

## List of Indicators that will be tracked by Clinic Competition and Clinic/Community Monitoring Program

- 1) Number of maternal deaths
- 2) Number of deaths of children under 5
- 3) # of children 12-23 months completing vaccinations by 12 months of age during one month (March 2013)
- 4) # of births which occurred in health facility during one month (March 2013)
- 5) # of pregnant women who completed four antenatal care visits during one month (March 2013)
- 6) Whether fees are charged for maternal and under-five health services
- 7) Nurse absenteeism
- 8) Staff attitude

These eight indicators have been selected to track the impact of the two interventions, community monitoring of maternal and child health clinics and non financial awards for maternal and child health clinics. *These indicators cover both health outcomes tracked during the clinic/community monitoring intervention, and service provision criteria (more specifically in the last three indicators) that will be tracked by the clinic competition.*

In 2010, the Government of Sierra Leone (GoSL) launched an initiative to institute free healthcare for pregnant women, new mothers and children under-five. The policy abolished user fees, while at the same time raising workers' salaries. The two interventions evaluated in this randomized controlled trial target issues that pervade the health care system following the introduction of this policy, such as illegal fee-charging, nurse absenteeism and poor health outcomes. It is such issues that the study aims to track the potential change in as a result of the two interventions, through the eight indicators given above. The first five indicators track the potential change in health outcomes for pregnant women, new mothers and children under-five. Indicator number six will track the implementation of the removal of user fees, and the final two indicators will track potential changes in health care delivery.

Each of these eight main indicators has several further indicators that feed into it. Information on these indicators is gathered in four different surveys (clinic survey, community leader, user feedback and household survey) at the start and end of the interventions. This creates a baseline with which to make conclusions about the change in the eight main indicators as a result of the interventions.

The further indicators given below are the direct indicators that are followed during the two interventions. There are a number of further indirect questions that are asked in order to colour the indicators and provide further understanding. Therefore, this list is not exhaustive.

## 1) Number of Maternal Deaths

The clinic records (clinic registers, ICS tally sheets, monthly ICS report) are requested during the survey and the following indicators are recorded:

- a. Number of people seeking family planning services
- b. Number of pregnant women completing first, second, third antenatal visits
- c. Number of pregnant women completing TT2+
- d. Number of assisted deliveries

This information is triangulated by user recall of information gathered in the user-feedback and household survey including:

- a. Women seeking family planning services
- b. Pregnant women seeking ante/post natal care
- c. Number of assisted deliveries
- d. Maternal deaths in the past 6/12 months

*We appreciate the point about including indicators such as the number of women screened for anemia, and number of women given antimalarial prophylaxis, and will be including these indicators in our endline survey.*

## 2) Number of deaths of children under 5

Again, from the clinic records the following indicators are recorded:

- a. Number of children completing the routine schedule of vaccinations by 1 year old
- b. Number of children completing BCG vaccine, penta-3 vaccine, measles vaccine
- c. Number of diarrheal cases in children under 5
- d. Number of malaria cases in children under 5
- e. Number of outpatients under the age of 5

This is also triangulated using recall information from the user-feedback and household survey including:

- a. Incidences of children seeking health care
- b. Child weight
- c. Child height
- d. Child vaccinations-(BCG, OPV0, 1, 2, 3, Penta1, 2, 3, PCV1, 2, 3, measles, yellow fever)
- e. Under 5 deaths in the past 6/12 months

*The use of an indicator such as 'children correctly treated for fever' is also a possibility and will be taken into consideration during the endline survey. Although there are limitations with*

**Comment [C1]:** Thank you for this comment. We are happy to change the language to 'number of maternal deaths'

**Comment [C2]:** We are happy to include this question in the endline surveys for the users and households

**Comment [jmb3]:** That's great, but I'm not sure how much utility they will have at endline only. Please only include them if there will be value-add

**Comment [C4]:** There should be some value added of having these questions due to the randomization factor. As we have a control group to compare to, we can assess the impact of the interventions on these indicators (even if not measured at baseline).

**Comment [C5]:** Thank you, happy to change this language to 'number of deaths of children under 5'

**Comment [jmb6]:** I assume this means something along the lines of 'number of times over the past 6/12 months that caregivers sought care for children under five at a health facility'

**Comment [C7]:** Yes-this is more clearly phrased in the endline questionnaires through a number of questions

**Comment [jmb8]:** Again, that's great, but I'm not sure how much utility they will have at endline only. Please only include them if there will be value-add

**Comment [C9]:** See above

*measuring such indicators due to confidentiality issues, we are planning an audit verification exercise to audit the register information provided by the clinics. One possibility that we are currently exploring for this audit verification exercise is to compare the self-reported information and clinic registers from consenting individuals on clinic visits/prescribing practices with user feedback. This information could be triangulated with common prescribing practices in order to obtain a picture of quality of treatment for fever in children.*

3) # of children 12-23 months completing vaccinations by 12 months of age during one month (March 2013)

4) # of births which occurred in health facility during one month (March 2013)

5) # of pregnant women who completed four antenatal care visits during one month (March 2013)

6) Whether fees are charged for maternal and under-five health services

Many nuanced questions are asked so as to try and assess the true situation of charges for maternal and under-five health services.

