GHANA QUALITATIVE HEALTH WORKER STUDY

Draft report of preliminary descriptive findings

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This report contains preliminary descriptive findings and has been produced for participants in the November Health Summit, November 19-23 2007, Accra.

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

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Abbreviations

FGD	Focus Group Discussion
GOG	Government of Ghana
HRH	Human resources for health
MOH	Ministry of Health
OPM	Oxford Policy Management

1 Introduction

Health workers form the foundation for health service delivery. Both their career choices and their on the job performance are important elements constituting effectiveness of a health system. Currently there is very little understanding about the microeconomics of health worker career choice and performance. To help fill this gap, this study carries out some qualitative research on the behaviour and performance of health workers in Ghana.

Ghana as most Sub-Saharan African countries suffers from a severe shortage of health workers. In addition, there is a mal-distribution of health workers in favour of urban areas, a growing private sector at the expense of the public sector, and questions regarding the level of motivation and performance in the public sector. With these issues in mind, the Government of Ghana (GOG) is implementing health sector reforms to improve performance and retention of health workers in the public sector.

This study is concerned with understanding the labour market choices, motivation and behaviour of health workers. It seeks to provide descriptive information that will ultimately constitute potential input in the design of human resource policy, especially if complemented with quantitative operational research. This study is premised on the notion that health workers are not passive actors in the health system, but rather make choices about where, when, and how to work on the basis of personal characteristics, as well as the institutional and organizational environment in which they operate. Health workers do not only actively try to determine the sector or facility they work in, but also whether they work hard or not while on the job, their level of absenteeism, whether they engage in inappropriate activities and informal health care and so on.

The study jointly addresses the following research questions:

1. Elicit labour market choice determinants: What determines career paths of health workers and how does a typical career look like? How do health workers choose between employment in the public, private for profit and not-for-profit sector? How do health workers inform their decision to work in urban rather than rural areas?
2. Explain observed performance levels: Are there inter-sector differences in health workers' motivation? How do health workers allocate their time and what does time use tell us about coping strategies? Do health workers generally engage in income augmenting activities and what kind? How do job satisfaction and motivation affect health worker behaviour and what are their determinants? How do the recently introduced incentives impact on health workers performance?
3. Specific issues: external migration of nurses: What are the most important drivers of migration? Is the prospect of external migration a factor in the decision to enter the health sector? What are the barriers to migration both in Ghana and in the receiving countries? What are job expectations of candidate nurses and what are the actual job prospects of those that have migrated? When and why do nurses consider coming back to Ghana? How do the current incentives impact on the decision to migrate?

In recognition of the interdependencies between different segments of the health sector, the study focuses on all individuals with formal training in allopathic medicine, regardless of whether they work in the public, private or faith-based sector. The study will also include health workers active in hospitals, clinics and primary health care units. Similar research in Ethiopia and Rwanda has provided a framework and methodology for this study, also allowing comparing the situation in the three countries.

2 A note on the underlying theoretical framework

This section sketches roughly some of the mainly economic strands of theory and empirical findings that underpin the approach to this study. Health workers are seen as individuals actively making choices to maximise their well-being. Schematically, one could argue that health workers have to make three professional choices; relating to the sector they will work in, the job location, and their performance level.

Sector choice Health mainly concerns the public, private or faith-based sector. Additionally, they can also choose to work outside Ghana, take up a non-clinical job in the health sector, or leave the health sector altogether. They also choose the 'location' of their work. This refers to a number of dimensions, but the most important one is whether they will work in an urban or a rural environment. Importantly, health workers also determine some aspects of their 'performance' level, which includes whether and how much they are absent from their job, shirk or engage in inappropriate activities such as pilfering drugs and informal health care. Obviously, this list of choice-options is not exhaustive but focuses on the issues of concern to this study.

How do health workers practically go about maximising their well-being? First, they browse the labour market and the jobs potentially available to them. Each job has a number of characteristics which are partly determined by its sector, location and performance targets (or degrees of freedom the health worker has in choosing certain performance levels). These job attributes comprise remuneration (base salary and benefits), contract type (referring to the degree of stability of the job), options for training (continuous, on-the-job and further specialisation), social recognition (by peers, by patients), living environment (where one works to a degree determines where one and one's family lives; urban versus rural jobs are a point in case), professional environment (presence of colleagues, small health centre versus large hospital, quantity and quality of available equipment, supervision), etc.

Second, each health worker assesses the attributes of the jobs potentially open to him/her and in the end comes up with his/her 'most preferred job' which maximises well-being and will therefore be chosen. Obviously, this job is not the same for each health worker: while some think remuneration is most important, others will highly value the stability or long-term character of a job. In other words, health workers have heterogeneous preferences.

The health workers' decision space is the labour market for health workers in Ghana. This market has specific characteristics that are important to understand health worker choices. Labour market characteristics are for example the extent to which demand for and supply of health workers at different levels (doctors, nurses, etc.) corresponds; the degree to which health workers can move freely between health sectors (segmentation and path dependency); the extent to which labour market entry and job transfers are smooth; systems of performance evaluation and promotion. The study will also take into account some important labour market characteristics in analysing health worker behaviour.

In sum, this study regards health workers as individuals who make active labour market choices, including performance levels on the job. Not all individuals make the same choices, depending on differences in their individual tastes and preferences. An understanding of the health labour market characteristics in Ghana also contributes to understanding health workers' labour market decisions. The labour market outcomes, and most notably distribution of health workers over sectors and locations and on-the-job performance levels, thus depend on individual as well as on organisational and institutional characteristics.

Lastly, human resource policy for health workers can impact on job attributes and/or labour market characteristics health workers face. Human resource policy can therefore be seen as an instrument to impact on individual choices by health workers and to indirectly strive to obtain more desired labour market outcomes.

3 Methodology

This section briefly highlights some methodological choices made in this study. More precisely it explains why focus group discussions where chosen as an instrument to collect data, how the participants in the groups have been identified, the data collection supports and the data analysis tool used.

3.1 The choice of Focus Group Discussions as a data collection method

One of the first questions is how to collect data pertaining to health workers' career choices and performance levels in Ghana. Evidently, there's a wide range of qualitative and quantitative methods to choose from, and within each method, still quite some different tools available. This study was carried out using qualitative focus group discussions (FGD), for the following reasons.

Qualitative methods are useful to grasp issues that are difficult to measure. These abound when thinking about performance choices by health workers such as malingering (shirking), absenteeism, pilfering drugs and small medical equipment. Similarly, qualitative methods allow developing an idea of the relationship between variables: how does Additional Duty Hour Allowance (ADHA) impact on on-the-job performance levels? Does the availability and quality of medical equipment in facilities relate to external migration?

Qualitative methods not only give an idea of the magnitude of difficult to measure variables and how they relate, they also help to develop an understanding of observed behaviour: why do health workers keep up public sector jobs while simultaneously maximising income earned in the private sector? How do health workers plan for migration and what are the main barriers they encounter?

Qualitative methods such as FGD are equally fit to get an insight into the perceptions of health workers themselves. This point is not trivial, since it's their decisions based on their perceptions that ultimately determine health labour market outcomes strived towards by policy makers. Getting the views of health workers may for example highlight the difference between policy makers' intentions when designing ADHA and how health workers perceived the scheme, and enacted upon it.

Qualitative methods, and more precisely focus group discussions (FGD), have therefore been chosen to examine career and performance choices in Ghana. FGD, which are typically held with a number of participants ranging between 6 and 9, not only enable explore perceptions of group members concerning the issues discussed but also to confront their ideas. As such participants function as an 'information quality filter' in the discussion: highly individual or extreme points of view will provoke disagreement from other participants.

Qualitative methods have clearly some drawbacks and pose challenges to researchers. Typically, the magnitudes of difficult to measure variables observed is approximate only and the relative weight of related variables in often unknown. For example, health workers will explain that the absence of schooling for their children, as well as the lack of locums in rural areas are reasons to prefer an urban sector job; FGD will be ill-equipped to determine the weight of these factors in the decision to choose an urban job, and what their relative importance is. The data and information obtained via FGD are also only 'weakly' objective, since the researcher, through the interview script and by directing to some extent the discussion, interferes in the process of data collection and thus influences to some extent what participants report. Other challenges of FGD include

pressure within groups to conform to the norm which might lead to opinions not being expressed (conformity effects) and discussion being dominated by one or two individuals.

The inherent disadvantages of FGD can be partly overcome by following a strict methodology in study preparation, implementation and analysis. These issues are explained later in this section. It is also important that the moderator is aware of the group dynamics and is able to skilfully manage them to avoid or minimise conformity effects and some individuals dominating the discussion, leading to a 'false consensus'. This danger has been minimised by including experienced researchers on the study team.

We have argued in this section that the advantages of focus group discussions in studying health worker career and performance choices outweigh their inherent weaknesses. The awareness of the drawbacks of qualitative methods has led to careful study design, implementation and data analysis by experienced researches. Therefore, the qualitative data obtained in this study can be used to lay groundwork for other data collection methods, such as larger quantitative assessments, and can in itself—since a rigorous methodology is applied—be used as baseline information and subsequent monitoring and evaluation of policies. They also allow to elicit some explanatory hypothesis regarding actual health labour market outcomes which can inspire future policy making if interpreted with care by experienced policy makers.

3.2 FGD participants

The selection of FGD participants was led by three objectives:

1. within-group homogeneity,
2. within-group heterogeneity and
3. group dynamics.

The first objective is reached by bringing together participants of a similar socio-professional status. The first challenge here was to divide the Ghanaian health workers into a limited number of sufficiently homogenous groups that correspond with clear health career choices and we distinguished between 'doctors', 'professional nurses' and 'auxiliary nurses'. Alternatively, participants were also 'users of health services' and 'nurses' who plan to migrate', 'have migrated', 'have come back to Ghana' or 'do not want to migrate'. Within-group homogeneity is important to prevent that differences in social status originating from differences in professional status inhibits some participants to talk freely.

Once sufficient homogeneity is ensured, heterogeneity along other dimensions maximises the probability of participants having different experiences and views. Criteria for heterogeneity included: sex, age, having children, working in (or visiting) a different health centre and different health sector (public, private, faith-based), degree of poverty (for users only). Lastly, to ensure constructive group dynamics we tried to avoid that participants knew each other beforehand, visited or worked in different health facilities and were particularly shy.

Overall, the selection criteria (for more detail see Annex A) were well respected. However, characteristic to the limitations of fieldwork, some selection criteria were more difficult to respect than others. Non-compliance with selection criteria mainly concerned the difficulty to identify female doctors and male nurses and health workers active in the private sector in rural areas. Also, the distinction between public, private and faith-based sector sometimes led to confusion as health workers in many cases work for both public and private hospitals. Moreover, the notion that focus group participants did not know each other did not always hold, in particular for doctors.

