Effect of Incentives on Health Service Providers' Motivation and Performance in the Public Sector – A National Survey

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List of Abbreviations

CHN	Community Health Nurse
DOSE	Department of State for Education
DOSH	Department of State for Health and Social Welfare
FGD	Focus Group Discussion
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GAVI	Global Alliance for Vaccines Initiative
HIV	Human Immunodeficiency Virus
NGO	Non Governmental Organisation
RCH	Reproductive and Child Health
SEN	State Enrolled Nurse
SRN	State Registered Nurse
WAHO	West African Health Organisation

Executive Summary

Health service providers are now recognized as vital to any health system and a critical component for effective delivery of health services but are in short supply globally. In The Gambia, the national policy on human resources for health recognises that de-motivation of staff has contributed to attrition and underperformance which in turn have had a direct negative impact on quality of services and the health status of the country. To address this, the Government introduced a package of financial incentives and also received funding for incentives from the Global Fund. These incentives have been in place for four to five years but there is no information on their effects on the motivation and performance of health service providers. This study was designed to provide this information to inform decision making to maximize the effective use of resources to improve staff retention and the quality of service provision.

A nationwide cross sectional health facility based descriptive and comparative survey was undertaken to explore the hypothesis that the financial incentives provided had strengthened health service provider motivation and performance. All public sector health facilities (excluding hospitals) were surveyed using specially designed data collection tools. Data was collected through direct observation of practice, interview of health service providers in under 5 and antenatal clinics and exit interview & FGD of pregnant women and carers of children under 5. SPSS and NVivo were used for the management and analysis of quantitative and qualitative data, respectively.

The key findings were that a substantial proportion of health workers benefitted from incentives which were perceived as having a positive effect on retention, motivation and performance. However, most health workers were not satisfied with the incentive package with respect to the amount, distribution, timing and content and this contributed to low motivation. A particular interest was expressed in non-financial incentives especially those related to improving their work environment and housing situation. Using data derived from direct observation of practice, incentives had a positive correlation with performance in the under 5 clinic but not in the antenatal clinic. From the perspective of users of U5 and antenatal clinics, improving the quality of care would require increasing the availability of drugs, increasing the number of nurses and improving infrastructure.

On the basis of the study findings, a review of the existing incentives is recommended. This should be done through a participatory process which takes into consideration the following specific recommendations:

1. There should be an integrated package of incentives drawing on all available sources of resources
2. Staff should benefit from the package of incentives based on the principle of an integrated health service
3. Non-financial incentives should be part of the incentives package
4. The package should be designed to encourage deployment to underserved parts of the country
5. The financial component of the package should be paid at the same time as the salary
6. To improve performance, training to provide services of at least minimum quality and the provision of a conducive work environment should be undertaken as fundamental requirements rather than as incentives

1. Introduction

Health service providers are now recognized as vital to any health system and a critical component for effective delivery of health services [1]. What has become increasingly clear is that availability of financial resources and medicines are insufficient to effectively deal with disease burden without the personnel that deliver health services - health service providers [2,3].

Health service provider shortage is a global problem as almost all countries are faced with health service provider shortage, inequity in distribution of health service providers and suboptimal work environments [4]. However, the situation is particularly critical in Africa where 1.3% of the world's health service providers are required to cope with 25% of the world's disease burden [5]. Even when much needed drugs and other health commodities are made available, staff shortages compromise their delivery to those in need of them and diminish the possibility of achieving the Millennium Development Goals for health [2,6,7].

This awareness has led to urgent calls for more health service providers to be trained, retained and sustained in settings where health service provider to population ratios are low [7]. The World Health Organization has proposed a minimum threshold for health workforce density to guide the development of national human resource policies and strategies [1].

Although staff shortages are particularly prominent, there is also recognition that low motivation of available staff also affects the performance of individual health service providers and thus the quality of services delivered [8]. Thus, adopting strategies to improve motivation of health service providers is viewed as a vital component of efforts to address the health service provider crisis [9].

The critical role of the health workforce has been recognized by major international programmes to combat diseases in developing countries such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) [10] and the Global Alliance for Vaccine Initiative (GAVI) [11]. Both initiatives now provide funding to address human resource constraints in countries where they provide support.

Incentives in the health sector in The Gambia

In The Gambia, health sector resources are derived from a mix of public, private employers, households and donor sources. In the period for which data has been analysed, 2002-2004, the contribution of the Government of The Gambia grew from 18% in 2002 to 24% of the total health expenditure in 2004. However, in the same period, the total health expenditure as a percentage of Gross Domestic Product (GDP) declined from 16.1% in 2002 to 13.9% in 2003 and rose slightly to 14.9% in 2004. Health expenditure both in absolute terms and as percentage of GDP remains well below regional and African averages [12].

The decline in proportion of the national budget allocated to the health sector is due to several factors: a decline in the re-export trade that normally constitutes a major segment of economic activity, significantly lower prices and sales for the main cash crop, groundnuts and a decline in tourism. As a result the health sector has increasing

become dependent on donor funds and in particular the Global Fund. During the three years, 2002-2004, over 66% of the total health funding came from donors including international health development partners [13]. Personnel emoluments alone account for a significant proportion of the health budget. Government supported salaries for health service providers amount to 50% of all public health expenditure rising to approximately 60% if salaries for non-Gambian doctors and nurses supported by external donors are included in the total expenditure on salaries [14].

Despite this huge cost to the health sector salary payments to health service providers are low. In real terms salaries have not kept pace with inflation and have declined. In recent surveys of health service providers low salaries are a key de-motivating factor fuelling high attrition rates currently estimated to be between 30-50% of the skilled staff [14]. The majority of health service providers leaving the health sector are doctors, state registered nurses and midwives, and public health officers. The national policy on human resources for health recognises that de-motivation of staff has contributed to attrition and underperformance which in turn have had a direct negative impact on quality of services and the health status of the country [15].

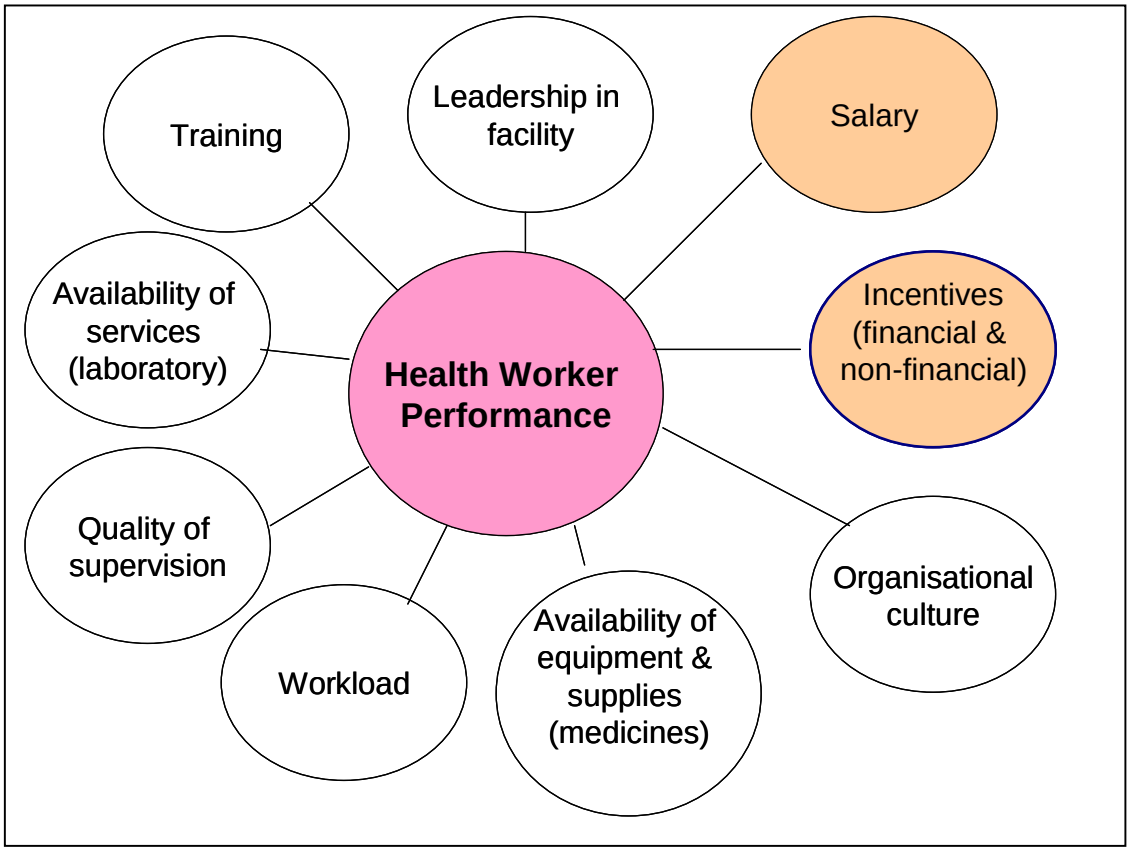
The Human Resource Policy calls for the provision of incentive packages to improve staff motivation, retention and performance. Many respondents in a situational analysis of human resources for health recommended a considerable increase in salaries and fringe benefits including housing while adding proposals for incentive schemes such as soft loans [14].

In 2004, the Department of State for Health and Social Welfare (DoSH) approved a financial incentive scheme for health service providers in the public health sector. Implementation was delayed until 2006 because of resource constraints. The incentive package consists of three allowances: hardship and at risk allowances provided to staff in rural areas; responsibility allowances provided to officer-in-charge of health facilities in rural areas (DPI, personal communication).