The clinics themselves are asked whether there are charges for services such as:

- a. Registration/records
- b. Consultation
- c. Medication
- d. Laboratory examination
- e. Admission
- f. Penta vaccines
- g. BCG vaccines
- h. Measles vaccine
- i. Polio vaccine
- j. Outpatient (new) OPD
- k. Outpatient (re-attendance)-OPD
- l. Antenatal care
- m. Family planning consultation
- n. Family planning prevention and treatments
- o. Delivery
- p. Delivery materials
- q. Laboratory testing for malaria
- r. Laboratory testing for TB
- s. Injections
- t. Exercise books

**Comment [jmb10]:** Please clarify why only one month's worth of statistics are being used.

**Comment [C11]:** We have used one month's worth of statistics for these indicators to maintain consistency with the INPS (Integrated National Public Services) surveys which were carried out alongside the baseline survey for this evaluation, and serve as a point of comparison for our data. We also used a month's worth of statistics to provide a point of comparison with PHU register data when it comes to carrying out an audit on the information provided by the clinics.

for children under 5, pregnant women, lactating mothers, and everyone else.

This information is triangulated by asking users in both the user feedback and the household survey about the amount they were charged (in cash or in-kind donations) last time they visited the clinic for the list of services given above. The charges are separated into charges for children under 2, pregnant women for delivery and ante/post natal care, and everyone else.

The surveys also ask the clinics certain questions about their knowledge of free medical care policy in order to illuminate any misunderstandings of the policy.

## 7) Nurse absenteeism

The clinics themselves are asked questions on:

- a. The Number of days the clinic was closed in the past month
- b. Opening hours of the clinic
- c. Whether there is someone present at the clinic after hours
- d. When/if different services are offered at the clinic/outreach (e.g. immunization, growth monitoring, treatment of sick children, antenatal care, family planning, treatment of STIs/STDs, wound care, deliveries, HIV/AIDS counseling and testing, health education, postnatal care, nutrition supplementation, pregnancy test, training of nursing aids, community health workers, traditional birth attendants)
- e. Staffing, vacancies
- f. Clinic oversight

This information is triangulated using user recall information from the user feedback and household survey:

- a. Staff absence in last month (during regular hours and outside of hours)
- b. Waiting times

## 8) Staff attitude

Both staff and users are asked about the staff attitude in order to get a full picture of the situation on the ground.

Staff are asked about their satisfaction with the clinic in terms of:

- a. The infrastructure
- b. Resources at the clinic
- c. Salary
- d. Support by community

**Comment [jmb12]:** Are they asked about supervision or training?

**Comment [C13]:** Yes they are. We ask questions on clinic oversight. And in the staff roster, we ask about prior training, as well as ongoing/recent training related to a number of different conditions.

Users are also asked about their satisfaction with the clinic in terms of:

- a. Infrastructure
- b. Cleanliness of the clinic
- c. The care they receive
- d. They rate the attitude of staff

# **Improving Health Service Delivery Through Non-Financial Incentives**

## **Baseline Report**

Innovations for Poverty Action

December 2012

# Acknowledgements

Housed within the Government of Sierra Leone's Decentralization Secretariat (DecSec) and funded by the World Bank's Decentralized Service Delivery Programme, the interventions that IPA are evaluating have been developed in partnership with both the World Bank and DecSec since early 2010. With support and supervision from DecSec, MoHS, and the World Bank, these interventions are being implemented by three non-governmental organizations, the International Rescue Committee, Concern Worldwide and Plan International. The NGOs have played a role in developing the interventions, particularly in the design of the scorecard to be used within community monitoring and the structure of the non-financial award intervention.

The World Bank's Decentralized Service Delivery Programme and Institutional Reform and Capacity Building Project (IRCBP) have provided the majority of the funding for this project so far, channeled through DecSec. In addition to providing approximately funding to the NGOs for implementation of the project, the World Bank has also provided funding for the baseline data collection of this project. In addition to funding provided by the World Bank, the project has funding from the International Growth Centre (IGC) and Namati to partially fund baseline data collection, clinic mapping and piloting activities as well as covering staffing and operating costs following the baseline data collection period. Lastly, the Center for the Study of African Economics (CSAE) at Oxford has provided in-kind resources to the project.

This report was written by Innovations for Poverty Action (IPA). The development of survey instruments, data collection, and analysis were managed by IPA, with technical oversight and support from Oeindrila Dube (NYU), Johannes Haushofer (J-PAL) and Bilal Siddiqi (Oxford University). In-country supervision was provided by Abebual Zerihun (Country Director, IPA), and research assistance from Ali Ahmed, Sarah Dykstra, Caroline Fry and Fatu Conteh.