We aimed to have between 7 to 9 participants in each FGD. While this target was reached in all groups, the FGD with migrant nurses in London (UK) was held with 6 participants due to lower than expected turnout.

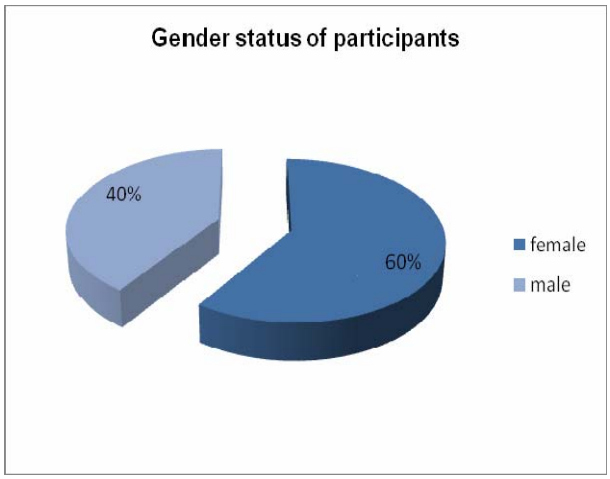
To capture the differences between rural and urban settings, sets of separate FGD were undertaken in Accra and Sunyani. A total of 94 persons took part in 12 FGDs. Table 3.1 gives an overview over the different FGDs, their location and number of participants.

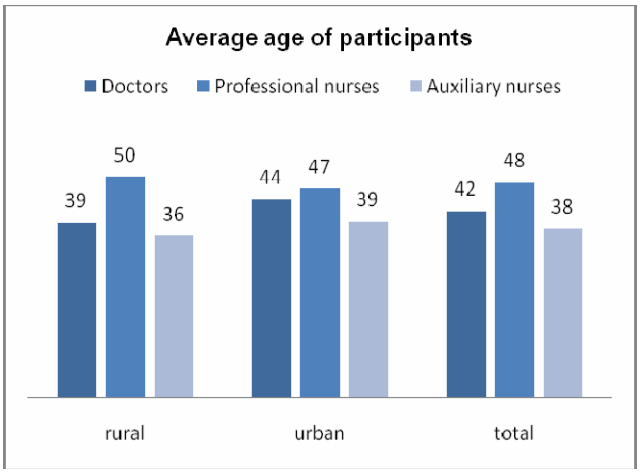
Table 3.1 Overview over FGD, location and number of participants

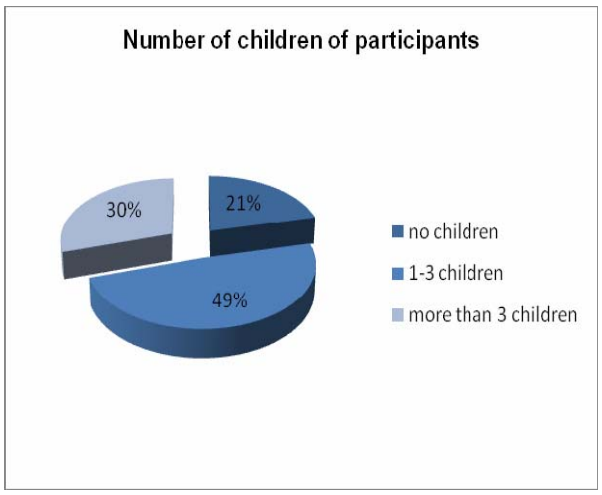
Code	Participants	Location	Number of participants	Length of discussion
U1	Doctors	Urban (Accra)	8	1h 49min
U2	Professional nurses	Urban (Accra)	8	2h 22min
U3	Auxiliary nurses	Urban (Accra)	7	1h 55min
U4	Users	Urban (Accra)	8	1h 52min
R1	Doctors	Rural (Sunyani)	8	1h 42min
R2	Professional nurses	Rural (Sunyani)	8	2h 06min
R3	Auxiliary nurses	Rural (Sunyani)	8	1h 55min
R4	Users	Rural (Sunyani)	8	1h 59min
M1	Nurses about to migrate	Urban (Accra)	8	1h 55min
M2	Nurses that have migrated to the UK	London, UK	6	1h 45 min
M3	Nurses that have returned to Ghana	Urban (Accra)	9	2h 07min
M4	Nurses that have decided not to migrate	Urban (Accra)	8	1h 40min

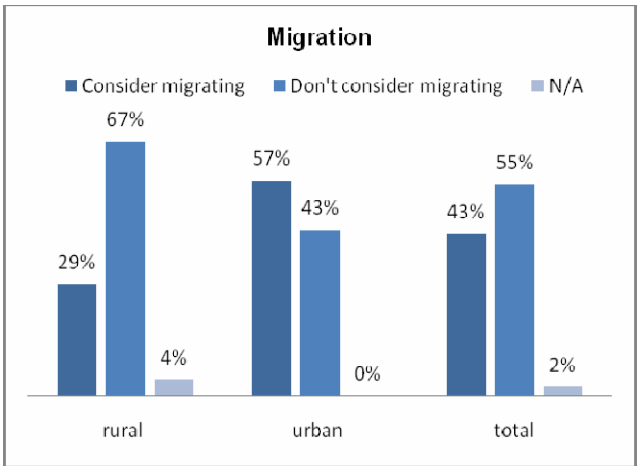
Figure 3.1 contains some descriptive statistics relating to the six health worker FGD with doctors, professional nurses and auxiliary nurses in urban and rural areas (U1-3, R1-3). The overall gender balance is in favour of females; this reflects that the majority of nurses in Ghana are female. Data on migration has to be interpreted with care as recently introduced barriers to migrate may have impacted on participants' responses.

Figure 3.1 Descriptive statistics of FGD participants









3.3 FGD, transcription procedure and analysis procedure

The FGD were conducted using semi-structured interview scripts. The interview scripts have been elaborated drawing from three different sources of information: (i) the interview scripts used in similar studies in Ethiopia and Rwanda; (ii) empirical findings on health worker career and performance choices, and; (iii) expert-interviews with senior decision makers and experts in Ghana.

Typically, each script focuses on a number of issues to which a prompt or trigger question is associated. The FGD moderator introduces an issue by stating the prompt question and participants subsequently 'freely' discuss the issue. Some 'probe' questions prepared beforehand are then used to further guide the 'focused discussion'.

Although all following the same basic structure, six separate interview guides were developed as follows:

1. Interview guide for the health worker FGDs (U1-3, R1-3): doctors, professional nurses and auxiliary nurses (one additional question was added for the doctors on post-graduate incentive)
2. Interview guide for the users of health services (U4, R4)
3. Interview guide for nurses about to migrate (M1)
4. Interview guide for nurses that have migrated to the UK (M2)
5. Interview guide for nurses that have returned to Ghana (M3)
6. Interview guide for nurses that have decided not to migrate (M4)

To ensure beneficial framing effects, all discussions took place in a meeting room in a hospital, either at the Legon hospital in Accra, the district hospital of Sunyani or the St George's University Hospital in London.

Participants were welcomed with a soft drink, relaxing the atmosphere and allowing for latecomers. FGD lasted between 1h 40 min and 2 hours 22 minutes.

At the beginning of the discussion, participants were informed about the objective of the study and its independent academic character was stressed (to avoid perceptions of strong linkage with the Ministry of Health resulting in possible inhibition of participants). Participants were invited to be open and honest in their interventions and to base the latter on personal experiences or direct observations. They were also asked to intervene when colleagues made interventions they did not agree upon. Even if discussions were recorded, full confidentiality and anonymity was guaranteed. At the end of the discussion, participants filled out an information sheet and were reimbursed for transport and opportunity costs.

The procedure followed generated one audio file per FGD. These files have been transcribed. Consequently, the analysis of the FGD is based on detailed written accounts of the 12 FGD. All FGD were held in English and only the user FGD in Sunyani was partly held in Twi; transcripts are in English only. The analysis is carried out using QSR NVivo 7.0, a qualitative research software package. Its main advantage lies in easiness of data coding and its functions enabling the visualisation of different data cross-sections.

At a practical level, the 8 health worker and user FGD transcripts have been coded, which consists in the allocation of a code to a quotation of a participant. A total of 54 codes have been used for the 8 health worker and users FGD (excluding the 4 migration FGD, which are separately coded), reflecting the diversity of the issues of interest in this study. A quote can be attributed different codes in case the quote refers simultaneously to different topics. When this occurs, association

between quotes can be looked into. In total 1,812 quotes have been examined (this excludes the migration scripts). The next section contains a selection of quotes per topic of interest. Quotes have been retained if they reflect a recurrent or an important theme in the discussions. However, further analysis is necessary if an accurate interpretation of the quotes is to be made. This will be carried out in future work.

4 Summary of selected FGD codes

4.1 A health warning: how to read these summaries

From the methodology section above it can be inferred how these quotes must be read. Most importantly, these summaries are based on what health workers have said during FGD. This does not mean that it is necessarily objectively true, or that the researchers agree: no filter whatsoever has been applied and the summaries are not censured. In essence, the summaries reflect how health workers perceive their professional environment.

Due to the method of double coding (see above), some important (and probably annoying) degree of repetition arises in the summaries. It is therefore warranted to browse through selected topics of interest, rather than read the entire summary as if it were one fluent text with a beginning and an end: it is all but that.

Lastly, these summaries are being released for the sake of the November Health Summit. They are to be seen as descriptive raw data, to which no analysis whatsoever has been applied. They aim to give participants an insight in the study approach and preliminary descriptive results, and perhaps will contribute to an enriching debate at the Summit.

4.2 Getting a career in the health sector

4.2.1 Dedication

Health workers report that working in the health sector is about saving lives. To do so well, dedication is important. Dedication means that you want to help and serve people, that you feel empathy with the patients, love and care for people, that you are compassionate. Sometimes, reference is made to religious belief when dedication is described.

Health workers say that dedication is a necessary condition to enter the health sector, and much more commitment is needed to work in the health sectors compared to other sectors. It is also necessary because working in the health sector is sacrificial. A dedicated health worker will have job satisfaction, notwithstanding the lack of financial recognition.

A highly committed health worker will exhibit certain behaviour: he or she has is always on duty, is always available for emergencies, will improvise if working conditions require doing so and doesn't sit down when equipment lacks, doesn't migrate and didn't participate in the strikes.

Health workers hesitantly admit that external migration conflicts to a certain extent with being dedicated. At the one hand they argue that they take their dedication with them to patients in the foreign country. At the other hand, they are aware that people in Ghana need their services more badly than those in foreign countries. External migration seems to sit uncomfortably with the picture health workers have of themselves and of how health workers are socially perceived.

Health workers recognise that not all of them are equally dedicated, even if they believe most of them are. Users tend to believe the opposite: that the majority is not dedicated. Health workers and users alike indicated that health professionals today are less dedicated than before.