The health ministry has taken advantage of the GFATM's call to countries to identify health system strengthening needs and request funding to support this in their proposals [10]. Since 2004, the GFATM has been providing incentives for health service providers providing malaria and HIV-related services and more recently, since 2006, TB services. These incentives are programme specific and provided to selected health service providers at all levels of the health system.

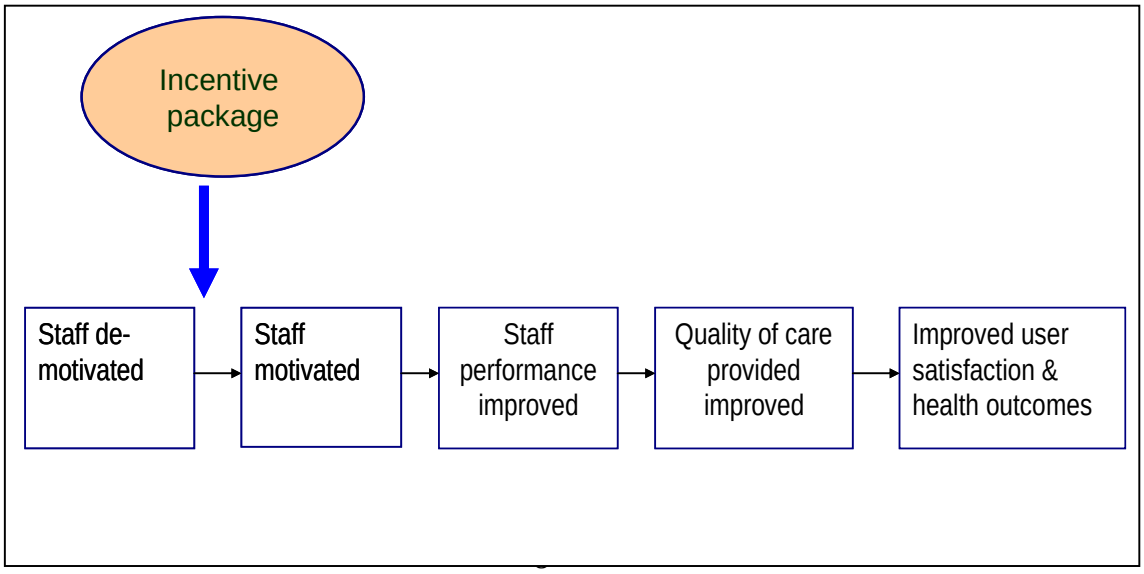
Although the performance of health service providers depends on several factors (**Figure 1**), salaries and incentives, both financial and non-financial, are critical and understudied contributors to motivating health staff.

Figure 1: Health system factors that affect health provider performance



The underlying conceptual framework underpinning this study is illustrated below in **Figure 2**.

Figure 2: Role of incentive packages in improving quality of care and health outcomes



Despite the implementation of implementation package health service providers remain de-motivated and attrition of health service providers out of the public sector is still high. There is currently no information on the effects of these incentives on motivation of health service providers and how this has affected the performance of health service providers in providing services.

The study findings would inform decision making to maximize the effective use of resources to improve staff retention and the quality of service provision.

Aim and Objectives

This overall aim of the study is to assess whether the provision of incentives to health service providers improves the quality of care provided in the public health sector.

The objectives of the study are:

1. To assess the effect of incentives on the quality of care provided by health service providers for common childhood conditions.
2. To assess the effect of incentives on the quality of antenatal care provided by health service providers.
3. To determine health service provider perceptions on range and type of incentives provided by the health sector.
4. To determine user perspectives on the quality of services provided by health service providers receiving incentives.
5. To assess the effect of incentives on health service provider retention in the public sector.
6. To use research findings to develop policy options to guide the implementation of incentive packages for the health sector.

2. Design and Method

2.1 Study Design

A national cross-sectional health facility based survey was conducted in Government owned facilities as these provide 70% of health care to the population of The Gambia [16]. A controlled study design, that is, quasi experimental or randomised controlled trial was not used because all Major and Minor health facilities in the public sector are implementing either the Government or Global Fund incentive packages or both.

The national survey assessed health service provider performance based on the quality of care provided to children attending the under-five clinic and pregnant women attending the antenatal clinic. Pregnant women and children were selected because there are the main priority populations in the national health policy. Therefore a large proportion of resources are committed to providing services to these two priority groups. Furthermore within health facilities health service providers spend the largest proportion of their time providing services to pregnant women and children under five.

2.2 Sampling procedure

Study sites
As the incentive schemes have been implemented nationally all health regions were included in the sample. The survey was conducted in 38 Government owned health facilities in the six health administrative regions of the country and 3 NGO run facilities providing antenatal and child care services (**Table 1)**.

Study sites consisted of

Table 1: Health facilities visited by study team

Health region	Major health facilities	Minor health facilities	NGO
Western	2	7	4
North Bank Region	1	7	
Central	1	8	
Upper River	1	5	
Lower River	1	3	
Total	6	30	4

2.3 Study subjects

Health providers
In these facilities, all nurses available in the under 5 and antenatal clinics on the day the study team visited the facility were interviewed. The breakdown by cadres is shown below in Table 2. A total of 163 nurses of all cadres were interviewed.

Table 2: Health providers interviewed by cadre

Cadre of staff	N	%
SRN(Midwife)	21	12.9
SRN	11	6.7
SEN(Midwife)	16	9.8
SEN	11	6.7
CHN(Midwife)	31	19.0
CHN	35	21.5
Nurse Attendant	19	11.7
Others/WEC trained	5	3.1
Missing	14	8.6
Total	163	100.0

Carers of children under 5 (U5s) and Antenatal mothers

The study team observed clinical consultations on 169 children under the age of 5 and 147 pregnant women. Exit interviews and focus group discussions were conducted on 148 pregnant women and 171 carers of children and pregnant women observed in the out-patient departments to minimise recall bias

A total of 16 focus groups discussions (FGD) were conducted by the study team as outlined below.

Table 3: Focus group discussions by type

Type	Number
Regional Health Teams	3
Health providers based in health facilities	6
Mothers and carers attending RCH clinics in health facilities	7

2.4 Data Collection

Four main data collection techniques were used to collect both quantitative and qualitative data: interview, focus group discussions, observation and document review.

Tool design
The main tools used for the conduct of the study were: semi-structured questionnaires; interview guides; focus group discussion guides; structured protocols and checklists for observations, and a data extraction tool for review of nominal rolls of health service providers.

For the development of observational checklists to assess performance in history taking and clinical examination in under five and antenatal clinics, the list of symptoms and signs to assess antenatal women or a sick child were drawn from two national standards, namely, the (i) National Standard Treatment Manual and (ii) the Reproductive and Child Health Programme (RCH) guidelines for clinic visits.

Details of the existing incentive scheme and the findings of pervious surveys on staff motivation in the Gambia were used to guide the development of the semi-structured questionnaire and interview guides for the Focus Group Discussions (FGD).

2.5 Data Management and Analysis

Quantitative
After the end of the field work, the questionnaires were edited for completeness, consistency and missing information. The quantitative data was first entered into a Microsoft database and later exported to SPSS 16.0. This was later followed by data cleaning to identify potential errors that could affect the quality of the data before data analysis commenced. Simple proportions were calculated for categorical variable and descriptive statistical analysis for continuous/ interval variables.

For the analysis of performance, a binary scoring system was used to assess performance in history taking and clinical examination of U5s and pregnant women (Box 1 and 2).

Box 1
Assessing performance of health providers caring for sick children

History taking
Poor history taking:
- Asking after 2 or less questions

Good history taking:
- Asking after 3 or more questions

Clinical Examination
Poor clinical examination:
- Checking for 2 or less signs

Good clinical examination:
- Checking for 3 or more signs

Box 2
Assessing performance of health providers caring for pregnant women

History taking
Poor history taking:
- Asking fewer than 5 basic questions (list them)

Good history taking:
- Asking 5 basic questions

Clinical Examination
Poor clinical examination:
- Checking fewer than 5 basic signs

Good clinical examination:
- Checking for 5 basic signs

Qualitative
For qualitative data FGDs were first transcribed. These transcripts were then imported into NVivo version 7.0. Each comment was allocated to a single category. The categories were collapsed into larger thematic categories and comments provided by nurses were then re-assigned to fit into one of these broad categories. The range of themes arising from the responses provided by nurses were then further analysed and will be presented in the section on findings.

2.6 Limitations to the study

Staff nominal rolls are not maintained by the Regional Health Teams. There is no relational database of employed staff. Therefore there is a lapse between a staff member leaving the service and the deletion of the name of this individual from the payroll. Pervious records of staff employed prior to 2005 were unavailable.

The small number of those who have never received any incentives made it difficult to conduct statistical tests for quantitative data.

3. Findings

The findings will be subdivided into 3 sections. The first section deals with the interviews and focus group discussions conducted with health providers; The second section reviews the quality of care provided for children under 5 (U5s) and pregnant women in antenatal clinics. The final section focuses on the perspectives of users of health services, mothers and pregnant women.

3.1 Characteristics of respondents

Socio-demographic characteristics

One hundred and fifty six health providers were interviewed of whom 50.3% were female. The mean age of respondents was 33.7 years for males and 33 years for females. The majority, 81%, were trained health providers. Community Health Nurses (CHNs) were the single largest group of health providers in the antenatal and under 5 clinics. The longest serving staff were SEN and CHN midwives.

