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May 2006



Preliminary draft. Limited circulation. Please do not quote.

SYNTHESIS OF FOCUS GROUP DISCUSSIONS WITH HEALTH WORKERS IN RWANDA

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Acknowledgements

Cooperation with the Ministries of Health and Finance and Economic Planning in Rwanda, and financial support from the World Bank³ are greatly acknowledged. We also thank Ben Karenzi, Vianey Nizenyimana and Agnes Soucat for their continuous support to this study; Damascène Bouterera, Gavin Roberts and Aline Umubyeyi for their collaboration on conceptual issues and Napthal Nyandwi and Kampeta Sayinzoga for assistance on administrative and financial matters.

³ 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.

Executive Summary

This report summarizes the findings of a qualitative study on health workers' performance and career in Rwanda. The study was commissioned by the Ministry of Health, and carried out by Tomas Lievens (University of Nottingham) and Pieter Serneels (Oxford University). Given the qualitative nature of the study, its findings should not be interpreted as representative in a statistical sense. Rather, they help to identify bottlenecks, strengths and shortcomings for human resources in the health sector, as perceived by both health workers and users of health services. This Executive Summary discusses the methodology that was followed and the key findings. The main report discusses both these aspects in more depth, and also provides a summary of the most recurring and relevant quotes.

Methodology followed

Because of its power to reveal and contrast a multitude of perceptions and opinions, we used Focus Group Discussions as our method of data collection. We followed a strict methodology in the preparation, implementation and analysis of these discussions.

The study was implemented in November 2005 and consisted of a total of ten Focus Group Discussions: six with different levels of health workers (doctors, nurses and auxiliary workers), two with users of health services, one with pharmacists and one with Persons Living with HIV/Aids (PLWHA). With the aim of capturing both the urban and rural dimension, we held half of the discussions with health workers and users in the capital and the other half in a provincial town. The participants of the group discussions were carefully selected respecting a number of strict criteria. Apart from some technical criteria, we assured that each group had enough heterogeneity along dimensions of interest, in order to provide us with rich data. For the health workers for example, we focused on a number of criteria that are known from labour economics to affect both career choice and performance (like sector of activity⁴, age, gender, having children and having multiple jobs or not).

The FGD were semi-structured with a detailed prepared script as check list and lasted on average two hours and a half. Participants were consistently guaranteed full confidentiality and anonymity. The discussions were held in Kinyarwanda or French. All discussions were recorded and transcribed in French. The text analysis was carried out in NVIVO 2.0 software, imposing as little structure as possible to let themes emerge from the discussions. In total 1,203 participants'

⁴ We distinguish between the public, the private for profit and the faith-based sector and NGO's.

quotes have been examined. The quotes adopted in this report were selected because of their salience or because they reflect frequently recurrent themes.

Summary of Findings

The importance of 'vocation' for health workers: Vocation is important for health workers; they cannot imagine a health worker doing a good job without having a vocation, if only because the profession requires hard work and gets limited pay in return.

On supply and demand for health workers: Although some claim that there is a shortage of health workers, others - especially lower educated health workers - argue that it is difficult to find a job. The general impression is that there is a need for more health workers, but the Ministry of Health and the facilities do not always have the funds to employ them. The shortage of doctors seems also to be linked to a movement towards work outside clinical health care, such as public health. Sometimes doctors move abroad. The limited education, for doctors because of numerus clausus and for nurses because of the limited number of people completing secondary school, also seems to contribute to the perceived shortage of health workers.

Job satisfaction: The discussions suggest that there is substantial heterogeneity in job satisfaction and motivation among health workers. Low pay relative to high effort, poor working conditions, the lack of career perspectives and the risk of getting HIV/Aids are all sources of frustration, while social respect seems a source of satisfaction. Work in rural areas is also often associated with dissatisfaction.

Job search and job mobility: Social relations seem to be less important to get a job than in the past. Job mobility between the private and public sector has increased. The private sector seems to have higher requirements than the public sector. Government policies such as a circular note from the Ministry of Health (MOH) seem to have made recruitment of public sector health workers by Non Governmental Organisations (NGO) less aggressive. Women seem to have a disadvantage when applying in the private for profit sector, presumably because of potential pregnancy and taking care of the children,

Rural versus urban careers: Although staying in a rural area for too long carries the risk of 'getting stuck' - among others because of the lack of information about employment opportunities elsewhere - and is perceived as signalling low quality service delivery, some years of experience in rural areas is often valued by NGO's. Doctors have almost no incentive to work in rural areas: they earn more, can specialise, and enjoy a higher quality of professional and private life in urban areas.

Job preferences: The main factors that explain job preferences are remuneration - including benefits like access to health, job stability and access to further training. The private for profit sector and the NGO's pay better than the public sector, while faith-based facilities tend to follow the salary scale of the public sector. Salaries in the private sector are often performance related, while salaries in the public sector officially depend on seniority, but it is not clear whether this is followed in practice; there are indications that the exact salary can also be negotiated in the public sector. Access to medical care is usually at a reduced cost in the public sector; this is not always the case in the private sector. Although low salaries are a complaint in the public sector, public health activities are seen as relatively well paid, probably because of the lower workload. Whereas the public sector provides job security, this is much less the case for NGO and private for profit facilities, which sometimes employ health workers without a written contract. Access to training and further study come up as an important motivating factor for health workers. The need for training also stems from the perception that (especially lower level) health workers get tasks assigned above their education level. The public sector provides access to training while the private sector does mostly not.

Patient management skills and attitudes towards patients: Both health workers and users confirm that there is a serious problem with health worker's attitudes towards patients. Far too often health workers are impolite or rude, sometimes because of being overstretched. There is also discrimination in favour of those who the health worker knows. Attitudes are better in the private for profit, NGO and faith based facilities. This is due to better monitoring and higher accountability, but health workers in faith-based facilities are also perceived as being more committed. There seems to be improvement in those public facilities where health workers have received training on quality assurance.

Waiting times: Waiting times are longest in the public sector, mainly due to a lack of personnel and more administration.

Workload: Most health workers feel they have a heavy workload. Some work many extra hours; these are paid for in the private sector, but less often in the public and faith based facilities. In the public sector, there often is a lack of time to adequately receive and treat patients.

Working hours, shirking and absenteeism: Absenteeism seems to be a problem in the urban sector, especially among doctors. Absenteeism is related to having a second job and is especially present in the public sector, where doctors also seem to organize their working time mostly themselves. In private for profit and faith-based facilities, health workers are better monitored. The current move towards performance related premiums is expected to decrease absenteeism and shirking (avoiding work). In some public facilities there are reportedly 'ghost doctors' who are on the pay roll but do not show up for work.

Second job: In urban areas, a second job is mostly in the medical sector, is usually not official and is very frequent among doctors in the public sector. Second jobs outside the medical sector occur mostly among nurses and auxiliary health workers in rural areas. The main reason for a second job is financial. A second job by doctors is associated with "embezzlement of patients": patients are referred to the doctors' private practice, where health care is more expensive, but service delivery quicker. Some nurses have a second job in a pharmacy, where they also seem to provide (illegal) health care; other nurses work at night in a private facility. In general nurses with a second job regularly suffer from tiredness, which affects the quality of their health care.

Technical skills: In general, nurses and auxiliary workers feel they have not enough skills for the job they have to do, and that there are not enough skilled people for the tasks that have to be done. All health workers feel that they received too little training to deal with HIV/Aids.

The impact of HIV/Aids: HIV/Aids has increased the workload substantially. Health workers are also concerned about the increased risks to which they are exposed, both for infection with HIV/Aids and tuberculosis. Protocols regarding how to treat HIV/Aids patients are not always known, and are often not implemented.

Health worker attitudes towards HIV/Aids patients: Persons living with HIV/Aids often complain about rude behaviour of health workers. HIV/Aids patients often receive worse and/or less treatment than non-infected patients. They are sometimes avoided altogether. Specific training seems to be effective to improve the way health workers deal with PLWHA.

Performance evaluation, disciplinary measures and promotion: Overall, doctors appear to be weakly supervised. Monitoring of health workers by other health workers – through passing on the service to the next shift and via modalities developed under the Initiative for Performance – has increased. There is officially an annual performance evaluation in the public sector, but it isn't often used. Its value is also questioned since it is perceived as subjective. There are also mechanisms in place to deal with misbehaviour, where the legal framework, health committees, government officials and the media all can play a role. Some argue that these procedures are only used for very serious cases, and that there are usually no consequences related to misbehaviour, especially in the public sector. The private for profit facilities cannot permit to allow bad behaviour, since this would make them loose clients. Misbehaviour by doctors is sometimes dealt with by the order of doctors. Patients complain about the absence of procedures to deal with medical faults. There seem to be no clear rules for promotion and some argue that a system of promotion is altogether absent. Health committees have some discretionary power to provide incentives to health workers.

Performance pay: The Initiative for Performance (IP) that started in 2002 in some public and faith based facilities generally receives a positive evaluation from both health workers and users of health services. Health workers monitor each other more and this has improved accountability and productivity. IP seems to have had both a quantitative and qualitative effect: it has increased the number of vaccinations, pre- and postnatal care and curative care consultations; and it also has improved the motivation of health workers, their attitudes towards patients and their teamwork. Perceived shortages of IP are that it is only related to payment and not to career development. Also, it has not solved the shortage of equipment and technical skills of health workers. A challenge for IP is that some tasks may become routine and that this may erode the quality of care. Some health workers are also dissatisfied with the lack of transparency of how the premium is distributed within the facility.

Inappropriate activities like corruption and embezzlement: These activities occur more often in public facilities than in private for profit and faith based facilities. There is ample evidence of corruption, but it is unclear how systematic it occurs. There are different types of corruption, from bribe payment, to embezzlement of drugs and material, to fraud. Some perceive monetary gifts as a token of gratitude. Bribing seems to occur in a variety of contexts, including to reduce waiting times, to escape high bills, or to get extra service outside working hours. Embezzlement of drugs is a frequently recurring theme, but it seems to occur less than in the past. These drugs are sold on the market or privately used. Health workers also report of wide spread embezzlement of -

mostly small – instruments. In general there is a feeling of increased accountability compared to the past.

Pharmacies: All pharmacies and drug shops tend to give medical advice and some are involved in clinical care. The fact that advice in pharmacies is free, that the waiting time is shorter, and that the attitude of health workers in public facilities is poor, are some factors that explain the involvement of pharmacies in providing health care. Pharmacists agree that in general they earn well. They want more training, especially in relation to HIV/Aids, and about new medicines. Pharmacists usually do not seem to have a second job. In general, pharmacists feel evaluated by the fidelity of their clients.

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 Rwanda.

Rwanda 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 GOR 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 and analytical 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 the career paths and outcomes 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 does the prevalence of HIV/Aids affect their career choices?

2. Explain observed performance levels

How do health workers allocate their time and what does time use tell us about coping strategies and income augmenting activities? How do job satisfaction and motivation affect health worker behaviour and what are their determinants?

3. Specific issues: HIV/Aids and Pharmacies

How does the prevalence of HIV/Aids affect their daily performance and on the job behaviour? Does HIV/Aids affect labour market choices? To what degree do pharmacies engage in medical advice and clinical acts? What is the quality of these advise and acts? Why do pharmacies engage in these activities and why do patients use them?

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 has provided a framework and methodology for this study, also allowing comparing the situation in the two countries.

2. Theoretical framework

This section has not the intention to elaborate thoroughly on the economic theories underlying the set-up and analysis of this study. It's sole objective is to point out that the framework used is to some degree different from a standard public health approach to health worker behaviour.

Economically spoken, health workers are seen as individuals actively making choices to maximise their utility, or more broadly, 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.

The 'sectoral' choice health workers face in Rwanda, concerns taking a job in the public, private or faith-based sector. Additionally, they can also choose to work outside Rwanda, take up a non-clinical job in the health sector, or leave the health sector altogether.

They also choose the 'location' of their work. While this refers to a number of dimensions, the most important one is whether one will work in an urban or a rural environment.

Importantly, health workers also determine their 'performance' level, which include 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 choices is not exhaustive, but arguably encompasses most of the issues of concern to this study. It has been said health workers make professional choices to maximise their well-being. Concretely, health workers browse the labour market and the jobs potentially available to them. Each job has a certain number of characteristics or attributes such as 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.