Because jobs in other sectors are scarce, in contrast with the health sector where vacancies abound, and because the medical schools have a higher capacity to take up students, some undedicated students end up working in the health sector. Also, some health workers choose to enter the health sector 'to go to London', or because the sector offers good financial perspectives.

Health workers indicate that their dedication is not always recognised, and that the younger ones have learnt from the older ones that 'self-preservation' is important. They indicate that initially dedication is independent from external incentives. However, they report that incentives and monitoring can enhance commitment in staff and also that when levels of incentives are too low existing levels of dedication are eroded.

Dedication can be instilled in training, and health workers believe that dedication is higher in those that work in the faith based hospitals, also because monitoring and sanctions are in place and because the health workers have the 'fear of God'.

4.2.2 Health sector entry & career choice

Why do people enter the health sector? There're many different reasons for entering the health sector and become a nurse or a doctor. However, health workers are unanimous: if you're not dedicated, you will not be a 'good' clinical health worker and not be satisfied, because the job comes with a lot of sacrifices. Then it is better to for example become a pharmacist, as you'll need less dedication, have better working hours and carry less responsibility.

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 for example teachers and they can also more easily find a well paid job abroad. Compared to other sectors, there's less unemployment in the health sector. Increasingly, families urge some of their school aged members to opt for the health sector because of the expected financial returns, especially when the health worker would be able to migrate.

Health workers also benefit from generally high social esteem. Some choose to become a health worker because a family member is.

Some health workers choose to leave clinical care to take up a job in public health, where one is not confronted with the sight of blood and promotion goes faster. Some doctors in Accra say that a job for an international organisation is a dream job, however is very difficult to obtain. You can only get a job with for example the WHO when you know someone in the right place. Health workers believe that generally the preferred candidate is anyhow chosen, regardless the outcome of the selection procedure.

4.2.3 Career path & stages

In Ghana, bonding regimes apply for subsidised training programmes in the public and faith based sector, where most students are trained. These bonding regimes do not necessarily correspond with health workers'—especially doctors and professional nurses—view of an ideal career development over time and across sectors, which is broadly as follows:

A health workers career should start in the rural area, because it is here that clinical experience can be acquired and where the population can be served (dedication). After having acquired some first experience, the health worker should come back to the urban centres if he or she wants to work on career progression. It is also advisable to start in the public sector because it provides access to further training and specialisation. Going abroad is warranted for specialisation or further training. Doctors generally prefer specialisation 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. This desired and ideal career path does however not exclude the existence of other career paths that correspond better with the preferences of some health workers.

4.3 Quotes relating to health job attributes

4.3.1 Salary and income

Health workers believe there's quite a large variation in financial remuneration in the health sector, depending on the sector, the geographical location, whether supplementary hours are paid for or not and the incentive structures in place. They are generally not keen to openly state and compare remuneration levels. Also, since ADHA (Additional Duty Hour Allowance) has been incorporated in the salary package, there is more uncertainty over the level of remuneration in the health sector.

Health workers report that they do not know anymore which sector (private, faith based or public) pays most for equal qualification and workload. There is a timid consensus that the private sector pays most, at least for health workers that are permanent staff. There's further the general perception that the private sector pays well, but it is also argued that remuneration basically depends on the owner of the health facility – so there's quite a lot of diversity in private sector pay. Pay for locum work is per hour worked in the private sector.

Today, the faith-based sector and the public sector pay the same basic salary. There has been a time where the faith-based sector did not receive ADHA and so health workers were paid less in the faith based sector compared with those in the public sector. Whereas the basic salaries are the same, health professionals in the faith based sector receive additional incentives and benefits: internal allowances, performance based bonuses at the end of the year, presents and financial gifts for religious festive occasions, the diocesan health allowance and so on.

Since the salary increase, however, salary differences over sectors have decreased and there's a general feeling that the additional advantages in the public sector, such as access to training, specialisation, job security, increases the relative attractiveness of the public sector. This reportedly explains part of the observed flow from the faith based and the private sector to the public sector.

Health workers believe that the basic remuneration is the same for urban and rural jobs. However, there are characteristics of the rural and urban areas that importantly impact on the opportunities for savings and additional income. For public sector workers, the urban area offers the opportunity to do locums in the private sector. This opportunity is far less available in the rural sector. On the other hand, the living costs in the rural areas is much lower than in the urban areas. Also, health workers tend to receive more presents from patients and more frequently get housing accommodation for free in rural areas. This means that many health workers are able to save more in the rural areas, at least for those where the potential savings in the rural sector outweigh the potential gain through locum in the urban sector. Health workers therefore believe that additional allowances for rural postings will make more health workers opt for rural postings. This however does not solve problems with other important job attributes in the rural areas such as the lack of equipment, lack of schooling for children, poor living conditions and fewer promotion opportunities.

Generally, health workers believe that the basic remuneration in the health sector is too low, especially when comparing with the sacrifices that need to be done in the job and in comparison with peers in other sectors such as banking, finance and accountancy. Health professionals therefore generally believe that the basic remuneration needs topping up[2], even if this view is not shared by all health workers. Some health care users are sympathetic to this argument; other users believe that salary levels are sufficient and that health workers are greedy.

[2] The data have been collected in June 2007, after that important salary increases had been granted to doctors and nurses.

Health workers believe that the strike actions to obtain salary increase have paid off well. They think it has been unfortunate that they had to strike but some health workers believe that people understand because it is generally known how tedious the health worker job is and that it deserves a higher pay. Other health workers believe that their reputation has been damaged and that health workers generally are now seen as greedy and money-oriented. Some health workers believe that the salary levels are good following the increase after the strikes: doctors are now finally given loans by banks and the salary levels are more in line with the responsibility of the job and its specific requirements such as the need for night duties and the frustration the job sometimes brings. Other health workers are still not satisfied, also referring to the 40-hour week that reportedly has been internationally agreed. The increased nurse salaries make that less nurses are seeking to migrate abroad. Nurses in Ghana also believe that the current salary increases will attract back nurses currently abroad. Health workers in the private sector did not go on strike because they believe their salary level is fine and because they cannot go on strike.

Another consequence of the salary increase is that health workers believe that the health sector now attracts workers because of the higher salary level; however, they argue that the sector now tends to attract undedicated health workers who enter the profession for its rosy financial perspectives and the chances it offers to migrate abroad.

Health workers in Ghana believe that the comparative advantage of the health sector in terms of opportunities for international migration certainly attracts workers into the sector. At some point it took many health workers not more than two years to get out the country (when based in Accra), but this has now probably become more difficult. It is generally more difficult to organise external migration from the rural areas.

There's a lot of different opinions and debate between health workers when they compare the health sector to other sectors. They argue that teachers and health workers cannot be compared because health workers work more hours and have less holidays. Health workers believe that peers in the banking, accountancy, human resources sectors earn comparatively more. Also, doctors have the same social status than certain professional groups that earn more. For example, when going to a mechanic, the doctor is expected to pay as much as the lawyer even if she earns less. Health workers point out that it is quite unique to the health sector that they sometimes receive presents from patients, especially in rural areas.

Within the health sector, pharmacists cannot be compared with doctors because they have less education. Support personnel cannot be compared with clinical support workers because the latter haven't got night duties. Public health jobs are generally valued for their regular working hours and absence of night duties. In the private sector, the permanent staff is believed to earn much more than the locum staff.

4.3.2 Presents from patients

Health workers report that patients frequently reward them for perceived good treatment or a warm welcome. Rewards can be verbally, or they receive presents, cash or other goods such as food. The practice is more widespread in rural compared to urban areas.

Reward for informal care is however less frequently observed. Where health workers report that the population very easily asks for medical advice on an informal basis, this is not normally paid for.

4.3.3 Workload and hours worked

As with remuneration, there seems to be quite some variation in the number of hours health workers are expected to work per day or per week.

Health workers generally believe the workload is high, too high. Hours worked are often patient-driven (you work till all patients have been attended) leading to unpredictable working hours; or driven by colleagues of the next shift taking over (you remain in service till the colleagues from the next shift have arrived). There is often no time to take a break; and when an unexpected emergency comes in, you cannot leave the service. Since there's generally a lack of staff, when colleagues of the next shift don't show up, health workers stay in service. Many health workers put in more hours than they are contractually supposed to do. In the public sector extra hours are not normally paid for, whereas they are paid for in the private sector. Some health workers believe the remuneration is too low for the workload; others argue that they are paid to work hard. The duty roster normally determines who's on duty; however, especially in rural areas, health workers tend to be 'always' on duty. Even if they're not on duty, the health facility will call them in case of need, because there are simply not enough health workers. Some, however, refuse to go to the health facility when not on duty, but this seems to be mainly the case in the urban areas.

The patients' views on working hours are mixed. Some patients believe health workers have normal working hours but are often absent. These patients wonder if the health workers put in those additional hours that they claim they do. Other patients argue that they have seen health workers that have hardly time for a break and are being overworked. Most patients complain that they are not been given sufficient quality time by health workers.

Health workers argue that the generally high workload translates in less time per patient. Patients consequently think the health workers are not dedicated and for this reasons often insult them. Due to the high workload, health workers sometimes treat patient disrespectfully. They also say that they are often frustrated because they cannot give the quality care they would like to give.

Some health workers argue that dedication shows in attending emergencies at any time (regardless being on duty or not) and working till all patients are attended. And generally, dedication was repeatedly linked to the issue of workload and extra duty.

Some point out that the workload generally is on the increase. This is to an extent in line with expectations since the population growth is not matched with a corresponding enhancement of the supply side. HIV/AIDS has increased the workload because more counselling is needed and because the NHIS (National Health Insurance) requests patients to be tested. The NHIS in general has brought quite some additional work for some health workers, reportedly because of higher frequency of health care use. Also, in those facilities where staff leave to go abroad, those who stay behind see their workload increased.

Workload issues are to some extent different over sectors. Doctors in the public sector seem to be master of their time. In the private sector, locum practice allows the health workers to quite precisely determine the workload they are interested in taking up. Faith-based hospitals often require that health workers live on the premises, so that they can be available for emergencies. Public health jobs are interesting because they do not require duty work and have regular hours.

The ADHA (Additional Duty Hour Allowance) has drawn workers' attention to the issue of extra hours. Many public sector health worker categories consistently put in extra hours without being compensated for it. The introduction of ADHA to selected health worker categories only was therefore badly perceived by the others and this created quite some dissatisfaction and frustration. There was also a general feeling that the ADHA was misused and that some, such as

administrative staff, who should not have received ADHA nevertheless did. Those health workers that have seen a structural increase in hours to be worked per week since ADHA has been structurally incorporated in the salary find it more difficult to maintain locum work at the same level. Locum work is illicit during working hours, but can be freely decided upon when it falls outside working hours.