Table 4: Socio-demographic characteristics of health providers

Characteristic	N	%	
Sex			
Female	82	50.3	
Male	74	45.4	
Missing	7	4.3	
Age			
Male: Female:		mean (SD)	33.7 years (8) 33 years (10.4)
Nursing cadre	163		
SRN(Midwife)	21	14.1	
SRN	11	7.4	
SEN(Midwife)	16	10.7	
SEN	11	7.4	
CHN(Midwife)	31	20.8	
CHN	35	23.5	
Nurse Attendant	19	12.8	
Others/WEC trained	5	3.4	
Marital Status (married)			
Married	126	77.3	
Highest training level			
Certificate	132	81.0	
Diploma	14	7.6	
None	17	10.4	
Duration of employment			
		Median (years)	Interquartile range
SRN(Midwife)		11	15
SRN		2	10
SEN(Midwife)		16	9
SEN		2	11
CHN(Midwife)		15	13
CHN		3	7
Nurse Attendant		10	9
Others/WEC trained		7	13

3.2 Defining incentives

Staff of the Regional Health Teams (RHT) and health providers (HP) described incentives in both financial and non financial terms. Both groups emphasised that incentives were given primarily to motivate individuals.

> RHT: *If you say incentive, definitely it is a way of motivating people to make them go an extra mile in the rendering of their service*

> RHT: *Incentive could be in the form of money, accommodation, or communication, all that could be part of incentives. However, more so of financial, that is what people normally think is an incentive. That is an allowance in whatever form given to you at regular intervals.*

Financial incentives were seen as critical components of any incentive package as they are given on an individual basis and so can be used to address specific individual needs.

> *RHT:* Incentive could be in the form of money, accommodation, or communication, all that could be part of incentives. However, more so of financial, that is what people normally think is an incentive. That is an allowance in whatever form given to you at regular intervals.

> HP: *Financial incentives….. you know individuals have different needs you see somebody may need the finance more than the non-financial. I personally I have a land I could not develop it for almost fourteen years in the service. Now you know I cannot build a good structure in my compound. You see I am almost reaching the retirement age so when I retire that means I am going back to square zero so giving me money to build a structure in my land and at least to have some mobility to run my errands will also help.*

However, despite the importance given to monetary incentives, RHT staff recognised that non financial incentives were as important as financial incentives to retain staff in the health sector. The type of non incentives described by participants included improved accommodation, good working environment which includes availability of office equipment, consumables, communication facilities, opportunities for continuing education and career advancement.

> RHT: *It is not only money that is [an] incentive – that is a small part of what we consider as incentives.*

> RHT: *Even job environment, furnishing their offices with latest office equipments like IT plus internet facilities all these things are incentives to keep staff or workers at their places. If you come to monetary part, it is more of weight because that is what you can just get, take and then spend on your own personal issues but other incentives like staff accommodation ah…providing accommodation for staff, building offices where people can stay and work this at least can provides them with transportation for easy movement. All these are incentives which staff should get.*

3.3 Types of incentives

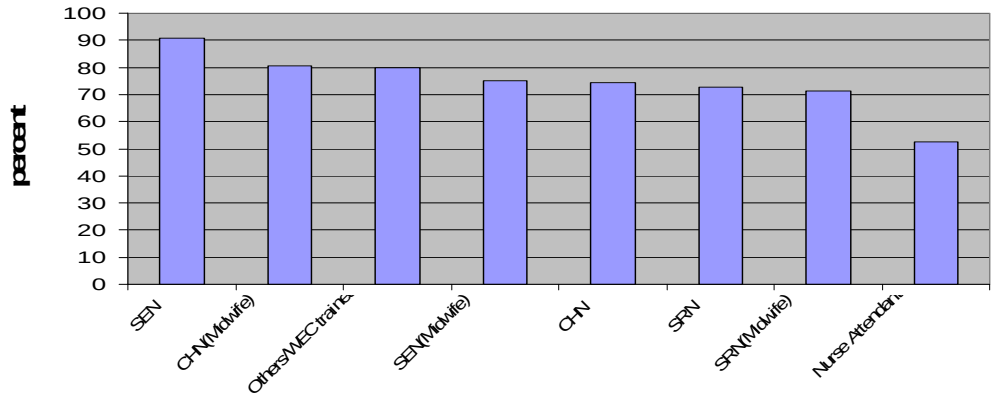
Of the public sector staff interviewed, 83% (122/147) were receiving incentives. The hardship allowance was the commonest government funded allowance received by just over a third of the respondents. A third of health providers received incentives from the government and from the national Malaria, HIV/AIDS and TB programmes that are supported by the Global Fund for AIDS TB, and Malaria (GF). The National Malaria Control Programme was the leading provider of incentives to health providers in the survey (Table 5).

Table 5: Type of financial incentives

Type of allowance	Percent
Ministry of Health	
Hardship	33.7
Civil servants SPA	31.9
Risk allowance	31.3
Responsibility	7.4
Special skill allowance	4.3
Others (professional allowance/ special allowance/ transport allowance)	2.5
On call	0.6
Incentives from donor funded programmes (Global Fund)	
Malaria	31.3
HIV	27.6
TB	10.4

With the exception of nurse attendants, the proportion of staff receiving incentives does not differ noticeably between the cadres.

Figure 1: Proportion of staff receiving incentives by cadre.



3.4 Perspectives of health providers on non financial incentives

The perceived absence of some non-financial incentives was seen as a disincentive. These included poor accommodation; inadequate access to water and electricity in houses and laboratories; inadequate quantity and quality of equipment provided in facilities; poor working conditions; lack of equipment; distance from the capital city; and inadequate supervision. These are discussed below under sub headings.

Training

In the period January 2008 to May 2009, 65% of respondents had attended a workshop. Of these 23.9% had attended one workshop (Table 7).

Table 7: Number of workshops attended between January 2008 and May 2009

Number of workshops attended	%
1	23.9
2	16.6
3	8
4	5.5
5	6.1
6	2.5
> 6	2.4

Training was perceived as important for career advancement and development. There were calls for continuous training so that staff can keep abreast of recent developments as explained by this respondent:

> RHT: *…in terms of incentives, I think also further training for staff is very important because staff are left in the field without being upgraded. We live in a dynamic and changing world and we have seen lot of emerging and re-emerging sorts of diseases which some of them are things people that nobody knew before. So I think training staff at regular basis especially to the high level is also…….and would make many of them to stay. However, it does not stop at only training them, once they are back; give them the status that fits their training. I think that is very important.*

Promotion

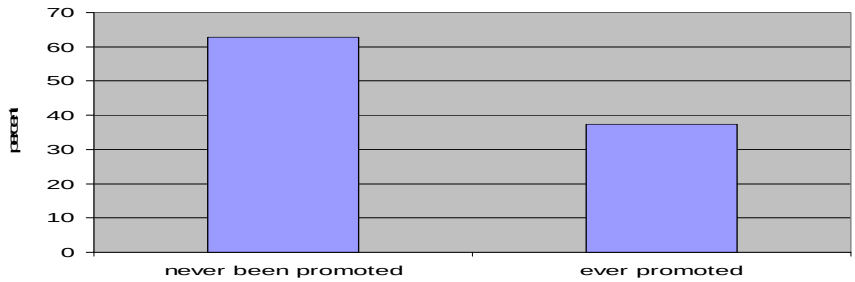
There are concerns about perceived delays in promotion and the absence of clear cut criteria to determine the basis for promotion. One in ten health providers cite concerns about the promotion system as one of the main reasons why they considered leaving the health sector. Further details were provided by a respondent during a FGD.

> HP: *I think delay in promotion is a big problem in the ministry not only those who you know even those who go to institutional training when they come, before you have your promotion, it take it years. I will take myself as an example, before I*

had my promotion, I served for almost eight months I could not be promoted in fact close to a year. I was in the file. I could not get promoted. Following up my promotion was the most discouraging thing. What I received from my senior was that promotion is not a right. So I was so agitated I nearly resigned, but I had to reassure myself that I applied for the job I am appointed like him so he cannot discourage me by telling me your promotion is not a right. So I reassure myself and stayed but had it been I did not I will have resigned from that day. But I felt he did not appoint me. So as a civil servant like him he cannot make me discourage to resign so some times promotion could be another thing and promotion also should include performance, but when somebody is commended hard working, doing well, he has not been promoted has not been given any motivation that means nonsense….

This frustration is supported by the observation that among the 110 respondents who have been employed for 5 or more years, 62.7% have never been promoted (Figure 2).

Figure 2: Proportion of employees employed for over 5 years who have ever been promoted



The majority of promotions, 51.2%, were carried out in the last 5 years. However the beneficiaries of these promotions were mainly employees who have worked between 5-14 years in the health sector though. Just over half of those who have been in service for 20 years or more have been promoted.

Table 8: Achievement of promotion by duration of employment

Employment status	Number of staff	Number ever promoted	% ever been promoted	Number promoted in last 5 years	% promoted in last 5 years
0-4 years of employment	53	2	3.8	2	3.8
5-9 years of employment	29	7	24.1	7	24.1
10-14 years of employment	27	8	29.6	6	22.2
15-19 years of employment	20	8	40.0	2	10.0
20 years and over employment	34	18	52.9	5	14.7

Living and working conditions

HP: *The level of motivation here according to how I see it is very poor because we are very far from the capital and the accommodation is not that much good and what helps us to deliver the service, the electricity, …a key to the service delivery here, is not here which is hindering our work at night …people come here all night there is no light here at labour ward here. We have cases here all*

night where nurses go and attend patents with a dim candle light. You have nurses who attend patients at the out patients with the help of candles so the motivation here is very poor. … government was supposed to provide the solar and electricity to the staff that are at the health centre, and that has not been done...