Each health worker will assess the job attributes of the jobs potentially open to him/her and in the end come up with his/her 'most preferred job'. 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 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. This study will try to explicit some of the driving factors of health worker labour market choices in Rwanda.

The health workers' decision space is the labour market for health workers in Rwanda. The latter evidently has a number of specific characteristics, which are also important to elicit if one is to understand health worker choices. Labour market characteristics encompass, amongst others, the equation between demand for and supply of health workers at different levels (doctors, nurses, etc.), the degree to which health workers can move freely between health sectors (segmentation and path dependency), labour market entry and job transfers, whether some sectors/jobs attract health workers with a specific profile (highly capable/incapable, high/low professional vocation, etc.), systems of performance evaluation and promotion (performance initiative/contractual approach, e.g.), etc. The study will also take into account some important labour market characteristics in analysing health worker behaviour.

Lastly, human resource policy for health workers, to which it is hoped this study will ultimately contribute, can impact on job attributes and/or labour market characteristics health workers face. Human resource policy is in this sense an instrument to impact on individual choices by health workers and to indirectly strive to obtain more desired labour market outcomes, including sectoral and locational spread of health workers, as well as their performance levels.

3. Methodology

This section briefly highlights some methodological choices made in this study. More precisely it defends why focus group discussions were chosen as an instrument to collect data, how the participants in the groups have been identified, the data 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' real live professional behaviour in Rwanda. Evidently, different options are available if qualitative analysis is envisaged. Ultimately, it was chosen to work with focus group discussions (FGD). Typically held with a number of participants ranging between 6 and 9, FGD allow confronting ideas and exploring perceptions of group members concerning the issues discussed, thus allowing not only obtaining punctual information, but also grasping some insights explaining this punctual information. At the same time, group members function as an 'information quality filter': highly individual or extreme points of view will provoke disagreement from other participants.

One potentially important drawback concerns the difficulty to discuss sensitive issues such as corruption, informal health care, HIV/Aids, etc. But arguably, even FGDs allow obtaining information on issues people are reluctant to speak about if led by able moderators. Training and experience in leading FGD consequently constituted one of the selection criteria of the consultants involved. It turned out that quite some information on sensitive issues has been collected in the 10 FGDs held in Rwanda.

3.2 FGD participants

Selection of FGD participants was led by three objectives: (i) within-group homogeneity, (ii) within-group heterogeneity and (iii) group dynamics. The first objective is reached by bringing together participants of the same health profession. Alternatively, they were users and in a special case, PLWHA. This is to prevent that differences in social status originating from differences in professional status inhibits some participants freely taking part in the discussion. Once sufficient homogeneity is ensured, heterogeneity along other dimensions is important to maximise the probability of participants having different experiences and views. Criteria for heterogeneity included, amongst others: sex, age, having children, working in (or visiting) a different health centre, different health sector (public, private, faith-based), degree of poverty (for users only), amongst others. Lastly, to ensure constructive group dynamics participants did not know each other beforehand, visited or worked in different health facilities and were not particularly shy.

Overall, the selection criteria were well respected. However, some difficulties arose in finding rural female doctors and health workers active in rural private facilities. A total of 81 persons took part in 10 FGD. Table 1 presents the number of FGD per participant profile.

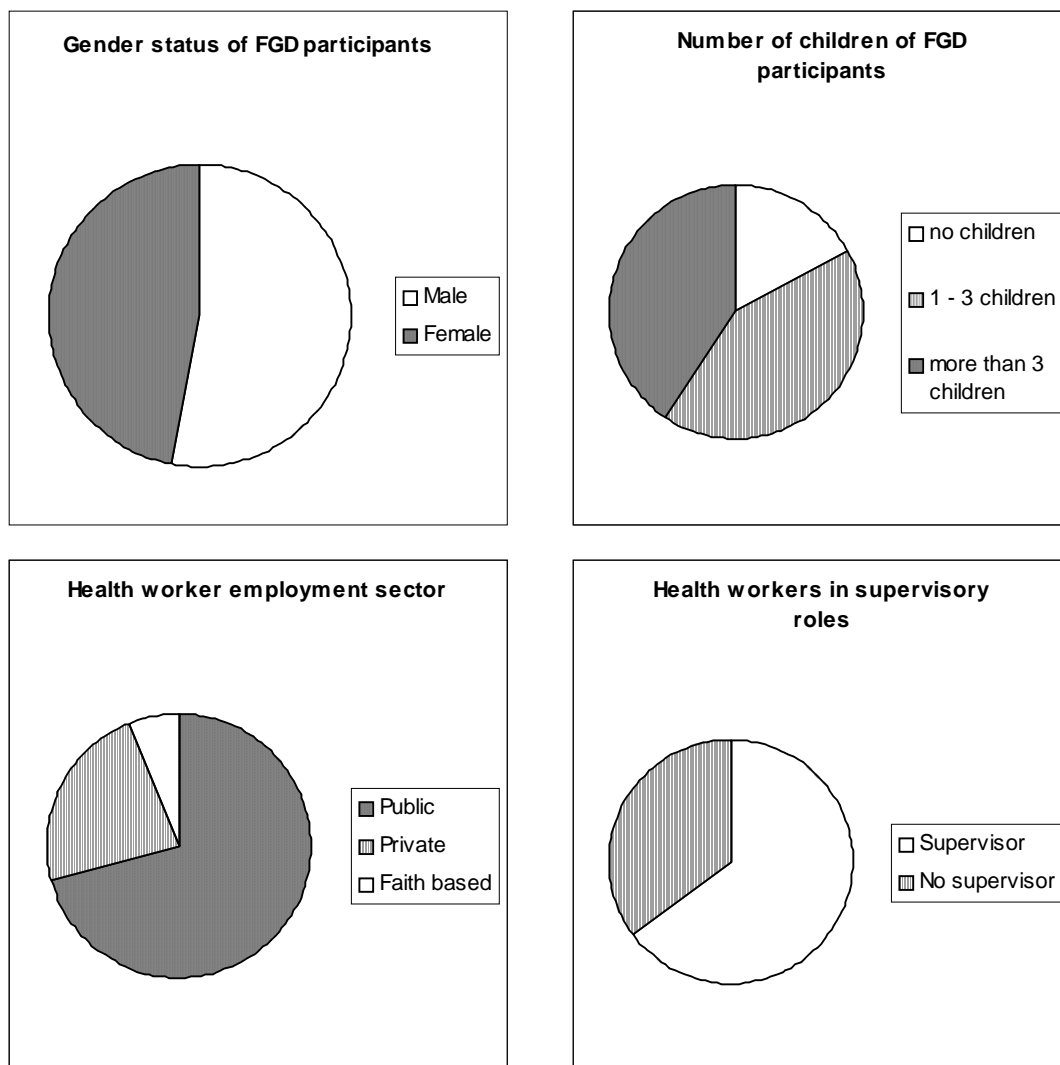
Table 1. Number of and participants profile in FGD		
	<u>Number of FGD</u>	<u>Number of participants per FGD</u>
Doctors (A0)	2	8
Nurses (A1 & A2)	2	8
Auxiliary personnel (A3)	2	8
Users	2	8
Pharmacists	1	8
PLWHA	1	9

Equality of participants in each group contributes to allowing a sensible comparison between groups. Since the group with PLWHA will be considered on its own, 9 participants were allowed. However, since PLWHA are equally health care users, independently of their particular health status, some quotations by PLWHA were also admitted in this document.

Separate FGD were held with health workers active in rural and urban areas. This was also the case for users, but not for Pharmacists and PLWHA, who were mainly urban.

Figure 1. contains some descriptive statistics relating to the FGD participants. The overall gender balance is slightly in favour of males and the number of children participants have appears rather well differentiated. Health workers are predominantly active in the public sector which both reflects the focus of this study and the difficulty to identify rural health workers active outside the public sector. The ratio public to non-public health workers was 14 to 10 for urban areas, but only 20 to 4 in rural areas. Also, most of them do supervise other personnel active in the health facility.

Figure 1. Descriptive statistics of FGD



3.3 FGD, transcription procedure and analysis procedure

The FGD were semi-structured using interview guides or scripts. 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'. In total, 5 different scripts have been developed to address differences in FGD participants' profile: doctors, nurses and auxiliary personnel, users, PLWHA and pharmacists. The scripts for doctors and nurses & auxiliary workers do not drastically differ.

Almost all discussions took place in a meeting room in a hospital, either at the CHUK (Centre Hospitalier Universitaire de Kigali) or the District hospital of Kabutare (province of Butare). Only the discussion with PLWHA took place at the Rwanda Network of People Living with HIV/Aids, which also provided assistance in the selection of participants.

Participants were welcomed with a soft drink, relaxing the atmosphere and allowing for latecomers. FGD lasted on average 2 hours and 35 minutes, with a minimum of 1 hour 31 minutes in the case of urban doctors and a maximum of 3 hours and 9 minutes with rural users.

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 MOH 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 sound file per FGD. These files are being transcribed. Consequently, the analysis of the FGD is based on written accounts of the 10 FGD, each between 10 and 15 pages long. Importantly, all FGD were held in either French or Kinyarwanda and transcripts are in French only. The analysis is carried out using QSR NVivo 2.0, 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. It does not enable, however, the production of an overview of the data in a matrix structure.

At a practical level, all FGD transcripts have been coded, which consists in the allocation of a code to a quotation of a participant. A total of 35 codes have been used, 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 at, which can be looked at in further analysis of the data. In total 1,203 quotes have been examined. 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. Detailed findings

1 The choice to become a health worker

The importance of 'vocation' to health workers

- Vocation is mentioned as important for health workers. Health workers argue that they cannot imagine a health worker doing a good job without having a vocation, if only because of the heavy work load and limited pay in return.

On supply and demand for health workers in Rwanda

- There are mixed opinions about how easy it is to find a job as a health worker. Some claim that there are not enough health workers, others, especially lower educated health workers, that it is difficult to find a job and that there is unemployment among health workers. Although there is a general impression that more health workers are needed, the Ministry of Health and the facilities do not always seem to have the funds to employ them.
- Among the factors explaining the perceived shortage of doctors (in clinical care) are (i) the movement of doctors to jobs outside clinical health care, cf. public health activities, and (ii) in some cases doctors moving abroad.
- Another important factor is the limited possibilities for education. For doctors there is a numerus clausus, while for nurses it seems that limited opportunities for secondary education affect the number of people who go on to study as a nurse.

Sources of satisfaction and frustration

- The discussions suggest that there is substantial heterogeneity in motivation and satisfaction among health workers. Low pay relative to the high effort required is an important source of frustration, while social respect is a source of satisfaction. Other sources of frustration and dissatisfaction are the poor working conditions, the lack of career development opportunities and the increased exposure to health risks, such as HIV/Aids. Work in rural areas is often associated with dissatisfaction.

2 How to get a job in the health sector and job mobility

- There seems to be a consensus that relations are less important to get a job compared to the past. The private sector seems to have higher requirements than the public sector.
- Job mobility between different segments of the health sector (public, private for profit and NGO's & faithbased facilities) has improved substantially compared to before. The problem of

NGO's 'buying away' people from the public sector has become less aggressive, among others due to a circular note by the Ministry of Health (MOH) asking not to recruit those who work in the public sector without prior agreement from the MOH.

- Women seem to have a disadvantage in the private for profit sector, because they may fall pregnant and frequently have to take care of their children.

3 Rural versus urban careers

- Apart from offering the possibility to quickly build some experience at the beginning of their career, doctors have almost no incentive to work in rural areas. They earn more in urban areas, experience a more interesting working and living environment, have access to specialisation and can build up a good professional reputation.
- Having worked in rural areas is perceived as an advantage in the private sector, especially in NGO's. Rural health workers are often at a disadvantage regarding information about other employment opportunities.
- Being posted to a rural area carries the risk of 'getting stuck'. Health workers having worked many years in rural areas acquire a reputation of delivering low quality.