# Executive summary

This report summarizes the results of the baseline survey of the randomized controlled trial to measure the impact of community monitoring and non-financial incentives on health care clinics. Baseline data was collected in order to match the intervention clinics into triplets to randomize them ensuring that each treatment/control group has clinics with similar characteristics, as well as to obtain comparison data to be able to assess the impact of the intervention.

Several trends were observed from the data collected:

- Under 5 and pregnant women morbidity mortality is reported to be relatively low in the catchment communities
- Almost all of the evaluation clinics offer vaccinations and maternal care
- The coverage for vaccinations for babies is very good, and most women are giving birth in the facility
- There is very little illegal fee charging
- Levels of nurse absenteeism are relatively high (over 10%), although many clinics have staff present out of regular hours, and waiting times are very low
- Staff turnover is not too significant (around 30% a year), but the number of vacancies is high, and levels of training are low
- Users are fairly satisfied with the clinics' performance and staff behavior
- The main problem for users seems to be the lack of drugs and equipment at the clinics
- Patients are not given much information at the clinic, both about their condition and treatment as well as about the functioning (funding etc.) of the clinic
- Staff, on the other hand, did not report such satisfaction with the facilities, although they do report to be fairly satisfied with their jobs.

# Contents

- Acknowledgements..... 2
- Executive summary ..... 3
- Contents ..... 4
- Chapter 1. Introduction ..... 7
  - 1. Interventions..... 8
    - 1.1. Past work in this area ..... 8
    - 1.2. Intervention 1: Non-financial awards ..... 9
    - 1.3. Intervention 2: Community monitoring..... 9
  - 2. Expected Impact..... 10
- Chapter 2. Methodology ..... 11
  - 1. Evaluation Design..... 11
  - 2. Baseline Data Collection ..... 12
- Chapter 3. Results ..... 14
  - 1. Community Questionnaire..... 14
    - 1.1. Location and accessibility..... 14
      - 1.1.1. Location..... 14
      - 1.1.2. Political engagement..... 15
      - 1.1.3. Communication..... 15
      - 1.1.4. Community structure ..... 15

1.1.5.	Clinic accessibility.....	15
1.2.	Water and sanitation .....	16
1.2.1.	Water facilities .....	16
1.2.2.	Waste disposal and toilets .....	16
1.3.	Projects in the village .....	16
2.	Clinic Questionnaire.....	18
2.1.	Clinic opening times .....	18
2.2.	Clinic hygiene .....	18
2.3.	Services .....	19
2.3.1.	Services available .....	19
2.3.3.	Charges.....	20
2.3.4.	Information availability .....	22
2.4.	Clinic resources .....	24
2.4.1.	Clinic infrastructure.....	24
2.4.2.	Equipment.....	24
2.4.3.	Drugs .....	25
2.4.3.1.	Medication .....	25
2.4.3.2.	Vaccinations.....	27
2.4.4.	Medical supplies and bed nets.....	28
2.5.	Records.....	29
2.6.	Staffing and support.....	30
2.7.	Challenges faced .....	32
3.	User Feedback Questionnaire.....	34
3.1.	Political engagement.....	34
3.2.	Household Mortality .....	34
3.3.	Healthcare services .....	34
3.3.1.	Clinic use .....	34
3.3.2.	Medicine and charges .....	35
3.3.3.	Reported problems .....	35
4.	Household Questionnaire .....	37
4.1.	Household resources .....	37
4.2.	Consumption.....	38

4.3.	Water and sanitation .....	39
4.4.	Community engagement and awareness .....	39
4.4.1.	Political engagement.....	39
4.4.2.	Community structure .....	40
4.4.3.	Health awareness.....	41
4.5.	Healthcare.....	43
4.5.1.	Western medicine .....	43
4.5.2.	Traditional medicine .....	44
4.5.3.	Religious assistance.....	44
4.6.	Health episodes.....	44
4.6.1.	Children under 2-vaccines and growth monitoring .....	45
4.6.2.	Childbirth.....	45
4.6.3.	Ante-natal care/Post-natal care.....	46
4.6.4.	Ill/injured.....	46
5.	Summary of treatment and control clinic statistics.....	48
Chapter 4. Conclusion .....		52
Chapter 5. Ongoing Data Collection.....		53
References .....		54

# Chapter 1. Introduction

In many developing countries, the health sector suffers from a severe human resources problem due to staff shortages and absenteeism (Chaudhury, 2006; Rogers, 2006; Banerjee & Duflo, 2005; Banerjee et al., 2004); for instance, Chaudhury (2006) finds average absence rates of 35% among health workers in six developing countries. Sierra Leone's health indicators are among the lowest in the world, and the country's health system is plagued by such chronic worker absenteeism, resulting in part from a lack of accountability between service providers and patients, and the weak incentives health workers face. Alongside a national decentralization program introduced in 2004, the Government of Sierra Leone launched an ambitious initiative in 2010 to institute free healthcare for pregnant women, new mothers and children under-five. The policy abolished user fees, while at the same time raising workers' salaries. However, these reforms occurred without introducing institutional features to improve oversight of health workers or changing underlying incentive systems, and the health sector continues to face such challenges as fee-charging, nurse absenteeism and poor health outcomes.