HP: *As she said we are trying our best to do what we can do. To make sure that the service keeps going. Actually what can make it quality service… since we have the laboratory service it means diagnostic procedures have to be in place and without electricity that cannot be possible. if they want us to provide quality service in the presence of the laboratory then what should make the lab functional should be in place which is electricity either the fuel to be forthcoming or the batteries that can sustain the room… if not the quality of the service will be compromised.*

HP: *… they [the equipment in the facility] are not even adequate they are in poor conditions, because these working tools are what keep you. To work without them you vamp. You cannot say anything about the particular person's condition because in the absence of the BP machine you cannot guess who has hypertension, in the absence of thermometer you cannot guess what the temperature of a child is, in the absence of electricity who is there to diagnose what is in the lab in the blood of a human …nobody can do that. So in a real sense I think these things - working tools are what matters. They need to be in place and be strengthened like bring couple of supplies and review them to see what is actually on the ground whether the things are still there and they have to try to have excess that is to say we have to keep this stock for this facility anytime there is a breakdown of this [equipment] let them try to provide this. …So… anytime we have a breakdown we should have a replacement.*

Written and verbal encouragement

Verbal and written encouragement from superiors and community members were received by 26.4% and 20.3% of respondents respectively.

HP: *Any way to me what discourages me most is lack of supervision from my seniors because you being a junior if you are not supervised nobody will know what you are doing on the ground. … if you are supervised [and] your seniors come to you and say well done, it encourages you and motivates you to do more. But lack of supervision it really disturbs my efforts.*

HP: *And it could have been better to improve supervision if you are trained during supervision but this recent type of supervision you come if I do something wrong you castigate me and go. If I should do something good you don't say anything, just keep quiet….a junior can be motivated during supervision.*

The absence of a formal system within the public health sector to address appraisals, complaints, selection for training and promotion bothered several FGD participants.

HP: *I will say no there is no complaint system [within the ministry]. What I know is that you complain to your seniors, supervisors in the end. You will not find any*

solutions to the problem because they will have nowhere to complain to or we have nowhere to complain if they did not take any action.

3.5 Satisfaction with incentive system

Only 36% expressed satisfaction with the incentives they are receiving. A greater proportion of health providers receiving government funded incentives were dissatisfied compared to those receiving GF incentives (Table 9).

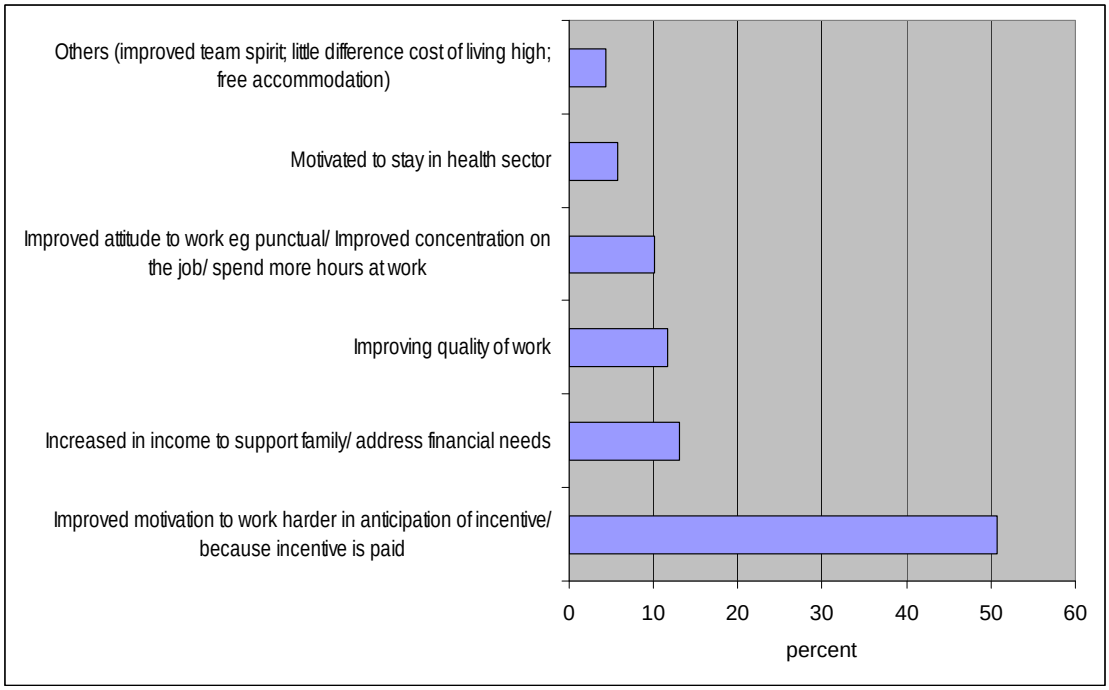
Table 9: Levels of dissatisfaction amongst health providers receiving government and GF incentives

Type of incentive	n	Satisfied with incentives	
		Yes	No
MoH	95	25.3%	74.7%
GF	93	36.6%	63.4%

3.6 Positive effects of incentives

Health providers reported changing their attitude to patient care and increasing their work output because of the incentives (Figure 3).

Figure 3: Reasons provided by health providers to explain how incentives have made a difference to them.



Timely data reporting by facility staff is another visible sign that the Regional Health Teams attribute to the incentive scheme. The early submission of programme reports by staff receiving incentives contrasts with the late submission of reporting on routine data for the health sector

> RHT: *…Like the one for NACP, [name of health facility omitted] is never late but with regard to other returns, you follow them for a while before you get the returns. For that of NACP, before the month ends they will submit their returns because there is incentive attached to it. Likewise EPI are also giving incentives and those returns are also not late. At the end of the month they submit it on time, unlike our routine returns which normally comes late from most of the facilities. Therefore, I think it really helps in improving performance.*

Financial incentives were perceived to be attracting staff from the private into the public sector and slowing down the steady flow of staff out of the public health sector. Measures taken by the health sector to improve the accommodation of staff in rural areas also seems to be paying off.

> RHT: *I think there are noticeable changes since this cash incentive stepped in. People have started coming back to civil service because of the cash that they are seeing as it is going now.*

> RHT: *Let say this year….actually I don't know what the reason is, it could be a coincident or because of the incentives but since they started bringing this thing (incentives), I have not seen people who have left but prior we have been having serious attrition rate because within one year 4 trained staff left. Since they introduced these incentives I have not seen any staff that left…so I don't know the reason, it could be the incentives or it could be that they have made up their minds or they have not seen a place that would worth them leaving because the last who left were two CHNs and an SEN ophthalmic that was shortly before they start these incentives.*

> RHT: *If you come to other incentives like accommodation that also can really improve performance, like in [name of village omitted], accommodation is not a problem there right now. Initially if you post a staff there, they will not want to go because even where to stay was a problem. However, right now there are houses there, if you post people there, they are really ready to go there. Therefore, I think they (incentives) rather help in staff performance*

3.7 Summary

Sixty five percent of respondents expressed dissatisfaction with their working conditions. The reasons provided can be found in Tables 10. The commonest themes were difficult living and working conditions including lack of access to equipment, drugs, utilities, sanitary facilities, mobility and opportunities for career advancement

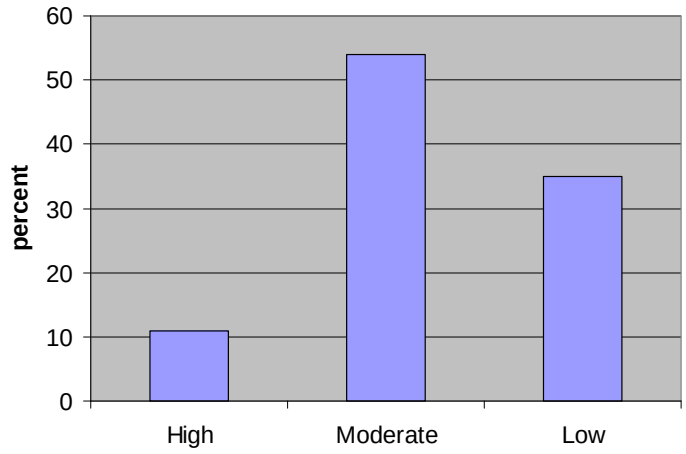
Table 10: Reasons for lack of satisfaction with working conditions

Reasons provided by respondents	% (n=163)
Financial	
Inadequate salary/ not receiving salary	8.6
Insufficient motivation/ incentives	6.1
Untimely payment of incentives	0.6%
Living conditions	
Poor accommodation(inadequate sanitary facilities and no place to eat)	18.4
Working conditions	
Inadequate working conditions / poor quantity and quality of materials, equipment & supplies/dug shortages/ inadequate physical infrastructure of facility / inadequate laboratory facilities/ lack of security for facility	33.7
Poor access to electricity and water	19.6
Heavy workload/long hour of work	10.4
Inadequate number of staff	8.6
No opportunities for promotion/ training/ or career development	4.9
Lack of fuel/ mobility/ lack of fuel for generator	2.5
Others (lack of standards in health facilities; assuming role for which health provider was not employed; distance to main highway disagreement with posting; Language barrier most of the time, patient unable to determine their ages; no permanent key village health post where we can stay	4.3

4. Motivation among health providers

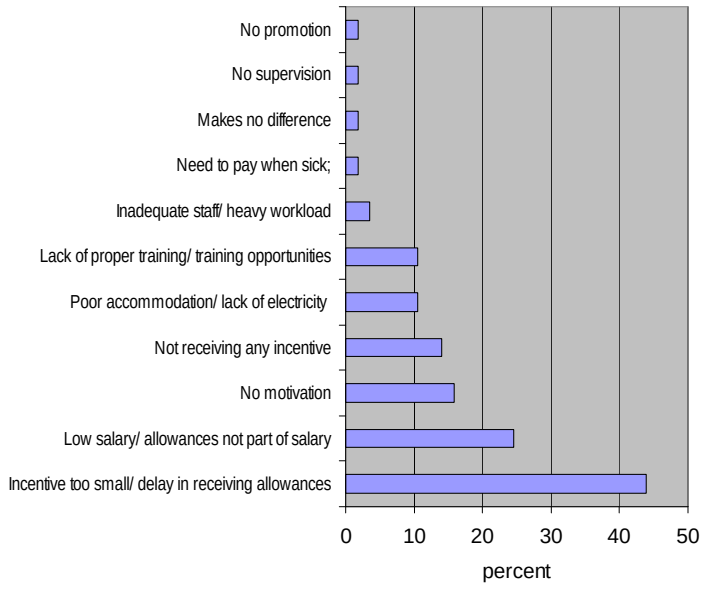
Nearly one in three are still poorly motivated (Figure 4)

Figure 4: Levels of motivation



For those with low motivation inadequate incentives and salaries were by far the most important reasons influencing their state of motivation.