4 Job attributes

Remuneration

- The private for profit sector pays better than the public sector, while the faith based sector tends to follow the salary scale of the public sector. NGOs seem to pay better than the public sector.
- In the private sector extra hours are typically paid, while this is less obvious in the public and faith based sectors.
- Salaries in the private sector are often performance related, while salaries in the public sector officially depend on seniority but premiums seem to be awarded in an untransparent way. Public sector health committees seem to have a large discretion in the distribution of premiums to the health workers.
- There are indications that the exact salary can be negotiated in the public sector as well.
- Access to health care is usually at a reduced cost in the public sector, whereas this is not always the case in the private sector.
- Although low salaries are a complaint for the public sector, public health jobs are seen as relatively well paid, among others because of the lower workload.

Stability

- The public sector generally provides job stability while NGOs and the private for profit sector offer far less or no job security at all. In the private for profit sector health workers do not always have a written contract.

5 Further training

- Access to further training and study comes out as an important motivating factor for health workers. The need for training also stems from the perception that health workers are often under trained for the job they are expected to do.
- An advantage of the public sector is that it provides access to further training and education; those in the private sector have no access to training at all.

6 Patient management skills, attitudes towards patients and waiting times

- Both users and health workers themselves say that there is a serious problem with health worker's attitudes towards patients. Far too often health workers are impolite or even rude. The heavy workload may contribute to this. There is also discrimination in favour of those patients who the health worker knows. Health workers' attitudes are better in the private for profit, NGO and faith based facilities than in the public sector. This is most likely linked to the more intensive monitoring, higher accountability and stronger motivation. Market forces also 'force' health workers in private facilities to be kind otherwise their patients will choose to go elsewhere. Health workers in faith based facilities are perceived as being 'more committed'. Some argue that the situation in the public sector has improved in those facilities where health workers have been receiving training on quality assurance.
- Waiting times are longer in the public than in the private for profit and NGO sector. It seems that the administration of the public sector is more cumbersome and that private for profit and NGO facilities are better staffed.

7 Working hours

Contractual issues

- Doctors seem to organize their time themselves.

Workload

- Most health workers feel they have a heavy workload. Some work many extra hours; these are generally paid for in the private sector, but less often in the public and faith based facilities. The heavy workload seems to affect the quality of care. In the public sector, there is often a lack of time to adequately receive and treat patients.

Shirking

- Shirking or 'avoiding to work' is observed mostly in public sector facilities. In private for profit and faith based facilities, health workers are better monitored.

Absenteeism

- Absenteeism seems to be a problem in the public sector and especially among doctors. It is related to having a second job and seems to occur more in urban areas. Irregular hours and being on night duty also seem to explain some of the perceived absenteeism of doctors.
- The current move towards health committees attributing a performance related premium to individual health workers may decrease absenteeism since premiums are performance (and thus presence) related.
- In some facilities there are reportedly 'ghost doctors': they are on the pay roll but do not appear for work.

Second job

- A second job in the medical sector is usually not official. It occurs mostly in urban areas and very frequently among doctors. In the rural areas, second jobs occur mostly among nurses and auxiliary workers and are mainly non-medical.
- The main reason for a second job is financial.
- Many health workers refer patients to their private practice, where health care is more expensive, but also quicker and possibly of better quality. Some call it "embezzlement of patients".
- Nurses regularly work in a pharmacy as a second job. Although it is illegal to provide health care in pharmacies, anamnesis and minor clinical acts are often performed. Other nurses work at night in a private facility. The fact of having two jobs tends to negatively affect the quality of health care due to tiredness.
- There are also reports of health workers engaging in abortion, which is illegal.

8 Technical capacities

- In general, nurses and auxiliary workers feel they have not enough skills for the job they have to carry out, and argue that there are not enough skilled people for the tasks that have to be done. Auxiliary workers in rural areas sometimes run health centres for long periods without assistance.
- Many health workers feel that they lack training to adequately deal with HIV/Aids.

9 About the impact of HIV/Aids

Increased workload

- HIV/Aids has increased the workload substantially, in particular because of the need for frequent blood tests and follow up of the patient.
- Health workers feel a need for further training in this area. Doctors complain that they have often received only two weeks training.

Increased risks, procedures and post accident prophylaxis

- Health workers are concerned about the increased risks to which they are exposed, both for infection with HIV/Aids and tuberculosis.
- There are protocols how to deal with HIV/Aids, but they are not always known and are often not implemented. There often seems to be a shortage of long gloves for deliveries.
- The usual procedure after an accident seems to be to wash the affected body area with soap and water, to carry out a blood test on both the patient and the health worker and to start ARV treatment for 1 month, followed by another blood test.

Health worker attitudes and clinical acts towards HIV/Aids patients

- Persons living with HIV/Aids complain about rude behaviour of health workers . HIV patients often receive a worse treatment than non-infected patients or are avoided all together. There are also complaints about limited follow-up of HIV infected patients. At the same time some health workers are praised for the way they deal with HIV/Aids patients.
- Health workers sometimes limit their clinical interventions because patients are HIV+.
- Health workers having received specific training seem to deal better with infected patients and some health centers have recruited specialised personnel to deal with PLWHA.

10 Monitoring and performance evaluation

Systems of performance evaluation

- Most doctors are weakly or not supervised in the public sector.
- Health workers are monitored by other health workers where services are passed on to the next shift and has increased through modalities implemented under the Initiative for Performance.
- In the public sector there is officially an annual performance evaluation, but it is often not carried out. Its value is also questioned since it is perceived as subjective.
- There are also mechanisms in place to deal with misbehaviour:
 - In some health centres there is a bylaw that consists of a number of rules to follow. If those rules are not respected the health worker gets an oral warning first. If he does not adapt his behaviour, he receives a written warning. If he still does not change his behaviour, a sanction follows.
 - In health centres, there is now often a health committee. The community health assistant, who is part of this committee, is a representative of the population and monitors the behaviour of the health workers in the facility. The committee has the power to fire a health worker. This only seems to happen in very bad cases. In hospitals there is no representative of the clients / patients.
 - The media, both newspapers and radio, seem to play a role in reporting misbehaviour.
 - Government officials also may play a role in reporting misbehaviour. In some instances the mayor reported to the prefect, who informed the Minister. The MOH then started an investigation.
 - The best-known disciplinary measures are being fired or being mutated to another health facility. The latter seems to have been implemented in the case of drunkenness, regularly being late, fighting or embezzlement.
- Some argue that these procedures for sanctioning are only used for very serious cases, and that in the majority of cases, there are no consequences related to misbehaviour in the public sector. Cases where a health worker is fired seem to be very rare.
- There is a general perception that private for profit facilities cannot permit to allow bad behaviour, since this would make them loose clients.
- A major complaint from patients is that there seems to be a total absence to deal with medical faults.
- Problems with doctors seem to be addressed in the Order of the Doctors. Since its creation, there have been some investigations and some doctors have been suspended, although no-one seems to have been prohibited to exercise his profession.

Disciplinary measures and promotion

- Officially an evaluation can lead to promotion, but evaluations do not seem to be carried out systematically.
- There seem to be no clear rules for promotion ; some argue that a system of promotion is altogether absent.
- Health committees in health centres appear to be quite autonomous in distributing premiums - which may take the form of performance bonus, salary increase or softer signs of recognition (dinner etc.).

On performance pay

- In 2002 the Initiative for Performance (IP) was started. This allows the facility to complement the salary with a performance related bonus. It is implemented in some public sector and faith based facilities and is perceived as having improved the motivation of health workers and the stability of personnel. It has also improved the attitudes of health workers and their team work. Since the premium is allocated at the facility level, health workers now monitor each other more, so each of them is more accountable and more productive.
- Under the IP the health centres receive more funding if they reach a number of preset performance targets. The health committees decide on the distribution of the performance premiums among the staff. Qualification, seniority, and the number of tasks seem to be the major determinants of how the premiums are distributed among staff.
- The IP is perceived as having had both a quantitative and qualitative effect: it has increased the number of vaccinations, maternity care (reduced pre-natal deaths), curative care consultations and health care use in general. Although IP seems to have improved the attitudes, it is not perceived as having increased the technical quality of care, since there is still a shortage of equipment and technical support.
- A shortcoming of the IP is that it is related to payment only, and not to career perspectives in general. Another challenge for IP is that some tasks may become routine, which may make it difficult to keep up the quality. It is also unclear how the premium is distributed at the facility level. The perception is that two people with the same qualifications and seniority and behaving in a similar way may receive different premium, and it is unclear why this is so. Others have problems with performance related pay and find that it is in conflict with the dignity of the profession; that health workers should just receive a decent salary.

11 About inappropriate activities: corruption, embezzlement and the like

- Inappropriate activities seem to occur more often in public facilities than in private for profit and faith based facilities.

Corruption and Embezzlement

- There is ample evidence of corruption, but it is unclear whether corruption is systematic.
- There are different types, from patients paying bribes / health workers asking for bribes, to embezzlement of drugs and material, to fraud. Some perceive monetary gifts as a token of gratitude.
- Bribing seem to occur in a variety of contexts, including to being served or reduce waiting times, to escape high bills, or to get extra service outside working hours. One story that came up is that patients in hospitals pay the nurse and then disappear at night before they have to pay the bill the next day.
- Embezzlement of drugs is a frequently recurring theme, especially in health centres that receive gifts in drugs, but it seems to occur less than before. These drugs are sold on the private market. The embezzlement of drugs for private use seems to have diminished since there is reduced cost access to healthcare.
- Health workers reported wide spread embezzlement of - mostly small – materials like tweezers, scissors, thermometers; sometimes entire boxes would disappear.
- An example of fraud is that health workers, including doctors, sign medico-legal documents making things up.
- 'Embezzlement of patients', 'ghost doctors' and frequent absenteeism is usually not branded as 'corrupt' behaviour.
- The general impression seems to be that accountability has increased. More facilities inspect whether the materials are still there at the end of the day. In some places facilities organize an inspection of health workers' bags.

12 Special issues for pharmacies

- All pharmacies and drug shops tend to give medical advice and provide drugs without prescription. Some execute minor clinical acts such as taking blood pressure, stitching, etc. Three reasons are suggested as an explanation for this medical care in pharmacies: the advice is free, the waiting times are smaller and the poor attitude of health workers in public facilities. Nurses' having a second or first job in pharmacies also contributes to this trend.
- Pharmacists agree that in general they earn well.

- Pharmacists want more training, especially in relation to HIV/Aids, and especially those in wholesale pharmacies want more training about the many new medicines.
- Pharmacy-owners keep their pharmacy open depending on when they have patients, e.g. after 5 pm; agents have very regular hours.
- Pharmacists usually do not have a second job.
- They feel evaluated by the fidelity of their clients: the degree to which they speak out, the frequency of coming in and asking advice, even the day after, whether they come back to thank you, etc.

5. Selected Focus Group Discussion quotations

5.1 The choice to become a health worker

On supply and demand for health workers in Rwanda

"Is there unemployment amongst medical doctors in Rwanda?" No, no, no. There are not enough of them.

Doctor in Kigali

Today, there's no unemployed pharmacist.

Pharmacist

However, some pharmacies do not function properly. Pharmacists are engaged in pharmacies which are hardly functional, having a small turnover, they are almost unemployed, they do not receive their salary at each end-of-month and when the pharmacy closes, they're told there's no money available and asked to leave (...)

Pharmacist

There are nurses who left education two years ago and still haven't got a job.

Nurse in a rural district

It's difficult to find a job these days. Before, we didn't have to do much effort: the Ministry announced where you were assigned on the radio (...). Today, you have to look for a job yourself. It is as if the State has stopped recruiting people. There's a need for health personnel in the country, but the capacity to recruit health workers is limited.

Auxiliary worker in Kigali

There's unemployment [amongst nurses] but the need is there at the level of the hospitals, the health centres, but it's always the capacity of the State to pay the salaries. The health centres lack nurses but are not able to finance the nurse's salary.

Doctor in Kigali

The importance of 'vocation' to health workers

(...) some say it's an apostolate.

Doctor in a rural district

If one wants it or not: once you study medicine, you've got a vocation. If you haven't got a vocation, you fail. A doctor needs to be permanently devoted; a doctor without devotion is no doctor.

Doctor in Kigali

The fact of having a vocation makes it impossible to do something else.

Auxiliary worker in a rural district

The medical profession is interesting because after you have cured a sick person, the result is tangible. For example, after having helped finalising a birth, and the child cries and drinks, it offers me joy.