4.3.4 Incentives - ADHA

Some health workers point out that ADHA actually brought quite some problems to the surface. Before ADHA, many health professionals actually carried out extra hours and duties, without being paid for it. By offering ADHA to some health worker categories, all health professionals that regularly do extra hours were alerted to the possibility of actually getting paid for them.

Health workers generally appreciate the idea behind ADHA, however, the implementation of the schemes was seen as poor. Apart from lack of information about the scheme, the scheme badly targeted health workers: nurses were discriminated compared to doctors, administrators and accountants benefited more than some health workers that actually do quite some extra hours and there was generally a sense that some who did not deserve ADHA nevertheless accessed it.

At some point ADHA was consolidated permanently into the salary, and changed name to Salary Enhancement. This was mostly seen as positive, even if this came for some with the contractual obligation to work more hours a day. Some health workers also criticize ADHA's consolidation since it leaves out some worker categories that deserve it.

The faith-based sector initially did not benefit from ADHA, which caused some health workers to leave the sector and join the public sector. Since the consolidation, the basic remuneration levels in the public and faith-based sector are again similar.

Some health workers complain that since ADHA has been incorporated in the salary, they do not receive any incentives anymore.

4.3.5 Incentives - Deprived Area Allowance

Health workers think that giving an extra allowance to take up work in rural areas is a sensible idea, and they say they would act upon it. However, they point out that this is difficult to implement. The circumscription of a deprived area is seen as subjective and political. Also, those health workers that did receive a deprived area allowance, report that was small and only came irregularly, or only once. Health workers are particularly uncertain about this scheme, don't know whether it's still in place and if so, who's precisely entitled to what. Health workers have also mentioned their suspicion that this is merely a scheme that has been developed for political reasons.

4.3.6 Incentives - Post-graduate training

Health workers report that the post-graduate incentive scheme had been put in place to address doctors' need for post-graduate training abroad. Indeed, accessing further training was given as one of the major reasons to migrate. The scheme enables doctors to go abroad for postgraduate training but reportedly operates some bonding clause. Doctors know about the existence of the post-graduate incentive scheme and some have benefited from it. However, nobody seems to know if it's still in place and how to benefit from it today.

A few years ago, the Ghana College was put in place, providing specialist training in Ghana. It was mentioned that since the introduction of the Ghana College the post-graduate scheme was suspended.

4.3.7 Incentives - Car

Health workers understand the car-incentive scheme generally as an opportunity to import certain car types and brands free of tax. There is some uncertainty whether this specifically applies to those working in deprived areas or not. On top of that, some health workers can also benefit from bank-loans where monthly instalments are taken at the source from their salary.

Generally, there's quite a lot of uncertainty about this scheme and they think the system is not transparent. They're not sure whether the loan is managed and obtained publicly or privately, some don't understand the entire proposal; others think the scheme is suspended.

A few health workers argue that the scheme is interesting, that the monthly instalments are manageable given the current interest rates. Some health workers reported that nurses are discriminated against compared to doctors when it comes to obtaining bank-loans and that the choice of car brands is too limited. Also, the scheme is only accessible for those earning above a certain threshold and auxiliary nurses' salaries are generally considered below this threshold.

The car-incentive scheme is only available to public sector workers and not to those active in the private and faith-based sector.

4.3.8 Incentive - General

Unspecified incentives are strongly associated with the faith-based sector. Incentive schemes tend to differ from diocese to diocese, adding further to the variety of existing schemes: housing allowance, inducement allowance, internal allowance, end-of-year bonus, performance based yearly bonus, car diocesan health allowance, gifts and financial rewards with religious events, transport and telephone allowance. Incentives are far less frequent in the private and public sector.

When the Additional Duty Hour Allowance (ADHA) was introduced in the public sector, it was not applied to the faith-based sector, reportedly because the latter had the inducement incentive. This caused health workers to opt out of the faith based sector to try to join the public sector. This has reportedly been settled, since ADHA has been integrated as a fixed part of the salary, and basic salaries are again similar in the public and faith-based sector.

Since ADHA has been incorporated in the basic remuneration, some health workers now complain that they don't receive anything to motivate them, in contrast with earlier times, when ADHA was on top of the (then much lower) basic remuneration.

Some users acknowledge that health workers lack motivation and may receive incentives to tease out effort; others take the position that health workers are greedy because they have generally higher pay and incentive levels, and yet are not motivated.

4.3.9 Equipment

Health workers state that equipment generally lacks. Yet, it is important, even more so for specialist doctors. The lack of equipment requires a health worker to improvise. Working without or inappropriate equipment does not provide job satisfaction. Yet, some health workers argue that dedicated health professionals will not slack due to the lack of equipment, but on the contrary

improvise so to give the patient the best possible treatment. Users generally associate well equipped facilities with quality care.

Rural areas are generally associated with the lack of equipment, hence the need to improvise a lot, which leads to becoming a “village nurse”. While health workers express the willingness to go to rural areas when salaries are increased, they point out that the availability of equipment is also a complementary condition to taking up rural service.

The availability of equipment varies over training facilities. Generally, teaching hospitals in Accra are best equipped, rural training facilities are poorly equipped, thus producing reportedly lower quality health workers. Faith based training institutions are generally better equipped than public institutions.

Health workers say that private sector facilities are generally better equipped compared to public facilities, although some point out that more expensive equipment is difficult to obtain through private investment. Generally large differences in the level of equipment within the private sector facilities are equally reported. Staff in private facilities generally treats the material better than public facility staff; accountability in public facilities often lacks and handling rules and consequences for mishandling equipment are better specified in private facilities. Knowledge about and experience with equipment is seen as one of the barriers to setting up a private practice.

The lack of equipment in Ghana has been repeatedly cited as a reason for external migration. Also, some health workers that have come back to Ghana complain about the comparative lack of equipment, leading to frustration and the impossibility of providing quality care.

4.3.10 Family

This section gives an insight in the impact the health worker’s family has on her career decisions. Parents seem to influence some health worker’s decision to join the health sector, either because a young person follows their example or because they are forced into the health sector because of its rosy financial and external migration perspectives.

The decision regarding rural posting is very heavily dependent on the availability of schooling for the children. Since this is mostly lacking in rural areas, health workers with school-aged children tend to go to or stay in Accra. Single health workers also prefer bigger urban centres because they offer greater exposure to possible partners. Female health professionals have difficulties convincing their husbands to follow them to rural areas and internal migration to Accra is often motivated by family reasons. Some argue that the availability of quality cars would to some extent allow health workers to be active in rural areas while regularly joining their families in bigger urban centres.

Families seem to impact heavily on the decision to externally migrate. Either families stimulate health workers to externally migrate because of the financial perspectives and sometimes make financial contributions to pay for the outgoing air-ticket. Family reunion abroad is common; health workers abroad will generally maintain contact with the extended family and send remittances. Because of the high social status doctors enjoy in Ghana, the pressure from the extended family can be so important that health workers escape by migrating. Some health workers abroad decide not to return to Ghana because of fear for pressure and the inability to address needs expressed by the family when coming back. Inversely, families can exercise pressure on the health worker not to migrate. This is especially the case for female workers who remain in Ghana because of their husband or children.

Especially female health professionals complain about the heavy workload and the difficulty of combing work with family and educating children. Locums in the private sector are sometimes taken up to pay for school fees. Last, family relationships are commonly used to gain privileged access to health services.

4.3.11 Training

Training institutions. Health workers generally are of the opinion that the public training institutions in the South of the country are better than those in the North, mainly because they are better equipped. Not all health workers, however, agree with this statement. Since more students want to enter training institutions in the South, especially Korle Bu in Accra, and since entrance is based on school grades, the better students in principle end up in training institutions in the South. Mission training hospitals are believed to produce better disciplined workers; faith-based training institutions also tend to impose far more restrictions on students' liberty when they are on campus. Regardless the reported differences, all training institutions deliver the same type of degrees. While some health workers do not see any training institution that would prepare significantly better for external migration, others mention that teaching hospitals, e.g. Korle Bu, offers better chances because the health workers trained there are familiar with more equipment than people trained elsewhere. For undergraduate training, Legon University has a limited number of non-fee paying places, while the remaining places are to be paid for.

Dedication. Health workers and users alike argue that dedication in a health worker is something that can be learned and should be taught at a training institution. Senior health workers are often only willing to provide on-the-job training to juniors if they are convinced the latter are sufficiently dedicated to the work.

Rural versus urban sector. When it comes to training, rural areas are mostly associated with acquiring thorough first job-experience. This is explained by several factors: 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 presence of a multitude of diseases, more so than in urban centres, and the seriousness of the diseases, also because patients tend to come later to the health facility. Personal relationships between health workers in a rural area are often also tighter, allowing for more and easier learning. The draw-back of rural service is that the exposure to evolutions in technical equipment is less important. There's also less access to information on further training in rural areas. If one stays too long in the rural areas, one becomes a 'village nurse'.

Sector differences. Health workers generally belief that the public sector provides more opportunities for further training and specialisation compared to the private sector. The faith-based sector is sometimes associated to training opportunities within the public sector. There are exceptions: some private facilities have bigger budgets and periodically organise workshops for staff so that it keeps abreast of new developments.

Post-graduate training and specialisation. In the past, access to post-graduate training has been indicated as one of the driving factors for external migration. The Ghana College was set up some years ago to provide postgraduate training in-country. Today, many health workers however express frustration with the access conditions to post-graduate training at the Ghana College. Especially the need to have worked a couple of years before being admitted; the need to have done rural service and the need to be released by the employer for postgraduate training – which is not evident given that staffing levels are generally low – is negatively perceived. Access to post-grad training in Ghana is generally seen as difficult and frustrating. Consequently, some health workers still envisage migration, through which post-graduate training is more accessible and less

frustrating, especially to the US. Obtaining access to post-graduate courses abroad, however, also proofs sometimes frustrating.

Labour market. Bonding generally applies in the public and the faith-based sector. If studies are paid for by the public or faith-based sector, the health worker will have to work a predetermined number of years in either a public or faith-based hospital. In the public sector, first assignments are offered in the region of the training institution. In the faith-based sector, health workers are assigned to faith-based facilities, not necessarily in the area of the training institutions. Health workers tend to refer to the bonding practice in a positive way: it is pointed out that the public and faith based sector offer you a job after training. Bonding does not apply to private training facilities. In general, the labour market does not tend to discriminate against or in favour of specific training institutions, but focuses on the diploma of the health worker.

Under-qualification. Ward assistants doing jobs of enrolled nurses seem common practice in Ghanaian health facilities. Also in the private sector to reduce costs. Non-pharmacists also regularly sell drugs. Some health workers argue that they do not see a problem in this practice, as experience is more important than training level. Users tend to complain about the quality of care received from under-qualified staff.