Figure 5: Reasons given for low motivation



De-motivation is also affecting staff retention with 56.4% stating that they have contemplated leaving the health sector at some point in time. Despite the prominence of financial issues other reasons given included heavy workload, unfavourable posting policy, lack of encouragement and, poor accommodation.

Table 11: Reasons for wanting to leave the health sector

Reasons provided	Percent
Low salary	46.7
Heavy workload	12.0
Lack of motivation/	10.9
Unfavourable posting policy eg far from family; too long in one place	10.9
Poor recognition of job/ no encouragement/ no support from ministry when problems arise	9.8
low incentive (not equally distributed)/ delay in receiving incentive/ reduction in incentives	9.8
Poor accommodation-lack of access to utilities and sanitary facilities	9.8
Lack of promotion / delay in promotion/ Career advancement	8.7
Away from family/ marital reasons	7.6
Poor working conditions/ Poor staff relationship / unfriendly working environment	6.5
Unfair treatment of nurses eg no compensation for medical fees	5.4
Frustrated by superiors	3.3
Lack of training opportunities	3.3
Poor nurse-patient relationship/ poor relationship with community	3.3
No provision of transport/ broken down transport	2.2
Concerns about risks/ Non payment for risks taken	2.2
Plans to travel eg to study	2.2
Supervision irregular/ no appraisal	2.2
Poor job description	1.1

Those who stayed and did not leave the health sector were mainly driven by a sense of duty and obligation to serve the country. The payment of incentives was specifically cited by only 5% of respondents as the main reason why they stayed in their jobs.

Table 12: Reasons for staying in job

Reasons provided by health provider	%
Need job to support the family	1.8
More salary	1.2
Because of incentives/	5.5
Patriotism, altruism/ like the job/ contented	47.9
Expecting training opportunities in the future	3.7
Training opportunities	3.7
No alternative employment opportunity/ No other options	6.1
Career advancement in nursing	1.8
Hopeful that things would change in the future	1.8
Working near family/	3.7
Govt more reliable than private sector	1.2
Family pressure/ encouragement from family, & friends to stay/ marital reasons	2.5
Satisfactory working conditions/ good staff relationships/ Good relationships with the community / Availability of drugs and supplies	6.7
Encouragement from superiors	3.1
No visa to travel	1.2
Long time in the service /Not want to lose gratuity	3.1
Recently graduated/ Developing capacity on the job	1.8
Posted to urban area/ Withdrawn from posting/ transfer postponed	1.8

Reasons provided by health provider	%
Others (Complaint forwarded to higher authorities/ Good staff accommodation/ Regular feedback after supervision Job motivation)	2.5

Potential motivating factors

The reasons provided for wanting to work in the health facility and for why working conditions were considered satisfactory provide insights into potential motivating factors. These are summarized in Tables 13 and 14. Proximity to family members and the availability of equipment, drugs and supplies were the main reasons put forwards by those describing their working conditions as favorable.

Table 13: Reasons for wanting to work in the facility

Reason provided by respondent	**%**
Close to my family	40
Availability of drugs and supplies	24
Availability of working tools	22
Availability of social services	21
Adequate working space	17

Table 14: Reason for satisfactory working conditions

Reason provided by respondents	%
Good working conditions; Good working materials, tools, drugs and equipment available	18.4
No interference in each other's job/ staff cooperation	5.5
Mobility is ok/ ambulance available for outreach/ can reach working place on time	3.7
Monthly supervision with feedback/ supportive superiors	3.1
Good accommodation	1.8
Personal needs solved	1.8
Light work load/ adequate staff	1.8
Receive incentives/ improved salary	1.8
Like the job	1.8
Access to water and electricity	1.2
Fuel is available	0.6
In service training / workshops	0.6

5. Suggestions for improving the incentive system

Ninety eight percent of health providers felt that incentives should be improved. When asked to prioritise the five most important incentives valued by respondents, the suggestions given were listed in Table 15 according to the order of importance given by the respondents.

Table 15: Priority items to be included in a revised incentive package based on listing provided by health providers.

Priority 1	%	Priority 2	%	Priority 3	%	Priority 4	%	Priority 5	%
Increase allowances/ incentives	36.6	Increase allowances/ incentives	36.9	Increase allowances/ incentives	21.1	Increase allowances/ incentives	28.6	Increase allowances/ incentives	21.4
Salary increment	19.4	Improved staff housing	15.5	Training	12.6	Training	7.1	Work environment	14.3
Training	12.9	Allocation of land to health staff/ housing scheme	9.7	Improved work environment	10.5	Improved work environment	14.3	Access to loan scheme	7.1
Allocation of land to health staff/ housing scheme	8.6	Training	9.7	Access to loan scheme	8.4	Access to loan scheme	9.5	Salary increment	7.1
Improved staff housing	7.5	Salary increment	6.8	Allocation of land to health staff/ housing scheme	5.3	Salary increment	2.4	Improved staff housing	7.1
Improved work environment	4.3	Improved work environment	4.9	Salary increment	5.3	Improved staff housing	9.5	Allocation of land to health staff/ housing scheme	7.1
Scholarships	2.2	Access to loan scheme	3.9	Improved staff housing	4.2	Improved access to transportatio n	7.1	Others (posting, better access to electricity and water)	14.3
Others (Insurance, car, promotion, free medical treatment)	4.3	Promotion	1.9	Better access to utilities (electricity and water)	4.2	Others (scholarship, better access to electricity and water)	4.8		
		Others (Insurance, car, food, fuel, social amenities)	4.9	Promotion	4.2				
				Improved access to transportation	3.2				
				Others (child sponsorship, more staff,	6.3				

Priority 1	%	Priority 2	%	Priority 3	%	Priority 4	%	Priority 5	%
				impress, insurance, food, supervision)					

Suggestions put forward during the FGDs to improve the incentive system by staff based in the RHT and health providers are reported separately below as they differ in focus.

5.1 RHT suggestions

Suggestions stated by the RHT are discussed under the following sub-headings:

a. decision-making on the distribution of incentives,
b. beneficiaries of the incentive system
c. Increase access to non-financial incentives
d. mode of payment of financial incentives.

5.1a Who should decide on the distribution of incentives?
The RHT were seen as the team most well placed to make decisions about who should receive incentives because of their familiarity with staff and their knowledge of staff movements. Central level staff are perceived as being too far removed from the situation.

> RHT: *Therefore, it is either paid with salaries or the regional health management teams are given the mandate because they know their people…. they implement the programs that are happening in the region and they are able to retire them on time. So they know the people because it happens that all the time are asked to send nominal roles and usually the names they send, sometimes some names are deleted from the list they send, so the people on the ground will come to the RHT to try to find justification that the RHT cannot explain because who ever deleted those names, nobody knows from the level of the RHT, sometimes it is difficult to explain.*

5.1b Who should benefit from the incentive system.
There was strong support for incentives to be paid to all staff on the basis of equity since all staff contribute to the work of the team and to avoid demoralizing those not receiving incentives. Participants felt that payments made on the basis of individuals were discriminatory given the risks faced by all staff

> RHT: *..but if you give some and leave the others instead of making things good, you are making things very bad because some people can retaliate or do otherwise and sabotage the job but if you make it across the board, then everybody will be happy and everybody will be motivated on the job so in short this is what I know about [these] incentives.*

5.1c. Increase access to non-financial incentives

Training is seen as an important incentive that is often overlooked. Improving communication facilities were also highly rated. An interesting suggestion was the need for housing loan schemes to be put in place in rural settlements to assist nurses to build houses where they can stay when they retire from active service

> RHT: *Also training the staff like both for in country and out side the country. I think is a very good incentive and it motivates lot of staff.*

> RHT: *I will want to add on to the incentive package that we are talking about. You see, each and every civil servant would have to retire one day and going round the country, you see nurses who have retired and they don't have a home. Therefore, it is important that in places like Jarra Soma, Bansang, Basse, where there are growth centres, it would be better if the department would work with social welfare or social security to create housing schemes in these areas for people living around these regions. Whereas either they will be paying it, valued in whatever way they can afford, so that you can be assured of your own home by the time you retire. This will motivate people to work harder because at the end of the day, all what we are talking about these incentives, is to try to secure funds that will be your social security tomorrow. Many a time people would die and eventually the routes to follow for their families to get those monies from the social security or from the ministry becomes hard. Or even if you retire, by the time you are able to get your retirement benefits, is actually difficult for you, but when you have your own home, it is just like maintaining the family that is left with you. Therefore I think this need to be looked at for incentives.*

> RHT: *.. Provide housing scheme for them [health workers] to be able to have affordable housing for themselves not government quarters. Is very, very important I believe the government should also be thinking in that direction. We are not also sleeping; we are awake now you understand. They will say we are not banks to give you loan but then definitely government can give loans to staff…if they put it as a policy.*

5.1d. The mode of payment of financial incentives.

There was strong support for the inclusion of financial incentives into the salaries to minimize delays and facilitate access to allowances. Concern was also raised that allowances provided by donors is only temporary. Therefore mechanisms should be put into place for donor funded allowances to be part of the government system. This could enhance long term sustainability of the financial incentive system.