Auxiliary worker in a rural district

I wanted to say that in the motivation to do medicine, there's the value of treating one's peer, men such as myself, to treat society.

Doctor in a rural district

I will give you an example. I studied medicine and my sister economics and I think she earns much more compared to me who has studied medicine, studies which are much longer and far more difficult.

Doctor in Kigali

The medical profession is really loved; giving up this profession because of the low salary isn't easy because alongside the salary, there's the honour and the social recognition. Honour is our sole important remuneration.

Auxiliary worker in a rural district

(...) there's always this vocation, which pushes you to continue even if conditions are not met: the salary, the equipment, the other colleagues, the professional environment which is not favourable; but since life is sometimes threatened, you're pushed to continue, , the situation is more or less comparable in the public, private or faith-based sector.

Doctor in a rural district

If he does it for the money, he will not have much; and if he's not motivated by the idea to serve the population, he will be deceived.

Pharmacist

Sources of satisfaction and frustration

I have told him that the health sector is prestigious but that one works very hard for a very meagre salary.

Auxiliary worker in Kigali

Health workers are pleased with their job but are far from pleased with their salary.

User in a rural district

And sometimes it is said conditions will improve, but we're still waiting. What we actually observe is that doctors work hard and are very little paid, which is extremely discouraging, I believe.

Doctor in a rural district

If one tries to understand what the health worker does in the medical sector, one would find no proportional compensation to what he does. Those who finish their studies are told there's no salary, it's as working for free. In sum, we're sacrificing ourselves and tell ourselves we're in the medical sector to do some good for which we will be rewarded afterwards.

Auxiliary worker in Kigali

If our salary would be increased, we would work better and moreover be extremely happy while at work.

Auxiliary worker in a rural district

An aspect that should not be overlooked is the financial one: one cannot neglect that a person who owns it's own pharmacy earns well his living.

Pharmacist

This is because the rural areas are intolerable; life is difficult. If you want your child to evolve, you cannot accept it goes working in the rural areas and when it goes there, it will plunge itself in routine and will not be able to increase it's living standard, it will become a peasant.

Auxiliary worker in Kigali

If you are to work in the rural areas, you will be frustrated. You will go, but your added value will be meagre. If you've got 20 sick persons, you'll treat 15 and look for reasons to go to sleep.

Doctor in Kigali

I would encourage my children to study medicine because a nurse is seriously frustrated working alongside a doctor (...) Nurses are not really considered, they feel marginalized, inferior compared to the doctor who has a great superiority.

Nurse in Kigali

I wouldn't advise him to choose a career in the medical sector. First of all, I would tell him it's a tiring job; one becomes tired.

Doctor in a rural district

I have told her that in the medical sector one works hard and that there are risks; I've told her she can prick herself and get Aids, that she can treat tuberculosis patients and be contaminated and that she is not insured.

Auxiliary worker in Kigali

You stay put, but will not work because you have been prevented [by the State] to take up another job [with an NGO]. At that moment, you act as if you work.

Doctor in Kigali

It's even worse in the rural districts, there's no equipment and even the material available is 10 years old, you're doing a Caesarean section with tweezers that do not function. It isn't motivating.

Doctor in Kigali

On reconsidering entry or even quitting altogether

Why should we encourage him to do medicine while there's something else he can do?

Doctor in Kigali

If you observe well, you'll notice that amongst the doctors many do not treat, they work in something else; they're in politics. Finding a doctor is a problem; we have doctors but they're not in the medical sector.

User in Kigali

We had an experimented workforce, but after the war, people became dispersed. Now we reconstruct the country, which means we're lagging behind other countries on the international labour market (...) it's not the right moment to confront those that are on foreign labour markets.

Doctor in a rural district

To my knowledge, very few doctors leave to work in another country.

Doctor in a rural district

5.2 Education for health workers

There's only one institute offering education to become a medical doctor, there's no other choice. It's the National Rwandese University.

Doctor in Kigali

Since last year, the number is already fixed; the numerus clausus in the first year of medicine, only 60 students are accepted.

Doctor in Kigali

Even if today the supply of education for nurses is limited, some secondary schools have been closed; reason why it's difficult to enter education for nurses today.

Nurse in Kigali

I wouldn't allow him to go to a private school, because private schools haven't got a good reputation here; they're a bit commercial.

Nurse in Kigali

5.3 How to get a job in the health sector?

If you want a permanent job [in the public sector] you need to write to the Ministry of Health or the Ministry of civil service.

Nurse in Kigali

Before, you wrote a letter and waited one to two years for an answer. Sometimes, letters were even lost. But there has been some reform in the Ministries. Actually, it's running smoother. And with the decentralisation, you deposit your request at the district, which channels it to the Ministry.

Nurse in Kigali

To get a job in the private sector, you listen to the radio or consult weekly or monthly newspapers; we also consult friends.

Nurse in a rural district

While waiting for an answer from the Ministry, you can also look out for a fixed term contract in the private sector.

Nurse in Kigali

The need for personal relations decreases more and more. Hospitals such as CHUK, CHUB or Roi Fayçal for example are public sector but offer a good salary (...) It's difficult to have a job there. They launch a tender, organise a test and candidates get access to a job following their results on the test.

Nurse in Kigali

Relations are no longer important to get a job in the hospitals. I was part of a committee responsible to correct the entry exam and the cousin of the Director failed the test and was consequently not engaged.

Nurse in Kigali

(...) it's no longer the case in the public sector. However, in the private sector, if I have for example an uncle who owns a private hospital, it's excluded that I would not be recruited by that hospital.

Nurse in Kigali

And for the faith-based sector, one has to mention the need of a reference; you can be from a poor family, but with a recommendation by the bishop, or when you come directly from school, you can have a place in a faith-based hospital with a recommendation by the bishop.

Doctor in a rural district

Concerning requirements, the public sector is least demanding, it's the diploma only; the faith-based sector, it's the diploma and the recommendation; the private sector is more demanding, they require both experience and recommendation (...) Apparently, requirements increase from the public to the private sector.

Doctor in a rural district

Health workers in rural areas are sometimes informed with delay about employment opportunities, they lack information. However, if they're informed timely, they can answer and try to obtain employment.

Nurse in a rural district

Today, everything we do takes into account the dimension 'gender'. Before, women did not have as easily access to employment as men (...) I wish to draw attention to the private sector, women are expelled because the private sector is profit oriented and women often have troubles at home with the children or are at risk to become pregnant.

Nurse in Kigali

And even in the faith-based sector, married nurses leave afterwards because they can only have two children. So it is required to have two children only.

Nurse in Kigali

5.4 About job mobility in the health sector

If one has an opportunity, if one has the means, if one makes up ones' mind, there are no barriers [to leave the public sector].

Doctor in a rural district

Today, the choice is free, if you want to leave the public sector, nobody will hold you.

Nurse in Kigali

I started working in the public sector and then left for the private sector. I can't see any obstacle to introduce my file for a place in the public sector, like any other interested party (...) So I know that if I postulate like the others my chances are equal to the others.

Nurse in Kigali

You write [to the Ministry] to ask to be made available and wait to get a reply (...) otherwise it could be interpreted as abandoning one's job.

Auxiliary worker in Kigali

Before, there was some disorder, there were NGOs that recruited and people who integrated the NGOs (...) and the administrative procedures to leave the public sector appeared long, for the NGO, which wanted to start a programme, and for a doctor who wanted to organise his new post and that's why people took a shortcut (...) To end all this, the Ministry has made this circular note, which does not prohibit anyone to leave the public sector but simply ask not to recruit those that are still under employment in the public sector.

Doctor in a rural district

At present, there's competition, even in the private sector one is searching for those most experienced. That's why one observes this movement more often from the public to the private sector, which evidently pays more than the public sector.

Nurse in Kigali

To someone who would ask me some advice on how to organise a career in the medical sector, I would reply to start in the rural areas and it's there that the beginner will learn a lot, he will be better than those that go from school directly into the NGOs or the private sector. As a doctor you need to apply what you've learnt and that's good. In the long run, after having done clinical work, when one needs money, one can look out for other opportunities, the private sector, NGOs that

pay more. Otherwise, if one starts there, one risk to loose, to forget what one has learnt.

Doctor in a rural district

It's easy to find a job in an NGO when having worked in the rural area because the majority of NGOs request some years of experience in a public hospital for example.

Doctor in a rural district

However, you understand that the requirements are really different which means that moving between sectors is not very easy.

Doctor in a rural district

At present, it's difficult to find the job one wants. So I would advice to take the first job he finds, even when it doesn't pay well and leave when he finds something that pays better.

Nurse in Kigali

When you finish school, you haven't got anything, you look for any job, and so if you find someone who picks you up, who puts you in desolate area, after school, you learn a lot. But after having gone through the apprenticeship, when you observe you do not evolve anymore, you stagnate; you start to regret staying in the rural areas.

Doctor in a rural district

"Is it easy to leave the rural district?" It's difficult. It's because we don't have sufficient information, we even do not know the people in the city and they do not know the people in the rural districts.

Nurse in a rural district

5.5 Rural versus urban careers

[This section only contains those quotes pertinent to the topic that aren't cited elsewhere.]

It's Syberia!

Doctor in Kigali

(...) I would advice a doctor in the beginning of his career to start his career in the rural areas because the apprentice can learn a lot.

Doctor in a rural district

« What is an acceptable reason to be mutated from the rural to the urban areas ? » There're none. It's a miracle.

(...) because we earn 200 dollars. So it's necessary to have a second job. Experience shows that almost all doctors in Kigali have a second job. In the rural areas, this is not possible because there're no opportunities.

Doctor in a rural district

“What would you need to be motivated to go to the rural areas?” Increase the salary. [another participant] Equipment. Imagine, you're a doctor, you're before a patient, he's dying and you don't have any equipment but you're responsible. [another participant] It's necessary to have the possibility for further training. [another participant] There's also the social side (...) the education of the children; because you're children cannot benefit from the same educational opportunities you've got.

Doctors in a rural district

« Do doctors in the rural areas have a particular reputation in the medical corps? » Yes indeed, we know they make many mistakes, do things in a mediocre way (...)

Doctor in Kigali

In the rural areas, a doctor kills himself (...) You loose all elements that make out a real doctor, you will end up with 25% of what you knew (...)

A doctor in a rural district

5.6 On job attributes

Remuneration

The [private sector] contract offers something better compared with the others.

Doctor in Kigali

In the private sector, the salary depends on the employer and the money earned. There are those who say 'I will pay you according the money that will enter'.

Auxiliary worker in Kigali

There's a tendency for a doctor who works in a private clinic for example to earn according to effort, which is contrary to what happens in the public sector.

Doctor in a rural district

In the faith-based sector they try to follow the salary bands of the public sector in order not to create dissatisfaction and jealousy amongst the personnel.

Nurse in Kigali

(...) but it also depends on seniority and quotation, so gradually, the salary increases in the public sector.

Nurse in Kigali

In the public sector, it is encouraged to work in the rural districts and you receive a more important premium compared to those working in the city.

Nurse in Kigali

There is the training, medical care, annual salary increase. The most important advantage is the medical care; we only pay 15% of the bill, even of the drugs. This only concerns the public sector.

Nurse in Kigali

In the private sector, something interesting is that medical care is reimbursed for 100%.

Nurse in Kigali

In the private sector, extra hours are normally compensated.

Auxiliary worker in Kigali

Faith-based health centres, as well as public health centres, do not compensate for extra hours.

Auxiliary worker in Kigali

(...) in the urban centres, there's the duty premium, which you do not find in the rural districts.

Nurse in a rural district

It does exist but is not much. On top of the base salary of 33,800 FRW, there's the housing premium of 25,000 FRW.

Doctor in Kigali

With the decentralisation in Rwanda, there are many managers of the health centre, there's a representative of the State, but there's also the representatives of the population, the health committee. Depending on available income, the health committee can decide, for example, to pay the rent of that health worker, or for example, give him a premium of 10,000 FRW, or for example give a worker from that department 5,000 FRW per month. All this is on top of the salary. Sometimes, workers with equal qualification do not receive the same bonus.

Auxiliary worker in Kigali

(...) ten years can pass without receiving the seniority premium. And sometimes, when you're lucky, you can have this premium and those with incomplete files do not receive this premium.