The GoSL has requested support under the World Bank's Decentralized Services Delivery Project (DSDP) for social accountability activities designed to monitor performance and motivate workers within the free health care initiative. This report gives the results of the baseline survey to a rigorous, scientific investigation of two innovative interventions that aim to address failures within the system, through incentivizing health workers and stimulating demand for health services: (1) yardstick competition among clinics for non-financial awards, and (2) community monitoring using health scorecards and community-clinic interface meetings. Three NGOs are currently implementing the interventions across four rural districts of Sierra Leone, and the impact of both interventions is being evaluated using a randomized controlled trial.

## 1. Interventions

### 1.1. Past work in this area

Recent experiments have highlighted the power of non-financial incentives to reduce absenteeism and improve performance. Most prominently, the Björkman & Svensson (2009) study examining community monitoring in Uganda observed remarkable decreases in under-five mortality in treatment compared to control communities a year later, and significant increases in utilization for general outpatient services. The effectiveness of non-financial incentives was echoed in a second recent study. Ashraf et al (2011) found that a non-financial reward, namely social recognition, was a more powerful performance motivator and more cost-effective than both financial compensation and voluntary contracts.

The natural comparison would be to evaluate non-financial interventions alongside financial incentive schemes aimed at incentivizing attendance and performance at under-performing health centers. However, the evidence on the impact of financial incentives in improving performance is mixed in general (see Camerer & Hogarth, 1999, for a review), and in the health sector in particular (Christianson et al., 2007; van Herck et al., 2010). While some programs report positive results (Huntington et al., 2010; Basinga et al., 2010; Olken et al., 2012), others show little to no effect on attendance and outcomes. For instance, in a non-randomized evaluation of a “rural allowance” program for health workers in South Africa, Stilwell (2001) found limited effects on health worker retention and motivation. Similarly, Witter et al. (2011) suggested that paying health workers for performance in Pakistan had only small, if any, impacts on performance. In one of the few RCTs in this area, Bilardi et al. (2010) found no effect of incentive payments to physicians in Australia on chlamydia testing in young women. However, a more recent RCT (Olken et al., 2012) found positive effects of a financial incentive scheme in over 3000 Indonesian villages on maternal and child health outcomes.

Non-financial mechanisms for improving performance are attractive for three reasons. First, they are cost-effective: both theory and empirical evidence suggest that the likely channels through which these interventions operate are concerns for status and reputation (Tirole, 1996; Besley & Gathak, 2008; Frey & Neckermann, 2010; Banerjee et al., 2004; Yared, 2009), and it has been shown that such concerns drive behavior even in the absence of material benefits (Kosfeld & Neckermann, 2011). Thus, the deeply rooted human desire for recognition can act as a free-of-charge incentive that can replace financial incentives. Second, non-financial awards avoid the potential crowding-out effect that performance-based payment schemes can have on intrinsic motivation (Bénabou & Tirole, 2003; Camerer & Hogarth, 1999; Kreps, 1997). This concern carries weight because intrinsic motivation has been shown to be a major component in the job motivation of health workers in developing countries (Mathauer & Imhoff, 2006; Stilwell, 2001). Finally, non-financial incentives also obviate the significant monitoring and other administrative costs that are incurred by performance-based incentive schemes, and can operate even in the presence of limited liability and moral hazard (Kohn, 1999; Besley & Gathak, 2008).

However, the finding that non-financial incentives such as community monitoring improve clinic performance (Björkman & Svensson, 2009) leaves a crucial question unanswered: did community monitoring improve clinic performance because it was a bottom-up intervention which made clinic personnel socially accountable to their immediate neighbors? Or did it work because clinic performance was being monitored and evaluated per se, without it being necessary that this evaluation was

performed within the community? Put differently, might the monitoring as well have been top-down rather than bottom-up? The answer to this question is important because top-down monitoring is potentially much cheaper and more efficient than bottom-up monitoring; however, data on this crucial question is lacking. This evaluation will go some way in answering this question through the comparison of a bottom-up and top-down intervention.