Further training. Some health workers state they regularly attend workshops, others say the opposite is true. There seems to be a consensus about the allocative process for further training being non-transparent. Some health workers point out that where attendance fees are highest, the management takes up the training opportunities. Lower ranking health workers appear to benefit less from opportunities, even if this is contradicted by others. In some instances, allocation of training opportunities is according to area of specialisation and lessons learnt have to be shared with the staff that has not been able to attend the workshop. Workshop opportunities can sometimes not be taken up because of the lack of personnel on the service. Some feel that they lack crucial skills in relatively new disease areas such as HIV/AIDS; other health workers report they have recently been trained in these areas. Professional nursing associations try to play a positive role in facilitating access to further education, but this sometimes conflicts with interests of the nurse employer. The health workers appraisal form offers the opportunity to indicate areas for further training.

4.3.12 HIV/AIDS[3]

Many health workers feel sufficiently informed about HIV/AIDS, both regarding how to protect themselves and regarding how to treat HIV positive patients. Others report they have been receiving inadequate training on both accounts.

Health workers' views differ when it comes to assessing how AIDS has impacted on the health system in Ghana. The majority of health workers reports that the most important issue is protection, that all patients should be seen as possibly HIV+ and that in the end, all patients receive equal treatment. Health workers say that their non-discriminatory perception of HIV+ patients is also the result of the information and training they have received on the subject.

Health workers report they relate well to HIV+ patients because they know they cannot get infected by talking and sharing meals. It's also said that it's not nice to change attitude towards a patient when s(he) tests positive. Health workers have emphasised that much has changed over time: now everybody knows HIV/AIDS is like any other disease, unlike before, when for example doctors used to check the patient's HIV status before going into the operating theatre.

[3] Ghana has an estimated HIV prevalence rate of 2,3 % (UNAIDS, 2007).

This is not to say that fear and stigma are not present. Some health workers report that they prefer not to know their own status, because if they would they would become depressed; others refuse to donate blood.

Health workers report that protective materials are mostly available, although in some cases there's a lack of specialised material (for example long gloves in the maternity ward); in which case they sometimes buy it themselves.

The workload has not dramatically changed due to HIV/AIDS. Most extra work is due to NHIS requirements of having all patients tested – which reportedly is impossible – and the increased need for counselling.

Confidentiality seems to be largely respected, in that many health workers don't know the status of the patient they are treating. When health workers mention the status of a patient openly, this is seen as a breach of the ethics of the profession.

4.3.13 Appreciation & Social Recognition

Health workers are generally well respected in Ghana. They are esteemed, get respect from users, who claim they come after pastors but before lawyers and teachers and also say that a Doctor's Day should be created, similar to the Farmer's Day. Health workers are more respected in rural areas compared to urban centres. Social recognition however seems to have gone down over the years, also because of the recent strikes, which portrayed health workers as driven by financial reward and because patients were not attended during the strike and cases were reported where patients consequently died. Health professionals also indicate that the way politicians communicated about the negotiations damaged their reputation. Some users point out that the health workers have lost respect in their eyes because of the way they treat patients. Occasionally, users speak about drinking, shirking and corrupt health professionals at radio phone-in programmes and complain to other health workers privately about the bad behaviour they observe in other health workers.

Users show appreciation and recognition verbally or by giving gifts. Health workers are often allowed to jump queues; they occasionally receive a plot of land and free labour to build a house in a rural area, or are invited as a guest of honour to an event. When users express direct appreciation, it's mostly for having received a warm welcome, being treated well or when the health worker has been particularly nice to them.

Health workers from their side report that appreciation is motivating.

4.3.14 Satisfaction

Health workers report a number of reasons for being satisfied with their work: the fact that you're sought after for giving treatment, that you can help someone, because you get respect. Quite surprisingly, some argue that satisfaction from working in Ghana is higher compared to working as a Ghanaian nurse in the UK where they often have to do work for which they are under-qualified, or because there're bogged down by procedural requirements. Users say that health workers rarely complain to them directly about their work or their pay.

Some health workers are not satisfied with their work. The most important reasons are the lack of facilities and equipment, intimidation by colleagues and superiors, lack of promotion opportunities and access to further training, lack of incentives and adequate pay, lack of staff at the facility, the inability to provide quality care or because of too many clinical procedures have to be followed. Some users argue that health workers are just greedy: they already have so many incentives and

salary and still are not satisfied. Frustration was frequently cited as an important reason for health workers to migrate.

4.4 Career choices

4.4.1 Non-health sector

Health workers recognise that there are many other professional options available, although they argue that being a health worker is very different from other jobs mainly due to the much needed dedication. When comparing health to teaching, it is argued that health workers earn more because they work more, although some users argue that teaching is equally sacrificial. When it comes to salary and options to migrate, the health sector is a comparatively interesting job sector in Ghana. However, peers working in the banking, accounting and HR sectors tend to earn more and, importantly, health workers earn less than many workers with the same social status, such as bankers and lawyers. Health workers however sometimes receive presents from patients, especially in the rural areas.

4.4.2 Choosing and changing a sector in health

Health workers say that inter-sector mobility is smooth only in one direction. Leaving the public sector is done by resigning. Joining the public sector or re-applying to the public sector is cumbersome: it takes quite some time and administrative procedures, and those who have left, have to take up the job they left or even a lower-level one. It is said that the public sector limits the intake from the faith-based sector because the latter has mostly facilities in the rural areas and the public sector doesn't want to encourage internal migration. Re-applying to the public sector is more difficult if the health worker did not resign properly. Generally, joining the public sector is easier for doctors than for nurses.

Inter-sector mobility is also linked to rural-urban migration. It was reported that health workers who do not manage to get transferred from rural to urban resign from the public sector and join the military or police hospitals in bigger urban areas.

The public sector is appreciated by health worker because it provides access to further training, pension and personal development (especially compared to the private sector) and some say public sector salaries are higher than private sector salaries. Equipment, however, often lacks in the public sector.

Some health workers prefer the faith – based sector because of the performance based incentives. However, health workers recognise the many restrictions in the sector, leading to bitterness and frustration. Users prefer the faith-based facilities above the public facilities because the waiting times are shorter, the health workers' attitude is better and because health workers don't go on strike.

Some health workers prefer the private sector because its permanent staff has high salaries and many incentives. Some users prefer the private sector for its shorter waiting times, better and plentiful equipment, availability of staff and because you're well treated instead of looked down upon (as is often the case in the public sector). Some patients however point out that Korle Bu, one of the public teaching hospitals, has much more specialists available compared to the private sector, where doctors are mostly looking for financial return.

4.4.3 The public sector

Since training at public institutions is subsidised, bonding rules apply and health workers have to work for some years in the public sector. Interestingly, there's quite some confusion about the bonding regime: health workers were unable to say how long the bond exactly is, and whether rural service was mandatory.

Since public training schools are comparatively better equipped, and have more facilities, students receive a better training and are therefore more competent. Health workers generally praise the public sector for its focus on further training, compared to the private sector. Access to post-graduate training is also comparatively better.

When comparing remuneration levels between the public and faith-based sector, health workers argue that the basic salary is similar but that there're no additional incentives in the public sector. However, some health workers report that the car maintenance incentive is still there, but also point out that the deprived area and the car – incentive (which is not interesting because there's limited choice between car brands or cannot be afforded by some health workers) have been designed to ensure quick political gain and not to really address health workers' needs. Private sector health workers are comparatively more committed because they get an adequate benefit package. Public sector workers get a pension, their salary is paid regularly (which is not the case in private self-employment) but extra hours are not paid for. With the recent increase in public salary, health workers from the private and faith-based sector have tried to join the public sector, but this may now have been stabilised again.

Health workers point out that working in the public sector is more relaxed compared to the private sector because in the latter the health worker has to assume final responsibility to do a good job, often leading to frustration; and because cannot take sick leave.

Health workers argue that the attitude towards patients is generally the same in the public and in the private sector, although some boldly report that "health workers in the public sector are less motivated because they work to ensure a meagre salary, and not for the love of the work". Health workers admit that they sometimes treat patients disrespectfully because of the workload. Health users from their side report that they are regularly abused or shouted at in public facilities and that nurses sometimes look down on them.

Some health workers argue that public and faith-based sector workers are generally more competent than private sector workers, although this may not necessarily rhyme with the very widespread practice of public sector workers doing locums. Waiting times are however longer in the public sector. Private sector workers complain about the inadequate treatment received by patients referred from the public sector, suggesting poor quality care in the public sector. Users point out that waiting times are too long, that there's less equipment in the public sector, that health workers put in little effort and don't maintain the equipment well. The public sector also has a referral system that is not realistic and non-functional, where the patient has to buy medical support materials, wait a long time for test results that then sometimes prove to be lost.

4.4.4 The faith-based sector

Most mission hospitals are in smaller rural towns. Health workers tend to live on the premises and they have a comparatively high workload. They need to be a member of the church to work in the mission hospitals. Health workers emphasise the many restrictions imposed by the management. Ethics and morality inspire the management systems, pressure and supervision is generally very high. Health workers are unanimous that faith-based sector workers are most committed and are present when patients need to be attended. Health workers in the faith-based sector are religious

and some argue that they have fear of God and work for God and not for the money. These restrictions also lead so bitterness and frustration in some health workers. Because the faith-based sector salaries are the same as public salaries, and because sometimes incentives are not there, health workers leave the faith-based sector. Mission training schools not surprisingly produce reportedly more disciplined students, who equally have been subject to comparatively more restrictions on their liberty of movement when on campus.

Incentives are commonplace in the faith-based sector. They are not applied in a uniform way but decided at diocesan level. There are numerous examples of different types of incentives: internal allowance, end of year bonus, housing allowance, monthly diocesan health allowance, gifts during religious events, end-of-year individual performance pay, and incentives for rural service.

The quality of care is generally judged high in faith-based facilities, by both users and health workers. Transport for outreach activities is normally available, staff is competent, has a good attitude and is respectful towards patients, waiting times are generally shorter, they did not participate in the strike and tend to shirk less. When patients were not member of the church they were sometimes not attended, but this has reportedly changed.

4.4.5 The private sector

Opening a private clinic is capital intensive, requires a good client base, experience, equipment and knowledge of equipment. Some health workers that have returned to Ghana open a private clinic with their savings. Most private clinics are in town and competition amongst private providers is now quite high in Accra. There's reportedly a tendency to refer some patients with profiles of 'less interest to the private sector' to the public sector.

Most health workers' quotations regarding the private sector relate to how it relates to its workers. In contrast to health workers training in public and faith-based institutions where bonding applies, privately training health workers have to find a job themselves. This is generally not a problem, since nurses quite easily find a job in Ghana. Health workers report that career development, further training and access to post-graduate training is generally weak if not absent in the private sector. Some health workers argue that since the public sector invests more in continuous training, the competence of public sector workers is consequently higher. Other health workers point out that some private providers also provide further training opportunities.