Auxiliary worker in Kigali

I never had something on top of my salary at the end of the month but the others with whom I work in the faith-based health centre do receive 3% on top of the base salary. In sum, sometimes this premium changes for some, others do not receive anything anymore, and still for others this

premium is regular. So I ask myself how this is possible if we all have the same qualification?

Auxiliary worker in Kigali

People say it's a negotiation one has to do at the Ministry. Someone can say 'I go to negotiate', and then come back and say, 'I did it'. So those who cannot negotiate stay where they are. I do not know how this functions.

Auxiliary worker in Kigali

'What do you think about the remuneration of health workers?' We don't know anything about it.

Users in a rural district

'If you would make a comparison between salaries of health workers in the private, public and faith-based sector, how would they compare?' How should we know anything about their salaries?

People living with HIV/Aids

There's also a premium for the health workers, based on performance, following realised activities (...)

Nurse in a rural district

We have already said that the salary is insufficient, we work, we sacrifice ourselves, but the salary is really meagre.

Auxiliary worker in a rural district

That's a generalised problem: the entire medical sector complains about the salary. Not considering ourselves who are least qualified, even the doctors say they've got a meagre salary.

Auxiliary worker in a rural district

There's no material compensation. That's what missing; it's really not enough.

Doctor in Kigali

In the 1990's, being a nurse was a good business, it was a good employment, there were no problems, and there was a good salary to solve all basic problems. Today in the health centre, there are nurses who ask themselves why they are there, they flee the health centre when the patients are there and start complaining that they left home without leaving food for the kids.

Auxiliary worker in Kigali

It takes a long time to become a doctor, and once being one, we feel that we earn not proportionally to the time we spent studying. We have friends, lawyers, economists, and others and when we talk with them, to hear what they earn, we find that they work little to earn much.

Doctor in a rural district

This doctor needs to live, to ensure his family to live, if we want him to deliver a good service, he needs to have a good salary so that when he treats 10 persons, these persons are treated well.

Person living with HIV/Aids

It's true that the civil servants are badly paid, but for certain key sectors, such as health and education, the salaries should be increased.

User in Kigali

(...) a general practitioner wants to specialise in order to earn a lot of money.

Doctor in Kigali

The ambitions of the young are not those of the elder. The difference is that the young are looking for knowledge, but me [who is older], I've got my career, I'm interested in material compensation only, which I will pass on to my children and my family.

Doctor in Kigali

(...) the service that pays best is public health. They are better paid not to work. For example those who are in Aids.

Doctor in Kigali

Once in the private sector or in an NGO, he'll earn a lot of money.

Nurse in Kigali

There's the public sector in which there are projects, they pay better.

Doctor in Kigali

At the CHU [the University Hospital] they have a transport and housing premium, but notwithstanding, after having acquired experience in these hospitals, young nurses leave for NGOs who pay better.

Nurse in Kigali

In the end, after having done some clinical work, when one needs money, one can look for where to go, the private sector, NGOs which pay better.

Doctor in a rural district

Stability

What's important is the stability of employment, one has more security [in the public sector] even if one is not paid as good as in the other sectors, but one is stable. I know I'm going to work till the end of my life.

Nurse in Kigali

It's not that I don't want the money but I also think about stability; perhaps I'm going to earn that money during one year, but perhaps, afterwards, I'll be unemployed for three or four months, without salary.

Doctor in Kigali

It's true we've been talking about salary and other problems in the public sector, but it's not at all the same as with those Americans who are here for a determined period to leave afterwards and who can chase you at any time. Then it's better to earn a small but regular sum of money.

Auxiliary worker in Kigali

In private health centres, one never signs a contract. You just draw up a convention and when it's necessary, he fires you, but as long as you work well, he keeps you.

Auxiliary worker in Kigali

In the private sector, there's no job stability. Often there are some events and you risk losing your job or when you don't agree with your employer's point of view.

Nurse in Kigali

I'm working in a public health centre but I hear that the private sector functions well, that they welcome the patients adequately, but I think this is because their health workers are always distressed and tell themselves that when they do not work well, they risk being sacked each moment.

Auxiliary worker in a rural district

5.7 About training and education while employed

(...) the advantage of where I work is that they pay my training.

Doctor in Kigali

An advantage of the public sector is that one receives training.

Auxiliary worker in a rural district

If we had the choice between training and salary increase, we'd choose training.

Nurse in Kigali

I would advise him to go into the public sector because you find many specialists and many patients. These elements are important for a beginner who needs experience, practical training.

Nurse in Kigali

Mainly highly graded health workers receive training.

Nurse in a rural district

Our knowledge is not sufficient anymore. It would be great if we could receive training like the others, but the training that is being organised is not for our level of qualification.

Auxiliary worker in a rural district

In our health centre, we've got one nurse - A2 qualification. When she's on training, I'm all alone to do everything without having the proper qualification. I do it, but it's really a problem but when

I complain, they say it's not important: they are against training us, but in their absence we do everything.

Auxiliary worker in a rural district

A general practitioner wants to specialise (...)

Doctor in Kigali

A specialisation is generally obtained in the public sector; it's far more difficult to specialise in the private sector.

Doctor in Kigali

We try to work during the day and study at night; this isn't easy in the rural areas because there's no university. That's an advantage of working in the city.

Nurse in Kigali

There's a problem with nurses in the city working and studying at the same time; when they have exams, they do only a quarter of what they're supposed to do at work.

User in Kigali

You can't compare the faith-based with the public sector, for example concerning training; in certain faith-based hospitals, they have partnerships, there's specialists coming over and staying a month, two months in the hospital and then you receive training.

Doctor in a rural district

We in the private sector, in the pharmacies, in wholesale, we lack continuous training.

Pharmacist

I would like to say that there's no training for pharmacists available.

Pharmacist

5.8 Human resources and health care quality

(...) there are health centres where the auxiliary health worker is head of the health centre, which leads to a problem of quality of health care (...)

Doctor in Kigali

I have carried out supervision in Gakoma [rural area] and have seen cases such as in the textbook. I asked myself who treated there? Are children treating here? Little nurses become big doctors!

Doctor in Kigali

The low salary causes problems to the health workers and explains why they work badly; for example they took some credit somewhere and are stressed because of the debt and consequently work badly.

Auxiliary worker in Kigali

(...) he has consulted me in a hurry. He examined my glasses to check whether they were still adapted and when I had to look at the small and big letters of the alphabet and hesitated he said: "Please Miss, hurry up, tell me what you see. I'm in a hurry and have another appointment." After the consultation, I received an invoice of 5,000 FRW and I asked myself why I had lost my 5,000 FRW. It was as if I had lost them on my way to the hospital.

User in Kigali

(...) nurses working in the rural areas are not satisfied; they insult the patients (...) Doctors working in the rural areas become bitter to the point they don't take hitchhiking patients, and all that because they're blocked in the rural areas.

User in Kigali

5.9 Welcome, attitude and waiting time

Receiving patients

Doing their work well means saying hello to the patients, apologise for delays, treat first who comes first and not their social relations before all the others.

User in a rural district

The reception of patients is a serious problem in the health centres.

Auxiliary worker in Kigali

In our health centre, we believe we're well received.

User in a rural district

Another problem is that patients have to pay before being treated.

Auxiliary worker in Kigali

It's really shameful. There should be a service to receive urgencies and a separate one for all the other patients.

User in Kigali

They distinguish between patients based on whom they know. If you have a sick child for example and you need to do a test, it's much easier if you know someone, even if it's a workman at the health service.

Person living with HIV/Aids

In the rural areas it's much worse. They loathe the patients because often the people in the rural areas don't wash themselves.

Person living with HIV/Aids

It's true that health workers have lots to do but it would be better if they could talk nicely and improve the reception of patients.

User in a rural district

In the private sector, they treat patients rightly. From the moment you arrive, they ask what they can do for you, they show you where to sit, you can watch the television while waiting for the doctor, but in the public health centres, it's different, they ask you to wake up early and fetch a number. And sometimes they know who is going to come and they do not distribute the first numbers. You can arrive first and have number 10. (...) In the public sector, the doctor works well, but the nurse can insult you in a way that you say to yourself "If I had another place to go to, I wouldn't come here."

Person living with HIV/Aids

In the public sector, the health workers can receive badly the patients because they know there are no consequences, but in the private sector most often the employer is there and knows how things are done.

Auxiliary worker in Kigali

To receive the patients well, you need sufficient and capable personnel. The faith-based sector receives many grants and aid from NGOs and consequently they have enough personnel and equipment, whereas in a public health centre (...) most often they lack personnel and equipment. People don't like to go to public health centres because they have to do a lot with limited personnel and they do not have time to take care of the patients.

User in a rural district

Of course they're expensive, but it's the reception they offer that attracts patients.

User in a rural district

Sometimes patients think badly about health care personnel, also when this is not justified, for example there's a patient who wants to be seen directly while there are other urgencies.

Auxiliary worker in Kigali

And when the patient arrives he says to himself "Probably that health worker isn't even capable of treating me well". When he sees that moreover the health worker is a woman, he says to himself that that person cannot be a health worker.

Auxiliary worker in Kigali

When a health worker receives badly a patient, that patient will not return to the health centre.

User in a rural district

A bad reception of patients can be the cause of the low frequency of use of the health centre.

Nurse in a rural district

Going to the pharmacies to get treatment is the consequence of a bad reception in the health centres.

User in Kigali

There are patients who are annoying, who can push you to speak badly even if you didn't have the intention to do so. He can even go as far as inventing stories, such as say for example that you've received him badly.

Auxiliary worker in a rural district

Attitude towards patients

Today, health workers only seek money; when you consult, they look at you as if you were not together and say "Speak fast, I'm going."

Person living with HIV/Aids

We haven't got the time to let the patients explain. We consult quickly in order to see other patients.

Nurse in a rural district

People love to go to the private sector because the health personnel speak kindly (...) They treat few patients and take time to speak at length with them; consequently, when the patients leave the health centre, they are very happy.

Auxiliary worker in Kigali

'Is the attitude of health workers towards patients comparable across sectors?' Health workers in the faith-based sector are more committed to their work compared to those in the public sector.

Auxiliary worker in a rural district

Moreover, health workers insult patients who are for example dirty (...) They act in a wrong way to correct patients.

Auxiliary worker in Kigali

Since the training on quality assurance there's improvement in the attitude of health workers.

Auxiliary worker in Kigali

(...) nurses working in the rural areas are not satisfied; they insult the patients.

User in Kigali

(...) and if you dear saying you feel badly, they react angrily which makes you even sicker.

User in Kigali

When a nurse doesn't interact rightly with patients, community health counsellors can take action (...) they can decide to fire him if he's impossible.

User in Kigali

Waiting time

In the public hospital, there's quite a lot of administration to do, papers to collect left and right and to see a doctor, it takes a lot of time.

Auxiliary worker in Kigali

In the faith-based sector, they've got more personnel and are not as stretched as in the public sector.

Nurse in a rural district

People love to go to the private sector (...) they can rapidly see the doctor.

Auxiliary worker in Kigali

Since there's a lot of health centres in Kigali, private, public, patients choose where they want to go. A patient will not sit in the queue of a public health centre that receives 80 patients when he knows that he has to wait only two minutes if he goes to a private facility.

Auxiliary worker in Kigali

And they've put me on this bench, I was really touched, nobody took care of me. Since then I say to myself I'll take the same drug when I fall ill in order not to have to return to that place.

User in Kigali

I'm member of a mutual health insurance. Lastly when I went to the health centre, honestly, the waiting time was unbearable. You have to queue at the reception to obtain your file, you have to do another one at the level of the service of classification, then you have to queue to pay your co-payment, then you wait in the pharmacy and possibly in the laboratory. I prefer paying my drugs 500 FRW instead of waiting two hours and get them at 300 FRW.

User in Kigali

5.10 About working hours

Contractual issues

We start at 7 am and finish at 4 pm.

Auxiliary worker in Kigali

8 hours per day and 5 days per week in the public sector. That makes 40 hours per week.

Nurse in Kigali

I do not know whether there's a hospital that regulates the programme or timetable of a doctor. I think it's individual. If I take my example in a rural hospital, during mornings I take two hours to visit hospitalised patients, then I consult about 20 patients, which also takes more or less 2 hours and in the afternoon, I read.