### **1.2. Intervention 1: Non-financial awards**

The power of non-financial awards in improving employee attendance and performance has recently attracted increased attention from economists (Neckermann et al., 2009). Moldovanu et al. (2007) provide a simple theoretical framework showing that under simple assumptions (awards increase the utility of the recipients, and decrease that of non-recipients; and the utility of receiving the award decreases in the number of workers who receive it), awards should increase the effort provided by workers (as well as the variance). In line with this prediction, Kosfeld & Neckermann (2011) show in a randomized field experiment that purely symbolic awards boost the productivity of students performing database work by 12%. Since material benefits from the awards were ruled out, this study also showed that the performance improvement was driven by social recognition and status alone.

In line with these findings, the first intervention, non-financial awards, facilitates yardstick competition among groups of maternal and child health clinics, and rewards workers at both the best performing and the most improved facilities. At baseline, a relative ranking of clinics by district on key measures of performance, such as worker absenteeism, staff attitude and charging of illegal fees, and utilization for maternal and child health services was calculated, but not publicized (so as not to discourage the participation of lower ranked clinics). The competition, entitled “Respect Pass Money,” is being advertised through district-wide clinic meetings, posters on clinics and through individual meetings at clinics held by trained facilitators from partnering NGOs. Facilitators are discussing clinic performance and the competition with clinic staff; however, the indicators used to produce clinic rankings are not being revealed to clinics or the public, in order to prevent ‘teaching to the test.’ Clinics are being revisited three times throughout the course of the 9-month competition in order to sustain interest in the competition and at the end of the nine months, an audit of reported clinic results will be conducted, and any clinic found to be misrepresenting information will be disqualified. At endline, those clinics (i) which perform best in absolute terms on these indicators, and (ii) which show the greatest improvement over the course of the intervention, will be declared winners and receive non-financial awards. Specifically, staff at winning clinics will receive letters of commendation from high-ranking politicians, and an award at a public ceremony.

### **1.3. Intervention 2: Community monitoring**

The second intervention builds upon evidence from the recent community monitoring initiative in Uganda. This ‘bottom-up’ community monitoring intervention introduces health scorecards that provide information regarding the state of health care in each community, and facilitates interface meetings between community members and health facility staff. Prior to the meetings, communities have been

surveyed on their perception of service provision by the local clinic, and focus groups were held to discuss the state of health care in the community. During the interface meetings, information about the state of healthcare was disseminated via a community scorecard and mutual commitments were made to improve services through a joint action plan addressing such areas as staff absenteeism, maternal mortality and vaccination rates. Additional meetings are being held one month, three months and nine months after the initial meeting to review the joint action plan and progress made since the previous meeting. This framework aims to ensure participatory decision-making and hold both healthcare workers and the community mutually accountable, fostering increased access to and utilization of maternal and child health services. Service quality and quantity improvements due to the lower costs of collective action introduced through these meetings and the social accountability contract will be evaluated at endline.

## 2. Expected Impact

The study will achieve three goals:

- 1) It will yield the first quantitative evidence on the extent to which top-down, non-financial awards can improve health worker performance.
- 2) It will enable a comparison of the relative cost-effectiveness of this top-down approach with a bottom-up, community monitoring intervention. The expected returns on investment in community monitoring and non-financial awards are large: Björkman & Svensson find 0.17 SD weight gains for children, a 33% child death reduction, and increases utilization and preventative care in community monitoring compared to control communities. The cost-benefit ratio of these interventions, in contrast, has to date not been analyzed in depth; this is a focus of the present RCT.
- 3) It will provide the GoSL with exactly the information they require in deciding whether to bring these interventions to scale nation-wide, and will contribute to global policy discussions on the relative effectiveness of non-financial incentive mechanisms. This project has been in development in partnership with both the Government of Sierra Leone's Decentralization Secretariat (DecSec) and the World Bank since early 2010, with a self-sustainable model for scale-up through the Ministry of Health and Sanitation in mind. When the first round of the Decentralized Service Delivery Programme (DSDP) was introduced, plans were made to include and evaluate a social accountability component within four districts, and later extend these interventions to the rest of the country. As such, this project has been undertaken with an emphasis on the implications of scaling up, and stakeholders within the World Bank, DecSec and MoHS have been consulted throughout project development in order to produce innovations MoHS is capable of turning into a national program. The interventions are currently being implemented by NGOs, but results from the evaluation will directly inform MoHS of the impact and cost-effectiveness of each intervention, and will be evaluated in terms of the prospects for a nation-wide launch of the intervention by the GoSL through the second phase of DSDP.

# Chapter 2. Methodology

## 1. Evaluation Design

The study employs a randomized controlled trial methodology to evaluate these interventions. Two hundred and fifty-four health clinics in 4 districts of Sierra Leone were selected to participate in the intervention. The districts Bo, Bombali, Kenema and Tonkolili were selected to provide regional balance, they had a sufficient number of clinics to allow for the scale needed for randomization, and they had existing INGO presence. Prior to selection, a mapping exercise of 330 clinics and their catchments was undertaken in order to select clinics based on the least amount of overlap between catchment populations and minimize the possibility of cross-over between treatment and control clinics. The starting point was conducting GPS coding to track and establish the physical location of maternal and child clinics. This involved mapping the list of villages in each facility's catchment area and integrating it with existing Geographic Information Systems (GIS) data for Sierra Leone, so that the location and population of each facility's designated catchment area could be used to assess facility need and performance. 11 clinics were not used due to the fact that their locations couldn't be verified, and then the remaining 319 clinic were narrowed down to 254 clinics depending on distance between them.