> RHT: *With regards to others, the incentive from government, is not regularly coming and the way we want it is to be paid with our salaries rather than somebody coming here, that usually causes a lot of delay but if you can at least input this in our salaries at that level, I think that would be easier to access than every time to you have to update that list. Some may get it and some may loose their allowances for that particular period. I think putting it in our salaries is better.*

5.2 Health provider suggestions

Suggestions put forward by the health providers for improving the incentive scheme is subdivided as follows

a. Beneficiaries of incentives
b. Access to a loan scheme
c. Improvements to working conditions
d. Increase in financial incentives
e. Provision of opportunities for continuous education and career development
f. Setting up of an insurance system
g. Strengthening collective voice of nurses

5.2a Beneficiaries of incentives

Similar to what was stated by RHT staff there was strong support for the distribution of incentives to all staff.

> HP_Soma: *It should be across the board for all staff it should be across the board no single person should be left out as far as you are in the work force you should benefit from the incentive*

5.2b Access to a loan scheme

Housing is a major concern expressed by several participants. It was suggested that loans should be provided for health workers along with funding to develop the land and build a house. This was more so given that on existing salaries many health workers felt that it would not be feasible to buy land and build a house in the face of competing demands such as the need to feed family members before retirement from the civil service. Further suggestions were made that the government should give preferential treatment to health providers with respect to land allocation.

> HP: *Even land allocation for example where social security announce the forms most of[us] the nurses, if you apply you will be disqualified because financially we don't keep much at the bank but if government can create opportunity where nurses will be allocated land it can motivate us*

> HP: *I said land because is very important and is very necessary when one retires to have a place to settle and is very difficult in this civil sector when you retire and you have nowhere to leave with your family, you still continue in a renting life is very difficult so this why is necessary to have a land and the part of money too is very important just for thee fact that the small amount that is being brought is been share by all staff facilities so this is a concern so at the end of the day you see that what you have doesn't suit a lot*

Some participants called for an allowance or loan to buy a vehicle to be included in the package to improve mobility so that staff can report to work on time.

> HP: *…. and at least vehicle allowance. You see transportation also is key because if you stay at a quite distance from your work place where you need to travel to sometime there is jam at the traffic, you need to walk fast to your work place. You see patients are waiting. You need transport to go to your place.*

5.2c Improvement in living conditions
The main concern was for improvements to the existing accommodation provided for health workers with respect to improvements in the physical infrastructure and access to utilities. This was felt to be an important motivating factor otherwise failure to address this issue would result in poor work output.

> HP: *The incentive that I would prefer is not only cash but encouragement like you know if our working environment is made very conducive. Like in our situation now we don't have electricity there is almost no water supply. If you go into all the rooms within the facility you only find one tap that is functional and then the shower in the labour ward and definitely these two are very key in the health facility like water and electricity those are things that can motivate people to keep us stay in the system to work.*

5.2d Increased financial incentives
Participants felt that salaries should increase by 200 to 300 percent. Furthermore, incentives to be paid to all staff should be increased and suggestions varied from two thousand dalasi (US 78) to three thousand dalasi (US 115).

> HP: *Still about monetary aspect salary increment by two hundred percent*

> HP: *For me, two thousand or three thousand is okay*

5.2e Provision of opportunities for continuous education and career development
Training as a means of career development is considered important. However the participants recognized that because of the cost of training scholarships would be needed to support trainees

> HP: Some people would like to go in for some career development but at the end of the day what will happen is that they will go to the university or they go to an institution who may ask them good sum of money … I think scholarship package should also at least be encouraged here.

5.2f Insurance system
An interesting suggestion was made to set up an insurance system to support staff to meet financial obligations that may arise suddenly, for example with unforeseen illnesses. There were suggestions that the insurance scheme should also extend to more regular household expenses which are high and infrequent, such as the payment of school fees.

> HP: ….and lastly we also need insurance allowance for our families at least pay their school fees pay their all other bills at our family level is not really easy with nursing life is also at risk you are dwelling patients who are contagious very contagious disease are at our disposal every minute. Some times you are infected at your work place you are sick you go to the hospital you are even asked to pay and you are not even visited in your sick bed really we need those risk allowances that will also keep us you know at the risk environment.

5.2g Strengthen the collective voice of nurses

There are calls for a strong association of nurses to which all nurses of different cadres belong. Uniting in this way and speaking with a common voice is seen as a major step forward in resolving problems currently faced by nurses.

> HP: *The best way to solve nurses problem or health workers problem is to reform our associations you see nurses the reason why teachers over took the education sector is their development decentralisation [approach]. Teachers they don't sacrifice who is the great teacher and who is not a great teacher they all form a single association. Nurses also we should come as a single association so that we can have some where to address our problems, but am a CHN I belong CHN association am a SEN I belong to SEN association and an RN I belong to RN association am public health I belong to public health association none of this association is strong none of this associations will be able to pushed ahead to solve any problem now we are no where now. This association [should] come together so that we can have some where to lodge our complaints at least we will have a body that will speak on behave of every body.*

6: Assessing the quality of services provided for children under 5 (U5s) in RCH clinics

The findings are derived from observations made in U5 clinics. A checklist was used to assess the extent to which health workers asked symptoms and elicited signs for the review of a febrile child based on national guidelines. One hundred and forty three children were observed.

6.1 History taking

About 64% of health providers asked after two or less symptoms when faced with a febrile child.

Table 16: Performance of all staff in history taking for sick children

Number of symptoms asked after	No of carers of children under 5 years who were asked about the symptoms	Percent
0	23	16.1
1	38	24.6
2	33	23.1
3	22	15.4
4	8	5.6
5	13	9.1
6	2	1.4
7	4	2.8

Those receiving incentives were better at history taking particularly if they received incentives from two sources than those not receiving incentives (Table 17). In the group not receiving incentives, who performed the worst with respect to history taking, 73.7% were trained CHNs.

Table 17: Performance in history taking by providers receiving incentives compared to those not receiving incentives.

Number of symptoms asked after	Receiving GF incentives	Receiving GG incentives	Receiving GG+GF incentives	Receiving no incentives
2 or less symptoms	25 (58.1%)	23 (59.0%)	28 (56.0%)	18 (94.7%)
3 or more symptoms	18 (41.9%)	16 (41.0%)	22 (44.0%)	1 (5.3%)

Nurse attendants as a group were the worst performers. However, it is unclear whether these members of this group have been trained to attend to children or whether the quality of history taking is reflective of the fact that they are not receiving incentives.

Table 18: Performance in history taking by cadre of staff

	SRN (Midwife)	SRN	SEN (Midwife)	SEN	CHN (Midwife)	CHN	Nurse Attendant
2 or less symptoms	8 (88.9%)	1 (14.3%)	0 (0%)	22 (71%)	16 (64%)	40 (69%)	5 (100%)
3 or more symptoms	1 (11.1%)	6 (85.7%)	2 (100%)	9(29%)	9 (36%)	18 (31%)	0.0

Comparing public and non public facilities

The performance with respect to history taking in the NGO sector was better than in the public sector for both those receiving GF incentives and those that did not receive GF incentives (Table 19).

Table 19: history taking comparing public and NGO sector

	Health providers in public sector				Health providers in NGO sector			
	GF n (%)	GG n (%)	GF+ GG n (%)	Nil n (%)	GF n (%)	GG n (%)	GF+ GG n (%)	Nil n (%)
2 or less symptoms	25 (71.4)	23 (59)	28 (56)	22 (91.7)	0 (0.0)	0 (0.0)	0 (0.0)	1 (16.7)
3 or more symptoms	10 (28.6)	16 (41.0)	22 (44.0)	2 (8.3)	5 (100)	0 (0.0)	0 (0.0)	5 (83.3)

Those who received D2,000 or more performed better than those that received less than D2,000. However, only 11.3% of those receiving incentives were given D2,000 or more.

Table 20: Performance in history taking by the amount of incentive received

Total amount of incentive received	2 or less symptoms n (%)	3 or more symptoms n (%)
D50-999	36 (58.1)	26 (41.9)
1000-1999	34 (70.8)	14 (29.2)
2000-2999	4 (44.4)	5 (55.6)
3000 or more	2 (40.0)	3 (60.0)

Examination of a febrile child

Only 1.4% looked for four basic signs in examining a sick child. Those not receiving incentives performing the worst with respect to the examination of the child.

Table 21: Performance of all staff in the public sector on history taking for sick children

Number of signs looked for	No of children under 5 examined for signs (n= 143)	Percent
0	43	30.1
1	41	28.7

Number of signs looked for	No of children under 5 examined for signs (n= 143)	Percent
2	26	18.2
3	31	21.7
4	2	1.4

Table 22: Performance of providers on examination of a child under the age of 5 years by source of incentives

Number of signs looked for	Providers receiving incentives			Providers not receiving incentives n (%)
	GF n (%)	GG n (%)	GG+GF n (%)	
0	9 (25.7)	8 (20.5)	13 (26.0)	13 (68.4)
1	12 (34.3)	12 (30.8)	12 (24.0)	5 (26.3)
2	3 (8.6)	11 (28.2)	12 (24.0)	0 (0.0)
3	10 (28.6)	8 (20.5)	12 (24.0)	1 (5.3)
4	1 (2.9)	0 (0.0)	1 (2)	0 (0)

Table 23: Performance in examination by providers receiving incentives compared to those not receiving incentives.