Doctor in a rural district

The majority of doctors are bosses and clearly, when you're the boss, you organise yourself.

Nurse in a rural district

In pharmacies, there are agents and owners. For agents, working hours are respected, 40 hours per week. For owners, it depends, you observe when clients come, and you're not going to close the pharmacy when people come back from the hospital at 5 pm.

Pharmacist

(...) at the reception they tell you that the doctor will be working from 2 pm to 4 pm. We do not know whether these are the hours that are required by the State or whether they themselves determine them.

Person living with HIV/Aids

Workload

We always work longer than the planned timetable, it's a vocation; you cannot leave a patient because it's time to go.

Nurse in Kigali

I cannot close my door while there are patients outside (...) We sacrifice ourselves, but nobody sees it.

Auxiliary worker in Kigali

The nurses' workload is often too heavy.

Person living with HIV/Aids

The problem in the majority of public health centres is the heavy workload (...)

User in a rural district

(...) they even continue after working hours depending on the number of patients in the health centre.

User in a rural district

'What determines your workload?' It's the clients that determine the rhythm of work. When there are many, you are obliged to work hard. When there are no clients, you sit down and receive the one that comes.

Pharmacist

In the private sector, extra hours are normally remunerated.

Auxiliary worker in Kigali

Faith-based and public health centre do not remunerate extra hours.

Auxiliary worker in Kigali

In a public health centre, the head of the centre may ask a nurse to stay some extra hours, which he promises to reward (...)

Nurse in Kigali

That's the reason why they work badly; they even haven't got the time to eat.

Person living with HIV/Aids

(...) but it's frustrating to see somebody leave without having been treated.

Nurse in a rural district

Shirking

"What determines the pace of your work?" We schedule our activities in function of the number of patients in the health centre.

Nurse in a rural district

There are many who act as if they work.

Doctor in Kigali

It's possible that someone is chatting while patients wait outside.

Auxiliary worker in a rural district

When you go to a health centre, there're some health workers that telephone their friends while patients wait. These attitudes cause discontent with patients, makes people leave and drives them to pharmacies, since when they visit health centres, they feel neglected.

User in a rural district

In the faith-based sector, health workers are continuously monitored. It's impossible to have some time to waist.

User in a rural district

The private and public sector are very different. In the private sector you're received directly after you've arrived, but in the public sector (...) you wait an hour while they are occupied with their personal activities.

User in Kigali

"(...) or you find the health workers reading a book while you visit a health centre?" No, this doesn't exist anymore. It happened before, but now, they fear the health community workers.

User in a rural district

If a doctor [in the public sector] is not allowed by the Ministry of Health to take up a job [in the NGO sector] where he would earn 1,000 USD, will he work? (rhetorical question)

Doctor in Kigali

Absenteeism

The patient gets up early and arrives at the hospital CHK at 8h00 – 9h00 and the doctor arrives at 11h00 (...)

User in Kigali

(...) that doctors respect less well the working hours compared to other services, in other words are more absent during working hours.

Doctor in a rural district

There where I go, you always find a nurse, independent of the hour at which you arrive, even if you arrive at two o'clock in the morning.

User in Kigali

I think the problem is that it is rather difficult to organise the labour schedule of the doctor. If you are for example alone in a hospital, you're supposed to be there day and night. This is impossible for a human body. This means that you're in the hospital when you're not tired and that you leave when you're tired. By consequence, you will not necessarily be there during all working hours, while you'll be there outside working hours. The lack of definition of working hours, non-working hours and recovery hours, makes it difficult to make a sound judgement (...)

Doctor in a rural district

To complete, suppose that a doctor goes through a tough night till daybreak and that he's supposed to be consulting in the morning; being very tired, it's understandable that the doctor will be too late in the consultation. Somebody who's looking for him at 8h00 will not find him and think he's absent.

Doctor in a rural district

"And why are they so often absent?" Maybe he went to read his medical books, maybe he has a second job, maybe he's consulting elsewhere, teaching or administering training somewhere.

Doctor in a rural district

The health committees give these performance bonuses; if someone is absent, the bonus is stopped. Donors also give bonuses; if someone comes too late three times in a month, the bonus is stopped.

Auxiliary worker in Kigali

Mostly, the private sector [doctor] is less absent than the public sector [doctor].

Doctor in a rural district

There's health centres that are remote, (...) there, the personnel auto-manages itself. [reply by another participant] No, they do not auto-manage themselves, you can go there and find no one to receive you.

User in a rural district

The second job

I think it's outside your job; the employer is not informed (...) it's not official.

Nurse in Kigali

I don't know whether it's allowed or not.

Doctor in a rural district

I work in the private sector. In my contract, it's not allowed.

Nurse in Kigali

If you're in the public sector and you finish your job at 3h00 pm, you're not constrained to work in the private sector (...)

Nurse in Kigali

Today, if you want to do something alongside, you have to leave the public sector (...)

Nurse in a rural district

"Why don't pharmacist often have got a second job?" Because it's prohibited; they who do it, hide it.

Pharmacist

Experience shows that almost all doctors in Kigali have a second job.

Doctor in a rural district

Each time he leaves a place without having seen them [the patients], he gives an appointment at the health centre he goes next.

Person living with HIV/Aids

The advantage of the private sector clinics, is to have a doctor that works in a public hospital and who also works in a private clinic; if I'm ill, I get to know the hours he works [in the private sector] in order not to lose too much time (...)

Doctor in a rural district

Some like to have something extra, during daytime, they work at one place, and in the evening they work elsewhere; this isn't possible in the rural areas.

Nurse in Kigali

In the rural area this [having a second job in the medical sector] is not possible because there are no opportunities.

Doctor in a rural district

But few nurses administer health care only; most of them have a pharmacy alongside.

Nurse in Kigali

(...) during the day, she worked in a public health centre, and during the night, she was on duty in a private clinic (...)

Auxiliary worker in Kigali

I have a permanent job in the clinic of a private enterprise, but after 3h30 pm, I go to the public hospital in the city (...)

Doctor in a rural district

I can have a second job, such as a shop, without being obliged being there since I can recruit someone else.

Doctor in a rural district

(...) our workload doesn't enable us to have a second job. If you need to have a second job, it's necessary to find a collaborator who will be in charge of this second job and you can be less concerned.

Doctor in a rural district

Theoretically it's not possible, but in practice, the pharmacist can own a pharmacy, put someone else in it and in the meantime do something else.

Pharmacist

In the rural areas, after working hours, we can go cultivate something; [other participant], or invest in a shop and put someone in it; [other participant] do some business for example; [other participant] raise some cattle and sell it on the market; [other participant] for those that have a driving license, they can look for a job somewhere else; [other participant] sell some drugs in a private pharmacy.

Nurses in a rural district

Administering health care [in the pharmacy] is not permitted but it happens.

Nurse in a rural district

It's difficult to have a second job (...) I'll give you an example. When we finish working at night, we're so tired that it is difficult to work; even if you'd like to study, I do not know whether it's possible to memorize anything.

Auxiliary worker in Kigali

Given the workload, the hours it takes, even reading the newspaper or listening to the radio becomes difficult.

Doctor in a rural district

It's allowed [for nurses to open a private health centre] but the financial means to start are difficult to obtain. There're also certain conditions that are difficult to meet. [other participant]

Conditions such as professional experience, equipment, identify and present the personnel that will work there. That's why we work illegally.

Nurses in a rural district

The financial means are limited; it's difficult to set up a second job.

Auxiliary worker in Kigali

People are very poor [in the rural areas]; if a family cannot afford quinine treatment, it's certain it will not address itself to a private health centre.

Doctor in a rural district

(...) we do it because our salary does not allow us to survive; that's why we look for some extra money, but it's difficult.

Nurse in Kigali

(...) their salary should be increased in order that, when a doctor goes to work (...) he doesn't go to work some hours and then goes elsewhere to earn some more.

User in Kigali

It's a necessity, given the fragile financial situation of the Rwandese doctor.

Doctor in a rural district

(...) but it's difficult. Moreover, we're tired all the time and we do not work well anymore.

Nurse in Kigali

He can be intelligent; but because of being so tired, he can prescribe drugs thinking about another patient who perhaps has another illness.

Person living with HIV/Aids

(...) all of them [doctors in Kigali] having a second job and who take some time off their principal job.

Doctor in a rural district

(...) when a doctor has a second job, there's embezzlement of patients; he can embezzle patients at the level of the consultation, the laboratory or the pharmacy.

Doctor in a rural district

In the public hospitals there are doctors who do not treat patients well and who ask to come and see them in their private clinic. They try to demonstrate that nothing functions well in the public sector (...)

Person living with HIV/Aids

I know a woman who was with Doctor [x], a private doctor who also worked at the public hospital CHK. After the delivery, he took the woman to his private clinic to ensure the follow-up because he hadn't faith in the follow-up in CHK.

User in Kigali

(...) you go and do the test and they say the results will be available in two months; but they say that if you go to Biolab, you can have them the next day. (...) And when you go to Biolab, you find the same person that has sent you there.

Person living with HIV/Aids

5.11 Technical capacities

We're not at the level where we could say that we carry out our job totally accurate.

Auxiliary worker in Kigali

Our knowledge is not sufficient (...) The training that is administered does not arrive at our level.

Auxiliary worker in a rural district

In our health centre there's only one A2 nurse. When she leaves for training, I remain alone and do everything without being properly educated. I do it but it's really a problem (...)

Auxiliary worker in a rural district

We in the private pharmacies lack training which would help us do better our daily activities (...)

Pharmacist

(...) there're many new drugs, the pharmacy evolves, but we keep on selling drugs only.

Pharmacist

Take HIV/Aids for example; the information we have is the information we obtained ourselves, through the internet (...)

Pharmacist

It's important health workers are trained to receive and treat HIV+ patients;

Person living with HIV/Aids

We think technical knowledge needs to be improved because at the level of the public health centre, there's no doctor. If there's a problem, we prefer going to the hospital. It would help the population much if the nurses could continue their studies and become doctors.

User in a rural district

I think everybody needs extra training. Workers for example do not know how to carry patients (...) Due to lack of personnel in the health centre, workers for example manage the pharmacy. They touch the tablets with their bare hands (...)

User in Kigali

5.12 About the impact of HIV/Aids

Increased workload

"How does the Aids epidemic affect your work?" It negatively impacts on our work since it adds much work, many consultations, cases to follow-up, laboratory tests to carry out, many complications to manage. It adds work at all levels.

Doctor in a rural district

The [health workers'] workload has increased.

Person living with HIV/Aids

The personnel have remained the same but now we have to test pregnant women (...) administer ARVs to PLWHA. We're very much stretched.

Doctor in Kigali

The diagnosis has become much more complicated.

Doctor in a rural district

At the level of virology, biology, clinical training, it's like they only gave us some basic information in order to know something more than the population in general. After only two weeks of training, we have to be able to prescribe ARVs, follow-up the patients, prescribe laboratory tests and we received the training only once. Our knowledge really is highly insufficient.

Doctor in a rural district

About being exposed to infection by the HIV virus

We're too exposed. We can be contaminated. For example health workers who sew can prick themselves, we can infect ourselves by taking blood, etc. We are too exposed because we're in direct contact with the patients, the PLWHA.

Nurse in Kigali

There's really a big risk, just recently an important number of health care personnel has finished tuberculosis treatment; members of the personnel are often contaminated, but they can be cured and afterwards they change service.

Auxiliary worker in Kigali

(...) we're really overstretched, there're two patients per bed, some of them cough and you have to take care of them; that's why the nurses are really exposed to tuberculosis.

Nurse in Kigali

"How can you be infected in your daily work?" Through delivery, we cannot be sure that we will not be infected, even if we wear gloves. So we can be infected through contact with blood, but it's not frequent.

Auxiliary worker in Kigali

"Do you know how to prevent being infected?" People that are trained in counselling know what to do in case of an accident. But not everybody has received this training.

Nurse in a rural district

"Are there protocols on how to decrease the risk at infection on the job?" Yes, there are protocols.

Doctor in Kigali

It's not written down. We only had some training.

Auxiliary worker in Kigali

No, there's no protocol on how to prevent infection on the work floor;

Auxiliary worker in a rural district

We know the protocol, but it's not followed.