Using a non-bipartite matching algorithm created specifically for this project, the clinics within the sample were matched into triplets based on similar utilization and performance characteristics gathered during baseline data collection. Clinics were then randomly assigned within these triplets to participate in either intervention or act as a control, with one third of clinics allocated to each group (Figure 1 gives the distribution of clinics between study arms). As such, treatment and control groups are comparable across a range of indicators at the outset, and this structure will be used to perform a selection of analyses at the conclusion of the evaluation.

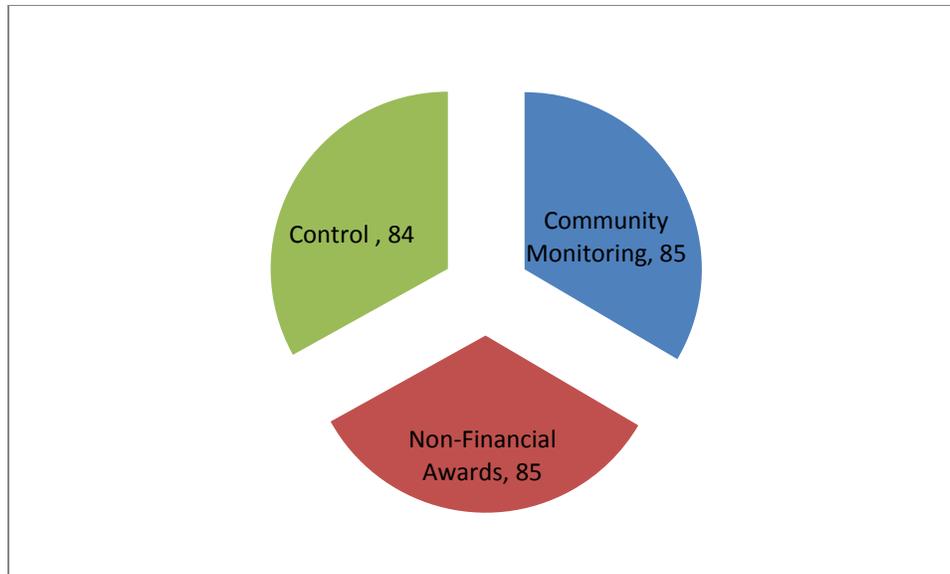


Figure 1. Number of primary health units in each study arm

## 2. Baseline Data Collection

An extensive baseline data collection was carried out in order to assess the situation on the ground prior to the intervention for comparison. Four types of survey were developed at baseline: clinic surveys; user-feedback and household surveys to respondents in clinic catchment areas; and community surveys to leaders in the villages where respondents reside. These surveys were based on the National Public Services survey (NPS) 2008, with some additional sections to tailor to the project. These questionnaires were the result of collaboration between the research team, World Bank and GoSL. Considerable efforts were put into designing and wording the questionnaire so that the questions capture baseline situation of the variables that are likely to be affected by the intervention. All clinics participating in the evaluation were surveyed to assess clinic services, resources and staffing, and underwent an audit of drug stocks and registers. In addition, randomly sampled individuals in the catchment area of each clinic were administered a user-feedback questionnaire to collect information on recent health episodes, and feedback on service provision and satisfaction. Further households in each catchment were administered an extensive household questionnaire, based on the National Public Services panel survey, to assess access to public services, current health and educational status and income/assets. Finally, community leaders responded to a questionnaire inquiring into their communities' remoteness, public health status and any on-going government and NGO projects.

The four surveys were piloted in June 2011 in three districts different from the intervention districts: Western Rural, Pejehun, and Port Loko. The pilot highlighted issues with the structure and content of the surveys as well as the audit verification which was planned to verify the information provided by the clinic. The largest change to the original process following the pilot exercise was to drop the audit verification (of which 5 were piloted). During the pilot, patient names were extracted from the clinic register, and then enumerators visited these patients to verify the information on their treatment as

stated in the register. This was observed to be highly sensitive, and with no ethical approval at that stage, it was deemed better to drop the audit altogether from the baseline survey. Other, smaller changes were made to the surveys, such as the way in which questions were asked, instructions, and flows of information were adjusted.