Working hours are not significantly different in the private compared to the public sector. However, permanent contracts are not widespread and the private sector recruits a lot of temporary locum health workers, who are paid according to the time worked. Some older health workers that want to work less and 'phase-out', find the private sector attractive for this reason. Extra-hours are normally paid for by the private sector; a regime known as 'banking'. When a health worker scheduled to come to work on a particular day is not available, another can take his/her place and be paid for the work delivered. Health workers tend to take far less sick leave in the private sector compared to the public sector.

Health workers make a distinction between permanent and locum staff when speaking about remuneration in the private sector. The latter have generally two salaries, one main salary from the public sector and a top up from private practice and so at the end of the month have a good total salary. Permanent staff employed in the private sector tends to be well paid and receives incentives such as car loans or car petrol. Most health workers in the private sector do not receive a pension. Health workers point out that private sector workers are normally more committed to their work than public workers and users also indicate that they put in more effort; which is attributed to the higher level of remuneration. Private sector workers also did not participate in the strike, reportedly because they are well paid. With the recent increase in public sector salaries the

attractiveness of the private sector has gone down, causing the trend of outflow to the private sector to reverse. Health workers say that the outflow has now stabilised.

Generally the private sector provides an environment where health workers can work efficiently: access to medical supplies and drinks are for example provided.

Health workers indicate that the quality of the staff is not always guaranteed in the private sector. Another observation is that sometimes ward staff act as nurse or doctor as ward staff, in an attempt to control costs.

Health workers point out that the attitude towards patients is generally better in the private sector, even if not all health workers subscribe to this view. Users confirm that more staff is available in the private sector, as well as more equipment, which is generally better maintained by the staff, waiting times shorter and there's no complicated referral system that anyhow does not function such as is the case in the public sector. Health workers say that the private sector facilities are generally better furbished with fridges, flowers and carpets. Importantly, both users and health workers indicate that there are high fluctuations of quality of care from one private facility to another.

Some users indicate that specialists are more available in the public sector and that private sector doctors are mainly seeking financial reward. The private sector is also said to be relatively inaccessible because of the high health care costs.

4.4.6 Self-employment

Health workers in Ghana are well acquainted with the idea of self-employment, which is mostly envisaged for financial reasons, either because returns are good, or to top up meagre public sector salaries. With the consolidation of ADHA (Additional Duty Hour Allowance) into the basic salary, however, some health workers have to work more hours and have less time to take up self-employment through locums after hours.

The most common forms of self-employment are drug shops tended by nurses, even if bureaucratic hurdles to set them up are reportedly very high. Nurses tend to recruit staff who manages the drug shop on their behalf; they will monitor after working hours. And some health workers have investments in other sectors they also look at after working hours. In rural and urban areas health workers have reported to bake and sell bread or do farming. Private clinics are also considered by some.

The main challenge for setting up a private clinic is the capital requirement. Even the smallest private clinic needs some personnel, equipment and facility space. It also requires competence and experience. Most often health workers finance the initial investment out of savings, often from work abroad, and then also often complemented with commercial loans. Partnerships are not common. Setting up a drug shop is far less capital intensive than setting up a private clinic and nurses can get a loan on which they buy the initial drug stock once they have secured the license is obtained.

The administrative requirements related to setting up a business are challenging. It can take a very long time to obtain a licence from the Pharmacy Board and mostly obtaining the license is more demanding than finding the capital. Other health workers report however that it is possible to simply register a pharmacy, open it and then wait for the license to come later on. A license in itself is also expensive and some drug shops use others' licenses.

4.4.7 Public health

Health workers point out that the preferred job depends on the individual – some like clinical work, others don't. As for a job in public health, it has reportedly a number of advantages such as the absence of night duties, the week-ends are off, promotion is swifter, less stress and no more sightings of blood and 'other nasty things'. Health workers point out that some nurses get fed up with bedside nursing, enrol in training to get a degree that will open up opportunities for a public health job.

4.4.8 Police and military hospital

Sometimes, military hospitals are an interesting option when internal rural-urban migration is difficult to obtain within the public sector. On the other hand, health workers in the police and military hospitals complain that they are disadvantaged regarding incentives such as ADHA. Military hospitals offer some of their staff the opportunity to do some missions in foreign countries which is appreciated because it offers experience abroad without having to go through the difficult and risky process of external migration.

4.4.9 International organisations

Health workers report that it is very difficult to obtain a job in international organisations (especially WHO) and they have the impression that you need to know someone there in order to be successful. Health workers believe that WHO, in Ghana as well as elsewhere, pays its personnel well. It is also believed that clinical experienced is valued by organisations such as WHO.

4.4.10 Rural & urban

In Ghana, rural facilities tend to be far less staffed, implying that health workers often have to assume responsibility for duties they have not been trained for. There's virtually no competition between health centres, generally a lack of drug shops and news tends to travel fast making that health workers' attitude will be known and discussed outside the health centre quickly. In the public sector, the salary in rural and urban posts is the same. Formerly there has been reportedly a rural incentive in place, which was small and came irregularly. Health workers were not able to confirm that the rural incentive is still in place throughout the public sector.

Health workers point at a large number of positive aspects to rural service. 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 and independently of their grade are called 'doctors' by the population. Moreover, the bonding between staff is generally higher in rural facilities. This facilitates on the job learning and as such 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 centres, rural service allows developing leadership and management skills.

Also, health workers point out that rural service allows them to satisfy their commitment and dedication to the profession well.

They report that they tend to receive quite some social recognition in the villages, which is often expressed verbally. They also receive presents, food, plots of land, free rent, free labour to build a house and money. They can therefore, combined with the lower cost of living and the absence of the ability to consume and spend, save quite a substantial part of their income. Opportunities to gain supplementary income are evidently limited; some health workers therefore engage in farming

or the sale of home-made bead. While there are reportedly quite some positive aspects to rural service, other health workers do not enjoy rural postings and point at the disadvantages.

Many single health workers point out that opportunities to engage in serious relationships leading to marriage are limited in rural areas and a sufficient reason to want to move to urban areas. Once health workers have children, the absence of quality schooling for the children is seen as a very important negative aspect of rural areas. Female health workers also argue that it is in general quite difficult to convince husbands to join them in rural postings.

Rural areas sometimes lack even the most basic amenities such as piped water. On top of that there's often no mobile phone coverage, a social and night life of interest and generally one obviously cannot 'enjoy city life'.

Exposure to technological advancement in medical equipment is limited or absent, equipment lacks, which makes it reportedly impossible that specialists practice in rural areas. The workload in rural areas is also often higher because there are more night and week-end duties because of the limited staff, and the work often requires outreach activities involving rough and uncomfortable transport. Some health workers argue that many villagers don't understand modern health care, but visit traditional healers instead: treating this type of patient-population is not very satisfactory.

Especially doctors refer to the lack of opportunities in the health sector to earn additional income.

Extended rural service leads to a reputation of being a "village nurse". Related is the question whether some health workers would be comparatively happier with rural service than other? It has been argued that those that opt to become a 'community health nurse' may have an active interest to serve at least in the beginning of their career in rural areas. Other health workers argue that those born in rural areas are more likely to want to serve in rural areas.

Health workers have subsequently signalled what it would take to have them happily accept rural service. Amongst the elements brought forward were adequate schooling for children, salary increase, a good car to be able to join the family in urban centres, a credible commitment from the employer to promotion after rural service, decently equipped facilities. One FGD summarised that a clear policy on a limited period of rural service accompanied with rural incentives and a firm commitment to promotion after rural service would go a long way for at least some health workers.

The actual affectation-to-rural-areas and transfer-to-urban-areas policy, mostly combined with bonding strategies, seems to be a mixture of the following recurrent elements: the health workers must take the initiative to request transfer; an official request must be addressed to the regional health director; the desired urban job must be available; and sometimes the health worker must find someone to take over the rural post. Health workers complain about this cumbersome process that can take a very long time. They indicate that there are short-cuts to this standard process if one knows someone high up in the HRD/MOH hierarchy or has friends in politics. In contrasts, requests to be allocated to rural areas are normally immediately approved. Health workers also indicate that willingly accepting the first rural posting, after studies, makes it easier to request transfer to an urban area later on. They also point out that the refusal of a rural post amounts to misconduct which may lead to a formal charge.

Transfers from the faith-based to the public sector are also said to be cumbersome, possibly because the faith-based centres are mostly in rural areas. The faith based sector, in contrast with the public sector, tends to give rural incentives more often.

4.4.11 External migration

Some, but not the majority, health workers have a rather negative perception of the jobs and lives of nurses abroad, in the UK and the US, especially since recently the administrative labour market requirement in host countries have been tightened. Whereas postgraduate studies are often a driver to leave the country, it appears not always easy to actually enter postgraduate studies abroad. Health workers in Ghana argue that nursing abroad has significantly changed over time. Now, it is not always easy to find a job as a nurse, or to find a job at all. It is said that doctors often work as nurses (or taxi drivers), and nurses work as ward assistants. Many Ghanaian nurses abroad are said to be frustrated, administrative requirements when looking for a job as a nurse are very high and some think nurses in Ghana have more job-satisfaction.

Health workers distinguish between positive (pull) and negative (push) factors to migrate, even if these are often opposite views of the same argument. The most important pull factor is undoubtedly the perspective to earn more money; the plans they have to use this money for buying a house in Ghana, opening a private clinic, invest in Ghana or help their children. Some argue health workers migrate to be able to enjoy the nursing profession *as they have been taught which* largely refers to be able to provide quality care, which is often not possible in facilities in Ghana. Some report that it is to enjoy and learn about another culture. Access to further education is also often cited, but perhaps in an abstract way, as this statement is not always backed by a concrete plan or remains vague such as ‘to follow courses that turn nurses into doctors’.

Push factors include the frustration of health workers with accessing postgraduate courses at the Ghana College, also because they need to have done rural service and/or have served a specified amount of years before being able to enter specialisation. Health workers report that this rigid entry system starkly contrasts with the ease of entering the US labour market, also in light of specialising there. Other health workers are frustrated with the promotion system in Ghana, which is not sufficiently performance-based and the lack of periodic salary increase. They also cite the lack of minimal payment in Ghana, and especially the inability to save and be able to buy a house or decent car, the lack of compensation in general, recognition, motivation. The pressure from the extended family can also help reinforce the decision to migrate, because health workers can’t cope with the pressure or because the extended family would be happy for the health workers to take up a job abroad.

External migration is however not easy, and has become more difficult over time. More health workers want to leave than actually manage to leave. The barriers most often cited are visa/working permit related and pressure from the family not to leave, especially for female health workers and health workers that stay because their children are too young.