Nurse in a rural district

For example if you work in a poor hospital and you need to perform surgery, he [the patient] cannot always afford two pairs of gloves, if you need to do a delivery, you do not have the gloves with the long sleeves, you only have the short gloves (...) often we do not find the maternity boots (...)

Doctor in a rural district

The protocols are available but we do the opposite: if you are used to taking blood without gloves, it's faster and more efficient.

Doctor in Kigali

There's nothing else than the gloves; we even don't have masks.

Auxiliary worker in Kigali

"Why is the protocol not applied?" Sometimes the necessary prevention material is not available and sometimes it's a question of time. If a woman is about to deliver, you haven't got sufficient time and you deliver without wearing the necessary material. Sometimes it's negligence of the personnel.

Nurse in a rural district

We have to apply prevention measures for all patients because we do not know whether the patient is infected with HIV or not. Moreover, there are many contagious illnesses, so we have to be prudent in any case.

Nurse in Kigali

When we share tasks at the health centre, some refuse to work where the risks of infection is highest, namely at the department of maternity and surgery (...) not everybody can work there where the risk is almost visible (...)

Doctor in a rural district

The Ministry of Health should think about the people working in the health centres and find them some life insurance.

Auxiliary worker in a rural district

"What happens when you're infected on the job?" They do not accept that you have been accepted on the job.

Auxiliary worker in a rural district

Once it happens, you're supposed to take the patient's blood to see whether he's ill and you will examine your blood also and begin the treatment. After three months, your blood is tested again.

Nurse in Kigali

Post accident prophylaxis

It happened where I work. We gave emergency care, cleaned with water and soap; we test the blood of the patient to see whether he's ill and transfer the health worker to a hospital to receive ARVs during one month. We also test the health worker to know whether he was not initially ill.

Nurse in a rural district

At this moment, there're many health workers receiving ARVs following infection on the work floor.

Doctor in a rural district

(...) if you have an accident, you're cleaned with water and soap and you're administered post-accident prophylaxis. But I think it's only in Kigali; elsewhere, nothing has changed.

Auxiliary worker in Kigali

When you prick yourself, you clean; that's all and you wait for God to protect you.

Nurse in a rural district

They can possibly accept that you were contaminated at the job, but they cannot do something special for you.

Auxiliary worker in a rural district

Health worker attitudes and clinical acts in the face of HIV/Aids

Some told you 'You, you've got Aids, why do you come to get treatment when you're going to die?'

Person living with HIV/Aids

I've got a 12-year-old child infected with HIV (...) The last time I took him to test CD4 and treat zona. We came across a social agent, who said 'Why has this child only 25 kg?' and he added 'A child who has HIV at this age cannot get older than 15 years'. He said it in public, there where one weighs the patients. Since then, my child cannot go to that health centre without me because of this social agent.

Person living with HIV/Aids

And when I went back to treat pneumonia they started saying 'This woman is still alive?'

Person living with HIV/Aids

There was a doctor who said to a child 'These people are already dead, but what are they looking for here?'

Person living with HIV/Aids

Nurses thus get disgusted with the patients because they come in an advanced stadium with opportunistic infections such as tuberculosis, skin diseases (...) By consequence, they will receive bad treatment.

Nurse in Kigali

"If you suspect or know some patient to be HIV+, does it change your behaviour when he comes to you to seek treatment?" Yes, it changes in an important way. There're measures the health worker takes, saying to himself that when he will administer care, he cannot be too prudent. Sometimes a list is elaborated of auxiliary workers to sequentially treat patients of whom it has been observed that the nurses avoid them.

Auxiliary worker in Kigali

"Are there some interventions that you would not administer?" No, no. For important surgery, people living with Aids have characteristic infections, I say to myself it's sure he's got Aids. In that case it not worth to do the necessary; what one should do for a normal patient.

Doctor in Kigali

(...) but for example a woman who wants surgery for reasons of infertility, I informed the gynaecologist because I said to myself, she's got Aids and it's important to tell.

Doctor in Kigali

Once in a hospital department (...) they do a HIV test on the patient, even if the test is positive, he's treated like the other patients.

User in Kigali

A doctor who receives a woman with a bleeding vein in the uterus, most often, what comes to mind is to safe, and protection comes afterwards.

Doctor in a rural district

"Don't you know any case where the health care personnel was hesitant to treat because they knew the status of the patient?" No, when one has to treat, one treats, there's no hesitation.

User in a rural district

We really take care because a HIV+ patient is not a patient like the others; we protect ourselves with gloves.

Auxiliary worker in Kigali

I'll tell you something, when I was at the hospital of [x] for the first time, they only had short gloves, so, with these gloves and without knowing the status, I have refused all deliveries till they

brought me long gloves. [another participant] What you say is not true. [first participant] You can go and ask, I went to fetch these gloves before continuing. If HIV would not exist, I would not react in this way.

Doctor in a rural district

Even when seronegative, I cannot sew without gloves.

Doctor in a rural district

There's another change, the notion of risk, before, we could touch blood, but at this moment, we always protect ourselves.

Nurse in a rural district

When you are hurt for example at your finger, you're obliged to get someone else to help him.

Nurse in a rural district

"If you know someone is HIV+ or you have a strong suspicion, and you don't have the means, it appears to be human to take other precautions, that one changes behaviour?" Certainly, yes. If for example you need to do a delivery with your hands without gloves, I cannot do it when I know the woman is seropositive. [another participant] And when she bleeds? [first participant] Seropositive, I cannot do it, bleeding or not, I cannot. [another participant] And you let her die? [first participant] In any case, I cannot let myself die to save another life. [another participant] But that's against deontology? [first participant] It's not against deontology. All work that kills, you have the right to refuse. [another participant] What you say, I think it's wrong and it's not what you do. You act humanly, you will give more to the patient, you've got a bigger tendency to save. [another participant] To be concrete, who already received a case knowing the status and touch the blood like that? [follows an incomprehensible discussion with diverging opinions]

Doctors in a rural district

In the past, before the training on HIV, someone who was suspected to be HIV positive was abandoned to himself, he was not treated, but that actually does not exist anymore, with the training, we help them, we treat them.

Nurse in a rural district

(...) but today, a health worker to deal with PLWHA is recruited. Each health centre has an agent responsible to deal with PLWHA; and with all these NGOs, sometimes a doctor is recruited.

Person living with HIV/Aids

5.13 Performance evaluation

Systems of performance evaluation

"Do you know how your performance is evaluated?" There's no system of supervision.

Doctor in Kigali

We've got an annual evaluation which normally should be send to the Ministry of Health but that has not been regular nor respected.

Nurse in Kigali

Performance evaluation was done using an evaluation framework, but it was of no use because there was a problem of objectivity: who evaluates whom and how?

Nurse in Kigali

I give everybody "very good"; it's subjective, it's sentimental because there're no objective criteria.

Doctor in Kigali

In any case, we work more because we're compelled to stay till our replacement arrives.

Nurse in Kigali

(...) at a certain moment here at the hospital CHK, we suspected embezzlement of drugs by the nurses and support personnel. So we took control measures. Apart from bag-searching at the entrance and exit, a drugs monitoring system (...)

Nurse in Kigali

But you cannot say pharmacists are Saints; they also make mistakes. In fact, what lacks is a service of inspection, but it's underway.

Pharmacist

"How is the personnel monitored?" There're the Bylaws of the health centre. We've done a distinction between posts and attributed tasks to each person; there're also the registers of presence, which are signed, and the reports that are elaborated by the staff of the health centre.

Nurse in a rural district

The Bylaw consists of a number of rules to follow. If a person doesn't respect a rule, you tell him he doesn't respect the Bylaw and you show him the sanctions. If he's done it several times, you apply the sanctions. So the phases are: an oral remark, a written remark and the sanction.

Nurse in a rural district

(...) since there're community health assistants who control the functioning of the health centre, these problems do not exist anymore. Nurses who do not behave well towards patients, community health assistants take decisions for these nurses. Community health workers give permission to recruit a particular nurse, and the way the nurse is recruited, is the same as he can be sacked when he becomes impossible. They have the power to expulse him from the health centre. This is why the health centres function better today.

User in Kigali

"If you accompany a woman for a delivery and you find health workers reading a book?" No it doesn't exist anymore. It happened before, but today, health personnel fears the community

health workers. There's always someone beside them. Even if the nurse goes out to eat, it's not far so that she can be called upon if there's a problem.

User in a rural district

Today, representatives of the population control the functioning of the health centre; if you're absent, even an ordinary citizen can accuse you by saying for example 'I've seen him in that place and he wasn't working'. When the population has a meeting, the one who has seen you or has had a problem will make it public.

Auxiliary worker in Kigali

Sometimes the population nominally accuses personnel of the public hospital in the newspapers.

Auxiliary worker in Kigali

There're 'idea boxes', we write but have the impression problems increase instead of decreasing. I suggest people would speak out on the radio.

Person living with HIV/Aids

What I can say on the health centres is that they're better organised than the hospitals. And at the level of the board of directors of the hospital, I think the population is never represented.

User in Kigali

Hospital personnel speaks to you simply the way it wants; you can't do anything.

User in Kigali

I've worked in the rural areas, there's the mayor who observes it, he speaks to the prefect, the prefect complains to the minister, the Ministry will open an investigation, openly or not, and can ultimately sack you.

Doctor in Kigali

In the public sector, the health workers can receive badly the patients because they know there are no consequences, but in the private sector most often the employer is there and knows how things are done.

Auxiliary worker in Kigali

"Are you evaluated by your clients?" The fidelity of the patients does. The degree to which the patients speak out, the frequency of coming in, asking advice and the day after, coming back to thank you; in fact, that's an evaluation.

Pharmacist

Disciplinary measures and promotion

Here in the hospital CHK, the nurse can commit a professional mistake but there's no law that can punish him.

User in Kigali

There was another woman that has come to deliver and the skull of her baby was cracked, but the nurse who did it was not even stopped. In short, there's no protection of the patient.

User in Kigali

There was a mother who took her ill baby to the hospital asking for drugs and the nurse has said 'Go away, when you baby dies, I will deliver another for you'; the nurse is still at the CHK; unfortunately the baby is dead (...)

User in Kigali

"This means that you can lose your job?" Yes, if you don't work well or in case of lack of discipline.

Doctor in Kigali

Here the regulations are clear, if you're an agent of the State, there's a certain attitude you need to have. If you haven't got these attitudes, most often, there's an administrative way to end your labour contract.

Doctor in a rural district

The health centre committee can take this decision [to sack someone]. It's rare but it happens even if you're employed by the State.

Nurse in a rural district

I've got like the impression there's a system when it really goes very badly, when it's absolutely clear there's a problem, then, something is done, a blame or something else is given.

Doctor in Kigali

A disciplinary mutation is imposed. One is put in another institution. Where there're less advantages, less or no bonus, in the rural areas, etc. One is obliged to leave one's family and to work far away.

Nurse in Kigali

This [the mutation] is applied in case of drunkenness at work, or when one fights, exaggerates in coming too late, but mainly drunkenness or when goods are embezzled from the hospital.

Nurse in Kigali

The disciplinary measures are quite clear. There's a series of sanctions, blames, warnings, mutation, etc.

Doctor in a rural district

Since the order of doctors has been created (...) investigations are undertaken, some doctors are suspended but I don't think a doctor has been prohibited to exercise his profession.

Doctor in a rural district

(...) there's no plan of development for a doctor working in the rural areas; once you're affected to the rural areas, it's as if you're lost in the rural areas. The lack of this career development for the doctor in a rural area means that once you're affected or mutated, it's like a punishment.

Doctor in a rural district

We've got the impression there's no system of promotion; we haven't got the impression people actually progress.

Doctor in Kigali

We're paid like beginners, the State doesn't take into account experience.

Nurse in a rural district

It seems that this evaluation can lead to a promotion.

Nurse in Kigali

If the health committee is willing, if you've worked well, they can take money out of the financial reserves of the health centre and thank you. For example, at the end of each year, I don't know whether it's to thank us, they take us where we want, we eat, we drink and the health committee pays the bill.

Auxiliary worker in Kigali

There's something, there's a motivation; there's the 'quotation'. There're different degrees of quotation, we're quoted but unfortunately, the government doesn't increase our salary.