Baseline data collection was performed in September 2011. The teams of enumerators were trained for 10 days (together with training for the parallel NPS survey (National Public Services) prior to going into field. Using 14 teams of 6 enumerators and 1 supervisor, all of the surveys were carried out in local languages, and then responses were entered in English into Computer Assisted Interviewing (CAI) technology and PocketSurvey™ software. The four different surveys were sampled as follows:

1. All clinics participating in the evaluation were surveyed to assess clinic services, resources and staffing, and underwent an audit of drug stocks and registers.
2. In addition, fifteen randomly sampled individuals in two villages (within 2 miles of the clinic) of the catchment area of each clinic were administered a user-feedback questionnaire to collect information on recent health episodes, and feedback on service provision and satisfaction – for a total of 30 individuals in the catchment area of each clinic, and  $30 \times 254 = 7600$  overall.
  - a. Random selection of the two target villages occurred in-field. Enumerators then visited the target villages and performed a listing of all households in the village, and according to a rule visited fifteen households in the village to administer the survey.
3. A further 5 households in each of these village were administered an extensive household questionnaire, based on the National Public Services panel survey, to assess access to public services, current health and educational status and income/assets. A total of 10 individuals in each catchment were administered this abbreviated NPS household questionnaire, for a total of  $10 \times 254 = 2540$ .
  - a. Selection of these households also occurred randomly in the field.
4. Finally, community leaders of these villages responded to a questionnaire inquiring into their communities' remoteness, public health status and any on-going government and NGO projects. A community survey was administered to leaders in each of the target 508 target villages.

Data quality was ensured as the research team closely monitored data quality while surveys were taking place. Extensive back-checking was performed and the incoming data was examined on a daily basis for measurement error. Supervisors and monitors provided feedback to enumerators and in-field refresher trainings were conducted as necessary. Range and internal consistency checks were done to yield a cleaned data set.

# Chapter 3. Results

## 1. Community Questionnaire

The 508 catchment villages of the treatment/control clinics in this study were approached for surveying at baseline. 506 communities/community leaders completed a survey on the village and community throughout the 4 intervention districts, as illustrated in table 1.

Table 1. Communities surveyed in the intervention districts

District	Number of communities surveyed
Bo	124
Bombali	116
Kenema	131
Tonkolili	135

### 1.1. Location and accessibility

#### 1.1.1. Location

The communities were all assessed to ascertain the village location and accessibility. It was found that 88% of the village are on a motorable road, and out of villages not on a motorable road, it takes on average 55 minutes to reach the road without transport (24 minutes with transport), with most of the transport to the road being by foot, occasionally by canoe/commercial motorcycle (ocada). The quality of the nearest motorable road was generally very poor (50%), with few saying it was good (8%) or very good (7%). However, 93% of roads are reported to be passable all year. Transport on the reported road is variable, with 49% of respondents saying that there was transport more than once a day, and 34% saying there was no regular transport.

### 1.1.2. Political engagement

In terms of contact with the government, 84% of villages had an average of 2.29 candidates for local council elections visiting them prior to the 2008 elections. 76 (15%) of the villages had a local council official from their community. 74% of villages had an average of 2.16 members of parliament visiting the village before the last elections. Again, 76 villages said they had an elected parliament official from the community. Just 27% of villages had a paramount chief visiting them in the last year, and 7% had the president visiting them.

### 1.1.3. Communication

In terms of communications in the villages, 87% of villages have phone coverage, of which just 21% report to be very good phone coverage.

### 1.1.4. Community structure

58% of villages have a primary school, and 7% have a secondary school.

55% of villages said that there is a village development committee, holding an average of 9.57 meetings in the past year, and 41% of villages have a health management committee holding an average of 7.91 meetings in the last year.

### 1.1.5. Clinic accessibility

The communities were asked how they reach any clinics that they use. As can be seen in table 2 below, to reach the majority of clinics only 1 leg of a journey is needed, which is on average 5.26 miles, and most villages reported that this is reached by foot. Very few clinics require 4 legs of a journey to reach them.

Table 2. Journey description from village to clinic

Leg of journey	Number of observations	Average distance (miles)	Average time taken for leg (mins)	Average price for leg (Le)	Most common form of transport
Leg 1	419	5.26	68	4272	Walk
Leg 2	111	15.85	74	9286	Taxi, poda poda
Leg 3	36	32	118	12722	Taxi, poda poda
Leg 4	4	22.25	105	12250	Taxi, poda poda

In contrast to the larger distances given above from the villages to the clinics, the average distance from villages to the target clinic is 1.24 miles.

The community is visited by a health outreach worker when necessary in 44% of villages, but 13% of villages are never visited by a health outreach worker.