Number of symptoms asked after	Receiving GF incentives	Receiving GG incentives	Receiving GG+GF incentives	Receiving no incentives
2 or less signs	24 (68.6)	31 (88.6)	37 (74)	18 (94.7)
3 or more signs	12 (34.3)	8 (20.5)	13 (26)	1 (5.3)

For all cadres, few staff looked for 3 or more signs during the examination of a sick child and there was no difference between nurses in the NGO and public sectors.

Table 24: Performance in examination by providers by cadre

	SRN (Midwife)	SRN	SEN (Midwife)	SEN	CHN (Midwife)	CHN	Nurse Attendant
2 or less signs	9 (100%)	5 (71.4%)	1 (50%)	25 (80.6%)	12 (60%)	45 (77.6%)	5 (100%)
3 or more signs	0 (0.0)	2 (28.6%)	1 (50%)	6(19.4%)	8 (40%)	13 (22.4%)	0 (0.0)

Table 25: Performance of health providers in examining a sick child in the public and NGO sector

	Health providers in public sector				Health providers in NGO sector			
	GF n (%)	GG n (%)	GF+ GG n (%)	Nil n (%)	GF n (%)	GG n (%)	GF+ GG n (%)	Nil n (%)
2 or less signs	24 (68.6)	31 (79.5)	37 (74)	23 (98.8)	0 (0.0)	0 (0.0)	0 (0.0)	6 (100)
3 or more signs	11 (31.4)	8 (20.5)	13 (26)	1 (4.2)	5 (100)	0 (0.0)	0 (0.0)	0 (0.0)

As was the case with history taking, performance improved with an increase in the amount of incentive received by a health provider. Among those that received D2,000 or more, 50% examined a child for three or more signs compared to 23% among those that received D2,000 or less.

Table 26: Performance in examination by the amount of incentive received

	2 or less signs	3 or more signs
D50-999	43 (69.4)	19 (30.6)
1000-1999	42 (87.5)	6 (12.5)
2000-2999	4 (44.4)	5 (55.6)
3000 or more	3 (60.0)	2 (40.0)

7: Assessing the quality of pregnant women in antenatal clinics

One hundred and thirty one pregnant women were observed in the public sector with respect to history taking and examination. Performance assessed by the extent to which practices were aligned to national standards ie asking and examining for 5 important symptoms and 5 signs.

History taking was poor as few staff, 6.1%, took a complete history. However performance improved during clinical examination with 34.4% looked for at least five basic signs

Table 27: Performance of all ANC staff in history taking

Number of questions asked after	No of women asked the question	Percent
1	1	0.8
2	16	12.2
3	41	31.3
4	65	49.6
5	8	6.1

Table 28: Performance of all ANC staff in examining pregnant women

Number of signs	No of women who were examined for 5 basic signs	Percent
0	1	0.8
1	4	3.1
2	9	6.9
3	23	17.6
4	49	37.4
5	45	34.4

SRN midwives performed the best with respect to history taking and clinical examination.

Table 29: Proportion of staff taking a good history and conducting a quality examination

cadre	N	Good quality history taking n (%)	Good quality clinical examination n (%)
CHN	18	0	5 (27.8)
CHN (M)	65	3 (4.6)	23 (35.4)
SCM	11	5 (45.5)	5 (45.5)
SCNA	5	1 (20)	2 (40)
SEN	5	0	0
SEN Midwife	18	0	9 (50)

Incentives do not appear to be improving performance in history taking and examination. Less than 10% of those receiving incentives took a satisfactory history. Performance in clinical examination was not related to either the source of the incentives or the amount received by health providers in the public sector. However more staff in the NGO sector conducted a good quality examination of pregnant women compared to staff in the public sector.

Table 30: Comparing history taking and examination of ANC clinics between those receiving and not receiving incentives

Source of incentive	n	Good history taking n (%)	Good examination n (%)
GF n (%)	29	0	7 (31.0)
GG n (%)	21	1 (4.8)	11 (52.4)
GG+GF n (%)	72	7 (9.7)	24 (33.3)
No incentives	9	0	3 (33.3)

Table 31: Examination of ANC based on incentive received

Range of incentive received	N (n=119)	History taking n (%)	Examination n (%)
D50-999	42	3 (7.1)	9 (21.4)
1000-1999	49	4 (8.2)	20 (40.8)
2000-2999	24	1 (4.2)	7 (29.2)
3000 or more	4	0	3 (75)

Table 32: Performance of health providers in public versus NGO sectors

Type of facility	N	History taking n (%)	Examination n (%)
Public	134	8 (6.0)	48 (35.8)
NGO	13	0 (0.0)	11 (84.6)

8: User perspective on quality of care provided for children under 5 years

Some mothers were satisfied with the care provided. Health talks provided by health workers are seen as valuable in providing information on the prevention and home treatment of common illnesses. Referrals are a major concern. Referrals are hampered by two main problems: unavailability of an ambulance when needed to transport an emergency case and relatives sometimes have to buy fuel for the ambulance which can lead to delays in evacuating patients.

> User: *Sometimes when they refer your patient, the ambulance will not be here so you will have to hire a vehicle to take your patient to go and sometime before you get there all those patients died on the way.*

> User: *Even when an ambulance is here me when I had difficult labour they call my husband to come and buy gas oil for the ambulance to take to Banjul my husband come few minutes I delivered*

A total of 171 carers were interviewed. 94.7% were females with a mean age of 25.7 years (sd 7.4 years). Of these women 62.4% had not attended school and 90.6% were at the clinic because the child was sick.

Waiting time
Thirty nine percent complained of long waiting times. However frustration was expressed with respect to long waiting times and people “jumping queues” unfairly.

> User: *I came here last night. The doctor I met here was good because he helped me, gave me medicine, had sympathy for my child and asked me to come today for another one [medicine] but mostly when I come here to look for medicine I buy all what they write on my card. It is just yesterday that I came here and had medicine and secondly when we come to nurse [MCH clinic] for our monthly check up we do suffer a lot here. We will be in a queue you see someone comes who knows the nurse who will help that to go before us .. we will be staying here for long before they weigh our children and they will not tell you the weight of your child and when you ask them whether there is injection they will tell you they don’t know; then you go and queue until you reach there [the end of the queue] they tell you there is no injection.*

Mothers were irritated by having to stand up for extensive periods because chairs or benches were not readily available. This irritation was compounded when, after waiting for long period, they were informed that the prescribed treatment was unavailable. The reason for the long wait is put down to staff attitude and people jumping the queue. Mothers were also frustrated that some individuals jump the queue simply because they are known to health providers.

> User: *[The service] is good and we want them to continue but at times when we come we spend a lot of time standing on the queue waiting to be seen. At times*

you queue up to the time you are seen and all what they will tell you is that, there is no drugs, when you have spent a lot of time in the queue with your sick child and the exhaustion you have gone through, that is very painful. You cannot go to another facility because it is already too late to take your child to another clinic and you wasted your time waiting in vain without having medicines that is very painful. The chairs are also not enough and we stand a lot waiting, that is also our problem here.

User: *Sometimes you leave your work at home and come early to the clinic and they would be sitting down chatting or going in and out, you know that's also a problem for one with a family.*

User: *Sometimes you come here early in the morning and would sit for a long time without seeing any nurse around, yes it takes time before they come, and when they come, it takes time again before they start*

Reasons provided by mothers for their dissatisfaction with the services provided can be found in box 1. They relate mainly to drug shortages, and a perception of inadequate attention to their needs.

Box 1: Comments of dissatisfied mothers

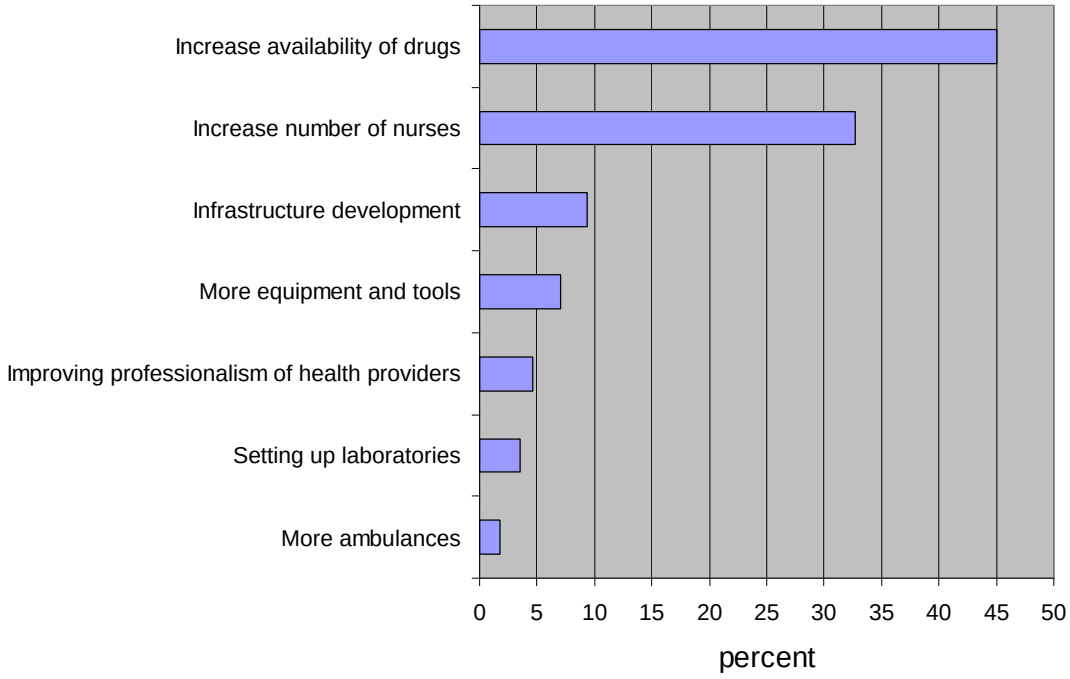
Because I could not have all the prescribed medicines
Because I did not get what I wanted
Because I have to go to [name of village omitted] for my child's treatment
Because I was not given what I wanted
Because my child was not given the proper attention
Because my child is not weighed
Because they gave me only syrup
I am not happy today because my child was suppose to be injected since last month but because in did not come he could not get it
I have to go to [name of village omitted] for drugs for my child
No service today ie no routine child clinic [RCH] today
The way the nurse approached me on the condition of the child, that is why I did not come earlier than now which I have reasons- transport problem
There was no drug given to my child

