research should test more formally some of the hypotheses generated by this work, for instance, to gain further insights on the relative power of extrinsic incentive structures and monitoring devices to elicit high performance. Second, planned new incentive or monitoring schemes, or planned changes to existing schemes, would greatly benefit from rigorous impact evaluation. Recent work in Rwanda (see Gertler 2009) shows how this can help to identify new approaches and provide robust inputs to more effective human resource policies.

The insights from this work also help to identify new directions for human resource policies. The findings underline the importance of obtaining better matching between health worker preferences and jobs available. This is now a standard issue in labor economics; to address this, we see two ways forward. First, job attributes must be better aligned with health worker preferences. As an example, provisions such as free transport and access to training for those taking up a rural post may go a long way in attracting novice health workers to rural areas. Second, the job market, where demand and supply for health sector work meet each other, must be better organized.¹⁰ A range of measures can help, varying from organizing market information to making the market more transparent so demand and supply *can* meet. Even a centralized web site may help, but a range of more ambitious initiatives are possible from setting up an employment agency specialized in the health sector to more advanced approaches to organize and design the market and improve matching, particularly for interns and first-time job seekers. While very advanced approaches (like market design in the United States) may be beyond the current capacity of the Ministry of Health, increasing transparency is certainly within reach.

Overall, the findings strongly indicate that more effective and purposeful human resource policies are needed and possible, and will help improve health service delivery.

10. Changes in how posts are advertised have come about between the collection of data and the publication of this report.

APPENDIX. PARTICIPANT SELECTION CRITERIA

Overview of the Eight FGDs

Urban	Rural
U1—Doctors	R1—Doctors
U2—Senior nurses	R2—Senior nurses
U3—Auxiliary nurses	R3—Auxiliary nurses
U4—Users	R4—Users

Each FGD will have eight participants who do not work at the same health facility and do not know each other. A reserve participant should be invited in case someone does not show up. The participants will have the following characteristics:

FGD U1 & R1—Doctors

- Eight medical officers, five are general practitioners and three are specialized.
- Of the five general practitioners, at least two are men and two are women
- Of the three specialized medical officers, at least one is a man and one is a woman
- Of the three specialized medical officers, at least one was trained or is in training at one of the new institutions (for example, Ghana College of Physicians & Surgeons)
- Two women with children and two men with children
- Two relatively young and two relatively old
- Four from Ghana Health Service (GHS), of which two do not moonlight
- Two from the private sector
- Two from faith-based organizations (for example Christian Health Association of Ghana), of which one does not moonlight
- The doctors do not work in the same facility

FGD U2 & R2—Senior Nurses

- Eight senior nurses, of which two are medical assistants, four, state-registered nurses, two professional midwives
- Four active in health centers, four active in hospitals/clinics
- Two that moonlight
- Five women and three men
- Two men with children, two women with children
- Two relatively young and two relatively old
- Four from Ghana Health Service
- Two from the private sector
- Two from faith-based organizations (for example, CHAG)
- The nurses do not work in the same facility.

FGD U3 & R3—Auxiliary Nurses

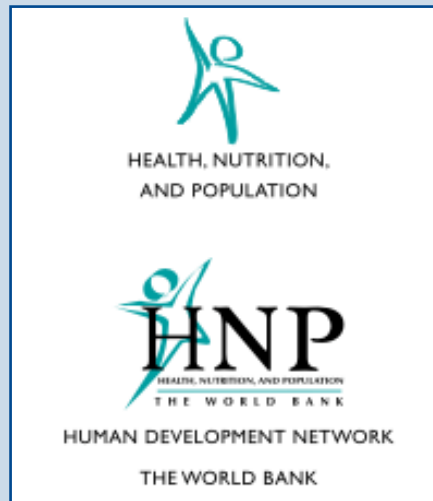
- Eight auxiliary nurses, of which three are enrolled nurses, three community health nurses, two health aids
- Four active in health centers, four active in hospitals/clinics
- Two that moonlight
- Five women and three men
- Two men with children, two women with children
- Two relatively young and two relatively old
- Four from Ghana Health Service
- Two from the private sector
- Two from faith-based organizations (for example, CHAG)
- The nurses do not work in the same facility.

FGD U4 & R4—Users

- Four have used a public health facility (GHS), two private, two faith-based (for example, CHAG) in the last year
- Two have visited a health center, two have visited a hospital/clinic
- Four women, four men
- Four rather richer, four rather poorer
- Two relatively young and two relatively old
- The users must not be relatives of health workers and cannot be well acquainted with any health worker in the facility they used to visit.

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