Health workers that externally migrate are often not positively perceived by those that stay in Ghana. Some point out that they have been trained using tax money and therefore are ‘thieves that should be prosecuted’. Some users put forward the same argument. Those that have migrated often feel bad about the fact that external migration worsens the lack of doctors in Ghana.

Health workers report that recent salary increases in Ghana have impacted on the migration flow, which has gone down at least for nurses. The effect on doctors’ migration is unclear. Users are of the opinion that health workers should stay in Ghana and not leave the country.

Health workers that migrate are seen as money-loving; those that enter the health sector in order to migrate are said to be undedicated. When speaking about migration, many health workers refer to dedication and commitment. Health workers say that very dedicated health workers don’t migrate, because they want to serve the population in Ghana. It is said that especially younger

health workers lack dedication and have entered the health sector for its perspectives to migrate. Part of the responsibility for this lack of dedication is put on a failing school system.

Health workers abroad do send remittances, although not necessarily regularly. The fact that they send remittances must also not be seen as a sign that they do financially well abroad.

Health workers often receive help form family in the migration process, from receiving information, to the extended family in Ghana that pools money to finance the travel, to initial accommodation in the host country. Sometimes they buy-off the bonding which they are subject to. What it takes to buy-off bonding is not generally known, even if the sum of 10,000,000 Cedis has been cited.

Many health workers that plan to or have migrated say they want to come back to Ghana. Some come back because of the stress abroad, because they can't find work or because the work is too tedious. When coming back, health workers often have to pass exams, even if they formerly already passed exams in Ghana. Re-joining the public sector is also difficult and some say one has to go do some training courses. Those that have returned come back to retire, or they open up clinics and pharmacies with their savings. Some don't come back, also because equipment to exercise their profession in Ghana lacks, as well as protective materials.

Health workers point out that lab-technicians also migrate. When young students evaluate the different job sectors available, they point out that the chance of finding a good job in Ghana in the health sector is higher than in banking. On top of that, they say that the health sector offers a better perspective for external migration, which are important reasons for some to become a health worker.

4.5 Health worker performance

4.5.1 Non-clinical support staff

Accountants and revenue collectors are said to be another entity within the hospital. They do the paperwork and sometimes cover each other to carry out inappropriate activities. But health workers also collaborate with non-clinical support staff in inappropriate activities. In some cases health workers collect revenue from patients in the absence of the revenue collector, and hand it over later on. In other places, revenue collection (by revenue collectors / cashiers) is strictly separated from those who write the invoices (health workers). It is also increasingly difficult for health workers to get access to drugs without a prescription.

One of the deficiencies of ADHA (Additional Duty Hour Allowance) was that it excluded some categories of non-clinical support staff (such as those working in the laboratories or plaster department) with whom health workers very closely work together at facility level. Inversely, another frequently cited weakness of ADHA was that other (managerial) categories of non-clinical support staff accessed ADHA without putting in extra effort.

Often users qualify all who work at a health facility as health workers. Quality of care is by users then also dependent on the attitude of non-clinical personnel. Users also complain about lab-technicians shirking.

4.5.2 Absenteeism

Health workers as well as users report that doctors are more absent than professional nurses, who are more absent than auxiliary nurses. Users report that doctors not always respect previously made appointments, or that doctors come in late: 'morning doctors' normally start at 8 am but

sometimes arrive as late as 1 pm, just before the afternoon shift. Even if many examples can be given, both health workers and users indicate that absenteeism is not very frequent.

Health workers as well as users point at the difficulty to distinguish between licit and illicit absenteeism. Supervisors lack the means to verify if health workers reporting ill are ill indeed, sometimes leading to extreme measures that health workers have to request a day off for illness at the job place itself.

Health workers as well as users do not seem to have a common accepted benchmark of what constitutes acceptable versus unacceptable absence. Health workers may be in 'a tight situation', or have to deal with social events, or may live far away from work and be regularly stuck in traffic. Especially in rural areas where health workers are often scarce, individual health workers may face irregular demands for service delivery, leading to consequently irregular absenteeism patterns.

Auxiliary and professional nurses say that one of the main reasons explaining limited absenteeism is because they cannot leave service before the next shift has arrived. This system of implicit monitoring is widespread and contains absenteeism. In the private sector, nurses that take over (part of) the shift of latecomers will be paid for doing so, unlike in the public sector.

Absenteeism amongst public sector doctors and nurses is mostly linked to locum work in the private sector, mainly available in urban areas. Most commonly, locum work will be done before or after pubic sector working hours. However, it is frequent that the locum work starts at the same time when the public shift ends; or that the time between the end of public service and the start of locum work is too short for the health worker to move from the public to the private facility. In those cases, health workers will mostly be absent from their public job, since coming late is not tolerated and sanctioned in the private sector.

Health workers at well staffed public services may 'cover each other up', so that each in turn can take up locums that partially overlap with working hours. Alternatively, auxiliary or junior nurses will have to take over work ('the donkey work') while the professional nurses are doing locum work. This practice is generally known and not enacted upon by those in charge of the service. Health workers in the public sector may also refuse to accept after-hours-duty to be able to take up locums.

Absenteeism by doctors is not normally sanctioned in the public sector. The widespread system of implicit monitoring amongst nurses may make it necessary that latecomers have to apologise to colleagues, or even pay them out-of-pocket for the time they worked on their behalf. Absenteeism in the private sector seems not to be tolerated.

4.5.3 Malingering

In Ghana, shirking is more commonly referred to as malingering. Health workers' reports on the frequency of shirking differ. Some say it's not present; others indicate it's frequent but remains rather the exception than the rule. Well staffed facilities in urban areas provide more opportunity for shirking compared to under-staffed rural facilities. Some health workers have observed technicians shirking; others say that it used to happen but not anymore.

Health worker behaviour is said to be shirking when they talk or chat away – which is most frequent – or are on the phone or sleep during working hours; or show their face at the service and then disappear.

Users, however, have ample evidence of health workers shirking. Users are upset with health workers serving them slowly, because they are talking with colleagues or friends, or talking too long on the phone.

Health workers argue that if shirking occurs it's because younger health workers are less dedicated, which is the result of allowing too much students to become a health worker. When argued that shirking is not frequent, health workers point at the workload that even does not allow to have lunch or other legitimate breaks.

Some argue that there's nothing wrong with some level of 'external phone calls', since health workers have a social live as any other.

4.5.4 Moonlighting and dual practice

Moonlighting in what follows refers to health workers having another professional activity alongside their main job as a health worker. Locum or dual practice is then used when this second job is as a clinician in the health sector.

Moonlighting is very frequent amongst health workers. Normally this is done after hours, because doing it during working hours is 'illegal'. Dual practice is most common in urban areas.

The range of professional activities and sectors in which health workers have a second job is vast and includes farming, owning and supervision drug shops, owning and supervision shops, baking and selling of bread. There's a pattern where higher educated health workers such as doctors and professional nurses tend to be more involved in locum work than lower educated health workers such as auxiliary nurses.

Health workers as well as users invariably report that health workers moonlight because of financial reasons, sometimes only when child-education related costs are highest. Doctors report that income from moonlighting complements their salary; auxiliary nurses point out that their base salary is not sufficient and therefore have to engage in second jobs.

Even if mainly restricted to urban areas, one of the most popular forms of moonlighting is locum work. Frequently, when health workers in the public sector get their period roster (work schedule), they contact private facilities and communicate the days they can take up locum work. These health workers are then pencilled in the private facility roster. Alternatively, public sector workers take annual leave and work up to a month in private facilities. Some public sector workers also get days off to compensate for night duty and use this free time for locum work.

Most health workers will not perform locum work on a daily basis; twice a week is a more common rhythm. Locum work is associated with absence from the primary job, because locums take place in the private sector that does not tolerate late-comers or absenteeism. When public services are well staffed, health workers often set up an informal rota system, where each in turn gets the opportunity to perform locum work while his/her work at the service is covered by the others. Health workers that take up locums are mostly employed in the public sector, and to a lesser extend in the faith-based sectors. Some private sector workers also perform locums, albeit often with their own employer, boiling down to paid extra-hours (banking).

Remuneration for locum work is limited to pay per hour worked. Locum staff tends not to have any additional benefit, in contrast with permanent staff. Locum workers are often supervised by permanent staff, especially for clinically challenging tasks that are perhaps performed more in the private sector compared to the public sector.

There're a number of difficulties associated with locum work. Most health workers point out that the combination of two jobs is exhausting, leading to decreasing efficiency and worse attitudes to patients. For these reasons, some health workers scale down their primary clinical public employment, to be fitter for the secondary professional private activity. Some health workers have seen their official working hours increased since ADHA has been structurally incorporated in the salary, making the uptake of locums more challenging.

4.5.5 Drug pilfering

All interviewees have indicated that only pharmacists or drug administrators have direct access to drug stocks. Even emergency drugs on the wards to be used by health workers themselves are not there anymore. This generally applied rule seems to limit drug pilfering by health workers. Health workers as well as patients get drugs when they present a prescription. Prescriptions can reportedly be written by doctors and some nurses, who consequently write these also on behalf of themselves. Health workers that cannot prescribe drugs have to obtain a prescription from other health workers if they want drugs. Consequently, if health workers request drugs from the drug store with a prescription, it's because they're ill and thus are 'patients'. Health workers that administer drugs at the facility generally make use of a drug sheet that indicates quantities and prices and which reportedly does not allow to pilfer any drugs.

However, pharmacists and drug administrators reportedly have some leeway in providing drugs to health workers – with or without prescription – when this is for 'personal use within the family'. This then suggests there's a possibility that some drug administrators can pilfer drugs, which is reported by some interviewees. Some drug administrators would take transfer on a piecemeal basis drugs from the workplace stock to their private drug shop in town. There's also some anecdotic evidence of health workers being involved in pilfering drugs, and selling them on market days. Some suggest that stealing drugs is more frequent in rural areas. However, health workers and users alike indicate that this practice is generally very rare. It is also indicated that drug pilfering is difficult to detect and only seems to be discovered by chance.

Drug pilfering is not normally tolerated, because it is unethical. There's some scarce reporting that a blame is given when stealing drugs is discovered, following dismissal when the activity is not abandoned.

4.5.6 Informal fees

Quotes in this section apply to informal fees, as well as to other forms of financial corruption.

Patients as well as health workers report that informal fees are not charged. Sometimes patients give a token of gratitude to the health worker, but on their own initiative.

Health workers point at management systems in place that make that they do not handle finances in the facilities. Health workers will dispense clinical care and write up the bill. The bill will go to the cashier/money collector/accountant, who receives payment from the patient. The latter gets a final receipt in return.

When financial corruption is reported, it is at the level of the administrators. Health workers point out that administrators, accountants, money collectors/cashiers, and record people tend to collude. Health workers report that patients not always receive receipts, indicating some sort of fraud.