Nurse in a rural district

"If you work well, what happens?" They add 3% of the base salary at the end of each year; it's only about 400 RWF that is added. Nothing else.

Auxiliary worker in a rural district

For example, when I was head of the health centre and thought we had been productive, sometimes, I said to the health workers of the health centre to go and relax in a tourist centre.

Nurse in a rural district

If someone is productive, one can write him a letter to congratulate him.

Nurse in a rural district

If you compare the public and the faith-based sector, you'll find that there are more problems in the public sector because the health workers know they cannot be sacked easily.

User in a rural district

In the public sector, there's first of all the blame, then the request to explain, up to being put at disposal. But very few people arrive at this stage. Even the request to explain is only given in case of recidivism, three to four times.

Auxiliary worker in a rural district

In the public sector you can be taken care of all the time even when you fall ill for a month, for years. But in the faith-based sector, if they think your illness is a handicap to their production, they can replace you each moment.

Auxiliary worker in a rural district

In the private sector, you're sacked even for a minor mistake, but in the public sector you're sacked only if you're really impossible.

Auxiliary worker in a rural district

(...) there's the health committee, which can meet to solve the problem, and one seeks a way to decrease the performance premium and try to correct him.

Nurse in a rural district

On performance pay

We got the Initiative for Performance (IP) in 2002; before we paid fixed premiums to everybody. The others that came afterwards have organised it so that it motivates the people and that the quality of care is promoted. (...) Now, we see that there's improvement in the motivation of people. Regulations have been elaborated by each health centre and have to be followed. The regulations are such that when they are not followed, part of the premium is withdrawn, which makes that the personnel is accountable because it receives something, it is motivated, feels responsible for the service. We work being conscious of what we have to do. The stability of our personnel is also assured by this premium. This premium is available in the public and faith-based sector but not in the private sector.

Nurse in Kigali

If you have carried out a caesarean section, there's an amount for each caesarean section, so there's a tariff for each activity. Before, we had fixed premiums. Because it was found that the fixed bonuses were considered as salary, they have been transformed to be able to give them in function of the performance in the production of services.

Doctor in Kigali

People have been trained so that this approach can begin.

Auxiliary worker in Kigali

The premium allows treating 5 destitute persons per cell.

User in Kigali

For example, to recuperate those 'out-of-sight' in vaccination campaigns, if you bring in 5 persons, they give you something.

User in Kigali

"What are the criteria followed by the health committee [to distribute the premium received at the level of the health centre]?" Qualification, seniority and the tasks of the health worker. If a health worker has many tasks, he will earn an important part.

Auxiliary worker in a rural district

(...) bonuses have been given to nurses, but it happens that the nurse, head of the health centre, receives 15%, the other nurses 10% and the others 5%.

User in Kigali

(...) we found an increase in vaccination coverage, health care use, maternity and curative consultations.

Doctor in Kigali

A nurse earns on average 16,000 to 20,000 RWF per month on top of the salary.

Doctor in Kigali

They're better received, you find for example the guards who are better organised at any moment, patients are really given consideration (...) but as to quality, technically spoken, there's not yet improvement. "Why not?" Because there's no technical support, no equipment.

Doctor in Kigali

(...) more and more the personnel is complementary; because you know that when you don't work well, if you're absent, if you're too late, if your service is not appreciated, this will decrease the premium that the health centre receives; this makes that the personnel controls each other. Everybody knows that the one that works badly can be sacked and risks being accused by his colleague; this leads to a certain degree of accountability and better productivity.

User in Kigali

(...) there has been an impact both qualitatively as well as quantitatively (...) at the level of the organisation, the satisfaction of the patients, better management of sanitary information, community participation, so at the level of many elements perceived by the community. And at the quantitative level, if one looks at the classical indicators for the health system in this country, Butare and Cyangugu [two districts where the IP has been implemented] are first.

Doctor in a rural district

You're the only doctor to consult. But with the IP, one recruits, and instead of one doctor, you're for example five. (...) So there's an improvement in the labour conditions and you're no longer stretched.

Doctor in a rural area

"Has the quality also increased?" Definitely. (...) "What do you call 'quality'?" For example, there where mothers who lingered at the health centre before the delivery; we counted prenatal deaths before and after the initiative and we have observed that the number has decreased visibly. "And how do you explain this?" (...) Before the premium, there was for example somebody that was not motivated who received patients not as quickly and not as efficiently as someone who is motivated. In vaccination for example, before the premium we asked ourselves why we had to fetch children that were not vaccinated (...) but since the premium has come, we are obliged to go and search this child that has not been vaccinated because we know that this activity is paid for. This is how the quality has increased, as well as the number of cases.

Nurse in a rural district

"Is it a good initiative?" It's a good initiative, but in order to be able to acknowledge performance, it's not only in financial terms, I think that people also want an advancement in their career, they want promotion.

Doctor in Kigali

But what often happens is that after a while, there's the risk of routine, to produce a lot of activities that are not necessarily of good quality; something that can make the Initiative for Performance perpetual is a constant monitoring system.

Doctor in a rural district

There's inequality in the distribution of the premium, even if we do the same tasks and have the same diploma. Another problem is that people of our level don't have access to training.

Auxiliary worker in Kigali

The more one pays, the more patients are listed, but the quality decreases. One does a lot but in a manner which is not correct.

Doctor in Kigali

I'm against these premiums in the medical career. The medical personnel should have a decent salary, in line with the dignity of their professional status.

User in Kigali

(...) This premium is dependent on the amount of money they bring in the till; this has as a consequence that the person who brings in 100 RFR and the one that brings in 1,000 RFR are not rewarded in the same way; the one that pays little is asked to wait or to come back; it's business, they look for money.

User in Kigali

Even if you increase the salary, they will later say it's too low. There's the one that earns 5,000 RFR and works well and there's the other that earns 50,000 RFR and works badly if he hasn't got an extra 50,000 RFR on top. In short, like all other civil servants in the Ministries, there're those that work and those that don't work.

User in Kigali

5.14 About inappropriate activities: corruption, embezzlement and the like

Corruption

"Aren't there health workers who ask patients some money which is not justified or to get access to treatment?" No, that's corruption.

Doctor in Kigali

"Does it happen that a doctor asks a patient money when he's in the consultation room?" The doctor doesn't touch money or drugs. The doctor only consults and performs surgery.

Nurse in a rural district

There's always people that like to be received well (...) I've seen a patient give 1,000 RFR to a nurse; the nurse was frightened, which shows that it isn't something frequent. [other participant] That's not corruption; it's just a token of gratitude.

User in Kigali

When the patients pay, nurses keep the money (...)

Doctor in Kigali

(...) there has been an agreement between the patient and the nurse; the patient leaves at night and in the morning the observation is made that the patient left without paying, but he has given some money to a nurse.

Doctor in Kigali

(...) patients paid more than was reported in the register (...) We've found many of those cases.

Auxiliary worker in Kigali

I know one who has been sacked because there was fraud in the payment register.

Auxiliary worker in Kigali

Some nurses picked up the little bills that patients had dropped on the floor to give them to other patients without registering the money that the latter patients gave.

User in Kigali

Some doctors sign medico-legal documents making things up.

Nurse in Kigali

They say that in hospitals in order to get a number [that indicates your place in the queue for the consultation] the patients have to give some money.

Nurse in a rural district

Workers are sometimes involved in corruption to have a number for consultation. They also take money from visitors who want to visit a patient outside visiting hours.

User in Kigali

Embezzlement

"Do some health workers sell drugs from the health centre?" It doesn't happen anymore, it's something of the past. (...) Perhaps in the rural areas, but here in the city, it doesn't happen anymore.

Person living with HIV/Aids

It happened when the health centres received gifts of drugs.

User in a rural district

A medical personnel never sells anything.

User in a rural district

The head of the health centre affirmed me that this theft occurred but that one is not aware of many cases.

Nurse in Kigali

There're those that have a clinic who steal medical material;

Doctor in Kigali

(...) but on the contrary, embezzlement of tweezers, scissors, needles and other small material is very frequent. However, it's also possible that these little materials are lost for example when one forgets to take the tweezers off a placenta or throw it away together with the umbilical cord.

Auxiliary worker in Kigali

"Is it frequent?" Yes. In our health centre a box containing 8 thermometers has disappeared together; there's no nurse who can do this but the theft of small material is really very frequent but you can never know who did it.

Auxiliary worker in Kigali

You hear that the material is lost but you cannot understand how this material can be lost.

Auxiliary worker in a rural district

I don't know how it happens in other places but the theft of material is really very frequent in the hospital (...)

Auxiliary worker in a rural district

The stolen drugs were sold in pharmacies.

Nurse in Kigali

The embezzlement of drugs had become important but now we require that the one that leaves the office shows the replacement what he has left (...)

Auxiliary worker in Kigali

We had the case where nurses embezzled drugs, sold them, took the money of the community and used it for their proper consumption (...)

Doctor in a rural district

What I do know is the theft of drugs of the Red Cross that where sold in the pharmacies.

Person living with HIV/Aids

(...) there was a seropositive nurse – who knew her status (...) she took a big doses of Nevirapine thinking she would decrease her viral load. She has had some problems and that's when we understood she took these drugs. It's exceptional, but it happens.

Nurse in Kigali

The habits of auto-treatment have decreased since RAMA [State health insurance] facilitates access to drugs for nurses and health workers.

Nurse in Kigali

Other inappropriate activities

"Can you tell us something about the inappropriate activities that take place in your health centre?" We don't often observe this kind of activities.

User in a rural district

I've heard that in the hospital CHK there're ghost-doctors, who are on the list but that one never sees in the hospital.

Doctor in Kigali

(...) drunkenness at work, fighting (...)

Nurse in Kigali

(...) it seems that nurses or doctors even assist in the provocation of abortions; it's not allowed but they do it secretly, not in the hospital but privately.

Nurse in Kigali

It also depends on where you work; fraud can occur in public health centres, but in the faith-based or private sector it's far more difficult since the control is much more rigorous (...)

Doctor in a rural district

In the faith-based health centres, there's often food and when you find the social agents distributing this food in a way that is not correct (...)

Person living with HIV/Aids

I will tell you how this happens with ARV: there's one HIV positive patient who doesn't want to go to the health centre and asks another HIV positive patient 'Enrol yourself in two health centres to take ARVs and I will pay you for my cure'.

Person living with HIV/Aids

(...) which means: receive first who got their first and not consult their social relations before anybody else.

User in a rural district

5.15 Special issues on pharmacies and drug shops

[This section only contains those quotes pertinent to the topic that aren't cited elsewhere.]

People [working in a pharmacy] today do consultations and then give some drugs.

A pharmacist

"Do you use some special strategies to attract clients?" The strategies consist in personal knowledge, of each pharmacist, because then clients know that if they go to a certain pharmacist, they get good advice (...)

A pharmacist

Two parties have the responsibility. There are the pharmacists but also the nurses working in the drug shops. They facilitate patients to have some drugs. If ever we would refuse patients this service they would go directly to the doctors (...). But one day it will be necessary that pharmacists take up their responsibility and tell clients that they won't be served if they don't have a prescription.

A pharmacist

(...) some give injections, they put perfusions in a room at the back (...)

A pharmacist

(...) some take blood to test malaria (...)

A pharmacist

"Is stitching done in drug shops?" Yes, it's done as well as putting bandages.

A pharmacist

"Could we say that pharmacists (...) give medical advice?" Of course, they even treat patients.
[other participant] More than half of the patients we receive have been to a pharmacist before.
[other participant] Because they don't want to pay for the consultation they start by buying drugs.

Doctors in Kigali

(...) they say that paying for the consultation and the drugs is too expensive.

A pharmacist

(...) instead of going to a consultation and having to pay for it, it's much easier to go to someone who gives the drugs directly.

A pharmacist

Even at the level of the health centres there's a lack of nurses. If you go to consult you find two nurses and many patients waiting in a queue (...) some patients are send to Kigali, which is yet another problem. And when you see a doctor, you tell him how you would like to treat yourself and he insults you.

A pharmacist

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 is concerned with understanding the labor market choices, motivation and behavior of health workers. It seeks to provide descriptive and analytical information that will ultimately constitute potential input in the design of human resource policy.

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