Suggestions for improving quality of care by carers of U5s

The two main suggestions for improving the quality of care provided to U5s were to increase the number of staff and ensuring the availability of drugs.[1]

[1] Others: prompt treatment; providing food for facility; mothers to maintain routine child welfare visits; improve care and treatment; provide 24 hour service

Figure 6: Suggestions of mothers to improve the quality of services



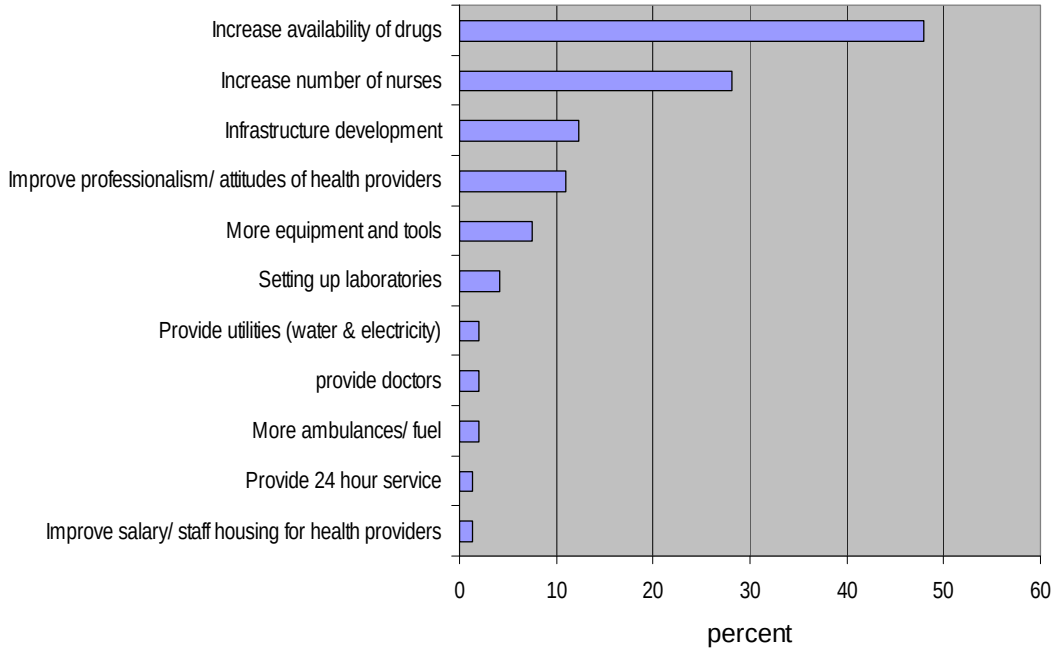
9: User perspective on quality of care provided for pregnant women

One hundred and forty six women were interviewed in the antenatal clinic with a mean age of 24.8 years (SD 8.3 years).

9.1 Suggestions for improvement of services

The main suggestions were similar to those made in the U5 clinics and relate mainly increasing the availability of drugs to prevent stock out; increasing the number of nurses and doctors; improving the infrastructure of the facility and strengthening the professionalism of health providers.

Figure 7: Suggestions of pregnant women to improve the quality of services



During the FGDs with pregnant women further ideas were presented about how the quality of services being provided to them could be improved upon. These are discussed below under sub-headings.

9.2a Improving quality of services

The suggestions made were beyond the performance of the individual health worker and focused mainly on systemic issues. The main suggestions were: expansion of the range of services provided by rural facilities; the availability of increased skilled manpower in rural facilities; strengthening the referral services; improvement of the physical infrastructure of facilities and increased access to drugs

Suggestions made with reference to expanding existing services in rural major health centres aim to bring these services closer to people and reduce the financial burden on families of looking after a relative referred or admitted to the main teaching hospital. Participants call for the expansion of services to be modeled on the existing tertiary hospitals so that the range of services currently offered by these tertiary facilities will be provided in major health centres

> User: *We want this health centre to be like Banjul hospital. The number of people that comes to Brikama health centre if it has good structures and more doctors it will be of great help to the people because when they refer your patient from here to Banjul you don't know anybody there someone must be everyday taking you food to you at Banjul to and from and to get fare for that person is another burden on you again we are appealing to the government to improve the standard of Brikama health centre …. so that all those services in Banjul hospital will be available here also that people of this catchment area will also be free from paying expensive fare to and from Banjul transporting food to their patients*

Several participants voiced their opinion that the number of ambulances needs to be increased and attention should be paid towards ensuring a reliable source of fuel for the ambulances to avoid patients suffering if relatives are unable to pay for the fuel.

> User: *If they can provide five up to ten ambulances here is good*

> User: *We are appealing to the government to increase the gas oil they supply because sometimes you come here the ambulance and the driver is here[but there is] no gas oil in the vehicle and you will be asked to buy and if you are not in the position [to do so] your patient will suffer…*

9.2b Improvement of the physical infrastructure of facilities

The main suggestions related to improving the availability of utilities, improved sanitation, and increased access to drugs, supplies and equipment

> User: *They should help us with water and electricity because if you are admitted here some times water and electricity is not available*

> User: *They should concrete the whole premises so that water don't stand in side is not long ago one woman fell into a gutter and died …*

9.2c Increased skilled manpower

An inadequate number of nurses in health facilities is seen as a reason for inadequate provision of services in facilities. References made to medical personnel were in the context of individuals with specialized skills to undertake specific tasks which are currently provided in the main teaching hospital.

> User: *…if there are enough nurses and drugs there will be no problem.*

> User: *… you know sometimes when you are sick they refer you to Banjul, so if we have enough doctors specialising in different areas, so [that] before you go to Banjul if those doctors are here, they can treat you. …you know its expensive in Banjul, anything you need you must buy, if don't have money, but if that is available here, you will not have that problem.*

10. Conclusions and Recommendations

When the study was conceived the number of health providers not benefiting from the incentive scheme was assumed to be larger than was found during the survey. As a result, because there were few health workers who had not benefited from the scheme this group was not large enough to be able to conduct more robust statistical tests of the significance of any observed differences between the two groups.

Despite this, the low amount of incentives provided and the infrequency with which it is distributed could themselves be undermining the expected effect of incentives on performance and leading to widespread discouragement among health providers. Whilst there are suggestions that incentives may be improving staff retention, increasing the recruitment of staff from the private sector and improving timely reporting at facility level, it is worth noting that only 5% of respondents those who wanted to leave the health sector did not do so because they were receiving incentives. Furthermore, the prioritization of improved financial remuneration in an improved incentive package by the majority of health providers suggests that the existing incentive system is widely considered inadequate.

The study pointed out the crucial role played by non-financial incentives in improving staff motivation and performance. Not only did health providers acknowledge that non-financial incentives were as important as financial incentives but there was a clear demonstration of the demoralizing effect of concerns about the absence of non financial incentives to address poor housing; inadequate access to utilities, lack of opportunities for training, promotion and career advancement; heavy workload; inadequate posting policy; and lack of support and supervision. The need to address these concerns in an upgraded incentive package was emphasized by the majority of those interviewed.

Several interesting themes have emerged from this study. One fear voiced by several respondents is the possibility of not owning a home after retirement unless the Ministry of Health makes attempts to set up processes to access financial resources over time such housing loan schemes and insurance systems for health staff. Concern was also raised about lack of clarity around career advancement within the public sector with training increasingly being seen as an unspoken precondition to being promoted

The proposals put forward by health providers to improve the incentive system called for improvements to both financial and non financial incentives. What was interesting was that the suggestions made would have direct benefits not only for the individuals but would also lead to improvements in working conditions within health facilities. This suggests that the gaps in the context in which incentives are being implemented need to be addressed simultaneously. Indeed for those health workers who expressed satisfaction with the incentive system, there was also satisfaction with working conditions. It would appear then improving the incentive scheme without taking into consideration working conditions is not likely to improve motivation and performance in the long run.

For the users of the system these more systemic problems, namely, inadequate manpower; stock out of drugs, inadequate equipment and supplies and overcrowding

and lack of amenities and utilities are considered the main pointers of the aspect of the system that needs to be addressed to raise the quality of services.

The fact that incentives had a positive correlation with performance in the under 5 clinic but not the antenatal clinic may indicate that factors other than incentives were at play. A substantial amount of training in the management of fever has taken place with funding provided by the Global Fund. Although not assessed, one possibility is that those receiving incentives have also benefitted from in-service training in the management of fever. On the other hand, in-service training of antenatal care providers with funds provided by the Global Fund, have focused more narrowly on the provision of IPT and PMTCT (which were not assessed during this review) rather than the full range of antenatal care. Thus, it is quite possible that training rather than incentives was the main driver of performance.

On the basis of the findings, a review of existing incentives is recommended through a participatory process. Specific recommendations include:

1. There should be an integrated package of incentives drawing on all available sources of resources
2. Staff should benefit from the package of incentives based on the principle of an integrated health service
3. Non-financial incentives should be part of the incentives package
4. The package should be designed to encourage deployment to underserved parts of the country
5. The financial component of the package should be paid at the same time as the salary
6. To improve performance, training to provide services of at least minimum quality and the provision of a conducive work environment should be undertaken as fundamental requirements rather than as incentives

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