Health workers report there are monitoring systems in place, even if they sometimes take up too much time. Importantly, patients seem to be proactively asking for receipts when settling final bills. Corruption may be more frequent in the public compared to the private and in the rural compared

to the urban areas. Generally, however, we have little reported evidence on informal fees and corruptive practices.

4.5.7 Patients' attitude towards health workers

Health workers report that some patients abuse them or are disrespectful. With the introduction of the National Health Insurance Scheme there are more patients visiting health facilities and patients have become more abusive and complain more about the long waiting/through-put time, or insist on being treated against insurance terms, even if their insurance rights have not been administratively confirmed.

Health workers also say that users think that all facility staff are 'health workers'. Health workers complain that some users don't understand them, which in some cases depends on the user's educational background. In those cases health workers shout at patients, or tell them off if they don't take drugs as indicated by the health worker.

4.5.8 Health workers' attitude towards patients

Health workers report they try to have a positive attitude towards patients, generally believe they succeed, but admit they sometimes have not. Users report quite some evidence about negative health worker attitudes.

Doctors believe that generally their attitude to users is good to excellent. One doctor cites a survey done at his/her facility which throughout the years confirms this. Health workers argue they try to be nice, show respect or are aware that patient's wishes need to be respected. Users confirm that a good relationship with health workers may pay off in terms of referrals or preferential care.

Health workers report they sometimes get impatient with users, have to show authority, be firm, tell them off, get angry with them, shout at them, loose their temper and insult them. Mostly this is because patients do not do as they are told, e.g. take drugs as prescribed, pay when asked to pay, be seated when asked to do so. Users confirm this type of health worker attitude and report being shouted at. Health workers often get angry or mad following an inquiry, question or remark by users. Sometimes health workers' negative attitude will be inspired by their personal opinion about a user.

Health workers argue that generally health worker attitudes are the same across sectors. They say this is even more so since the introduction of the National Insurance Scheme, where patients should get the same treatment in facilities in different sectors. The private sector is reportedly only interested in some type of patients and refers some of their users to a public facility in a rude way. Users confirm that they had also bad experiences in the private sector. Some users report that health workers have more time for them in the private sector. The faith-based sector is quoted as the one with the best health worker attitudes. Attitudes are also generally better in rural compared to urban facilities.

We have collected little evidence regarding the consequences of negative attitudes by health workers. Negative attitudes can lead to negative assessments for trainees, which in turn could negatively impact on the registration as a health worker. More commonly though is that a health worker acquires a negative reputation in rural areas. Users may also not seek to visit facilities where they are treated badly, if they have the choice.

4.5.9 Informal health care

Informal health care comes with being a health worker. When people, rich and poor, know someone is a health worker, they tend to feel free to approach that person and ask for medical advice. This may occur everywhere and at all times: after church, at the market days and funerals. As with asking medical advice in pharmacies, most informal care is given for free, further explaining why the practice is widespread. However, in some rare instances informal care is paid for; when this happens payment will be in kind rather than in cash and be more frequent in rural compared to urban areas.

Health workers argue that informal care is part of the Ghanaian culture and that not helping out patients would be seen as wicked and demonstrate that one is not a caring person. Traditional healers also work at different locations reinforcing the patients' habit of requesting informal care from allopathic health workers. Out of dedication and/or fear to damage one's reputation, many health workers feel they cannot refuse a request for medical advice.

However, health professionals increasingly refuse to provide informal care and send patients to hospitals, or inform them about the existence of the health insurance. This is mainly driven by health workers' awareness that they can be held accountable for the medical results of informally provided care.

4.6 Monitoring, career development, disciplinary measures

4.6.1 Performance evaluation

All health workers are familiar with the notion of performance evaluation. They cite the self-appraisal and the general appraisal for those working, the logbook system for those in training and less frequently that a monitoring team from headquarters comes and appraises the health workers.

In practice in the public sector the appraisal is linked to promotion and will often be carried out when the health worker will apply for a promotion. The most common system seems to be a face-to-face meeting using the appraisal form which is jointly filled out by the evaluator and the appraised health worker; when the health worker does not agree with the evaluator, there's room to say so and argue why both parties have divergent views; at the end the form is read aloud and signed by both parties. If they have disagreed on some sections, a panel can be called together and the arguments will be heard. There's also a section allowing for 'recommendations' which needs to be filled in by the evaluator. Normally the evaluator is the direct hierarchical line-manager of the appraised health worker. Most health workers indicate this system is fair.

A number of health workers however say that the system is not always applied. They believe it should be yearly, which it is not in practice. Also, some negative critique is not always put down in writing. Doctor/administrators argue they cannot evaluate all staff they should be evaluating because they are too many.

It has been indicated that performance evaluation is more rigorous in the faith-based compared to the public sector.

If carried out, the results of performance appraisal seem to have a bearing in practice. Health workers will not apply for promotions if the recommendation – section of the form suggests otherwise. In case the appraisal has been negative, then health workers may be dismissed if they do not change behaviour. If a health worker is sacked without having been appraised properly, then the trade unions may bring the case to court. In some rare cases appraisals are carried out twice a year and awards are attached to positive evaluations. Some health workers point to the

large number of undedicated and non-performing health workers as an illustration of a non-functional appraisal system. And users argue that it would indeed be an excellent idea to introduce performance evaluation if this could be a means to get rid of those health workers that do not perform well.

4.6.2 Promotion

These quotes in this section mainly if not uniquely refer to the public sector.

Health workers see various ways of getting promoted. Most common are either after positive appraisal or semi-automatically after a certain number of years in the same job. Alternatively, but this seems rare, one gets either promotion before or after having done rural service.

Appraisal leading to promotion has been reported under 'performance evaluation'. It is noted that sometimes it is asked to appraise a person several years back, which is not sensible or difficult.

Promotion based on seniority means that certain health worker categories, especially doctors and professional nurses, tend to automatically get a promotion after a number of years. When time has come they either receive an invitation for an interview, or they contact the Ministry and are consequently invited for an interview, after which they tend to receive the promotion. Auxiliary nurses in turn report promotion is rare or altogether absent. They are not aware of any way of getting promotion and their letters often remain unanswered.

Promotion is generally associated with higher pay and for this reason important. However, it is also seen as important 'as such' because you cannot stay at the same position for ever. Promotion is also felt as recognition and is motivating. The absence of promotion is also cited as a reason to externally migrate.

Health workers do not necessarily rate the promotion systems very high. Auxiliary nurses evidently complain about the lack of transparency and think the system is unfair to them. Other health workers argue that the system relies too heavily on colleagues and superiors, allowing for misuse of power and frustration. The actual system where promotion is based on seniority rather than on performance is negatively perceived by some.

4.6.3 Patient's Voice

Patients report that health care issues are not normally heavily debated. Sometimes they discuss amongst the population or complain to friends who are health workers. The most common way of airing disapproval with an aspect of health service is to call into radio-programmes. Some users point out that the effect of radio programmes is limited because they do not tend to actively involve health workers, who consequently aren't perhaps aware of what is being said.

Users generally complain about the lack of a way to post a complaint. They point out that there's no system. Some users have talked to health workers who are supposedly in charge, but this did not seem to have lead to any change.

Annex A Participant selection criteria

Overview over the 11 FGDs

Urban	Rural	Migration
U1—Doctors	R1—Doctors	M1—Nurses about to migrate
U2—Professional nurses	R2—Professional nurses	
U3—Auxiliary nurses	R3—Auxiliary nurses	M3—Nurses that have returned to Ghana
U4—Users	R4—Users	M4—Nurses that have decided not to migrate

Each FGD will have between 7 and 9 but preferably 8 participants who don't work at the same health facility and don't know each other[4]. A reserve participant should be invited in case someone does not show up. The participants will have the following characteristics:

1. Health workers – standard FGD

FGD U1 & R1—Doctors

- 8 medical officers, of which 5 are general practitioners and 3 specialised
- Of the 5 general practitioners, at least 2 men and 2 women
- Of the 3 specialised medical officers, at least 1 man and 1 woman
- Of the 3 specialised medical officers, at least 1 was trained or is in training at one of the new institutions (e.g. Ghana College of Physicians & Surgeons)
- 2 women with children and 2 men with children
- 2 relatively young and 2 relatively old
- 4 from Ghana Health Service (GHS), of which 2 that do not moonlight
- 2 from the private sector
- 2 from faith-based organisations (e.g. CHAG), of which one that does not moonlight
- The doctors do not work in the same facility.

FGD U2 & R2—Professional nurses

- 8 professional nurses, of which 2 medical assistants, 4 state-registered nurses, 2 professional midwives
- 4 active in health centres, 4 active in hospitals/clinics
- 2 that moonlight
- 5 women and 3 men
- 2 man with children, 2 women with children
- 2 relatively young and 2 relatively old
- 4 from Ghana Health Service
- 2 from the private sector
- 2 from faith-based organisations (e.g. CHAG)

[4] This might be ambitious for doctors.

- The nurses do not work in the same facility.

FGD U3 & R3—Auxiliary nurses

- 8 auxiliary nurses, of which 3 enrolled nurses, 3 community health nurses, 2 health aids
- 4 active in health centres, 4 active in hospitals/clinics
- 2 that moonlight
- 5 women and 3 men
- 2 man with children, 2 women with children
- 2 relatively young and 2 relatively old
- 4 from Ghana Health Service
- 2 from the private sector
- 2 from faith-based organisations (e.g. CHAG)
- The nurses do not work in the same facility.

FGD U4 & R4—Users

- 4 have used a public health facility (GHS), 2 a private, 2 a faith based (e.g. CHAG) in the last year
- 2 have visited a health centre, 2 have visited a hospital/clinic
- 4 women, 4 men
- 4 rather richer, 4 rather poorer
- 2 relatively young and 2 relatively old
- The users must not be relatives of health workers and not be well acquainted with any health worker in the facility they use to visit.

2. Professional and Auxiliary Nurses—migration FGD

M1—Nurses about to migrate

- 4 men and 4 women
- 2 with children, 2 without children
- 2 relatively young and 2 relatively old
- 2 formerly employed in GHS, 1 in CHAG and 1 in the private sector
- 1 nurse from each nurse training institution

M2—Ghanaian nurses in the UK

- 4 that work as a nurse, 4 that don't work as a nurse
- 4 women, 4 men
- 2 with children, 2 without children
- 2 last job in GHS, 1 last job in CHAG, 1 last job in private sector

M3—Nurses that have come back

- 4 that work as a nurse, 4 that don't work (or don't work as a nurse)
- 2 in GHS, 1 in CHAG, 1 in private sector
- 4 women, 4 men
- 2 with children, 2 without children

M4—Nurses that have decided not to migrate

- 4 men and 4 women
- 2 with children, 2 without children
- 2 relatively young and 2 relatively old
- 2 employed in GHS, 1 in CHAG and 1 in the private sector
- 1 nurse from each nurse training institution