## 1.2. Water and sanitation

### 1.2.1. Water facilities

The survey found that 70% of villages have a water facility, and the majority of the water facilities are dug wells with hand pumps, or boreholes with hand pumps. 69% of these water facilities were provided by NGOs and 17% by the government. 68% of the water facilities have had problems before. In 80% of facilities, the community manages the water facility, and makes repairs and maintains the facility with a good frequency. The communities were asked in the survey if they could always get water from the facility in the last year. 48% of communities said that they could always get safe water, 41% said that they couldn't get water during the dry season, and 7% said that they frequently couldn't get safe water from the facility. 39% of villages said that they had a non working facility in their community, of which 83% of these had stopped working in 1991, 17% in 2010 and 0.5% in 2011. The majority of these non working facilities stopped working due to a mechanical part breaking (62%), the water becoming polluted (19%) or the well drying out (13%). Other sources of drinking water in the communities are reported to be surface water (river/dam/lake/pond), and tube wells with hand pumps.

### 1.2.2. Waste disposal and toilets

Just 11% of villages have a communal waste disposal site in the village, which is usually burnt (47% of disposal sites) on a monthly basis (40% of sites).

There are public toilets in 17% of the villages, usually in the periphery of the village. The main users of these toilets are VIPs. 85% of these toilets are frequently maintained, mainly paid for by the community.

## 1.3. Projects in the village

As table 3 shows, the majorities of projects within the surveyed villages are supported by NGOs or are a collective community action. Most NGO projects are agricultural, or water related, whereas many of the local council and community action projects work on road rebuilding as well as sanitation.

Table 3. Number of projects across catchment villages by project type and project supporter

Project type	Local council	NGO	Paramount chief	Collective community action
<b>Total number of projects</b>	<b>96</b>	<b>240</b>	<b>17</b>	<b>228</b>
Agriculture projects	8	71	5	43
Building a bridge	9	1	1	0
Projects to build a community store	8	8	0	0
Projects to build community centers	4	10	4	17
Projects to rebuild clinics/health of community	6	11	1	11
Road rebuilding projects	13	1	2	52
School related projects	10	19	1	30
Toilet projects	14	39	0	11
Water projects	18	58	0	11

Several questions were asked in order to ascertain the level of community action and collective involvement. On average, communities have spent 4.57 days cleaning the health facility in their village in the last 6 months. 19% of communities have cleaned, repaired toilets in past 6 months, spending an average of 16.99 days in past 6 months doing so. 55% of communities have repaired the well in the last 6 months, spending an average of 13.47 days doing so, while just 9% of communities have helped to renovate facility quarters for the nurse in the past 6 months, spending a mean of 6.09 days in the past 6 months. The clinics also reported that in the past 6 months, 28% of facility staff have been helped by the community with personal work, on average 2.51 times over the past 6 months.

The tables below give further information the community action projects. As with the other projects, the headman is usually responsible for leading the community, and if the community needed help with the project, it generally turned to local council for assistance.

Table 4. Person responsible for organizing the community

Person responsible for organizing community	Number of projects
Headman	77
Youth group	38
VDC	23
Town chief	14
Paramount chief	13
Elders	6
Local councilor	2
Pastor/imam	2
Community members	2
Women's group	2
Chiefdom adviser	1

Table 5. External help source for the community projects

External help	Number of projects
Local council	31
NGO/donor	20
MP/honorable	11
Chiefdom authorities	7
Central government ministry	6

Problems were generally resolved due to external help, and in cases where they were not resolved, the most common reason cited was due to the lack of resources.

Table 6. Reason why project problems were resolved or not

Reason for solution	Number of projects resolved	Number of projects not resolved
Due to external help	61	31
Due to the community working together	47	4
Due to the community resources	23	69

## 2. Clinic Questionnaire

All 254 treatment/control clinics were surveyed, from the districts as assigned. Most of these were maternal and child health posts, with the remainder being community health posts.

Table 7. Clinics surveyed in the intervention districts

District	Number of clinics surveyed
Bo	62
Bombali	58
Kenema	66
Tonkolili	68

Table 8. Type of clinic surveyed

Clinic Type	Number of clinics
Community Health Post	62
Maternal and Child Health Post	192

### 2.1. Clinic opening times

In the past month, clinics have been open for average 6.14 days each week and 50% of clinics have been open from 8am to 5pm. In 19% of facilities in the past month, a trained health provider has not been available after working hours. The most common reason for absenteeism and facility closure is outreach activities as can be seen in table 9.

Table 9. Reason for clinic closure, number of days in past 4 weeks closed

Reason for absence	Average number of days absent in past 4 weeks
For visiting villages for outreach activities	1.66
Attending meetings	0.6
Supervising other facilities	0.57
Treating patients in own home	0.46
On holiday	0.22
Working in other public facility	0.18

The average waiting time in facilities is 14 minutes, and equally sick patients have been seen on a 'first come first served basis' in 87% of facilities.

### 2.2. Clinic hygiene

Most facilities clean their equipment either by scrubbing with a brush, soap and water or by soaking the equipment in disinfectant. Most equipment is sterilized by boiling, or by using a chemical method. Another popular method of sterilization is dry heat sterilization. The surveyor requested to see the safety box for disposal of sharp items, and in 95% of clinics reported that the box was in good condition.

In 5 (2%) clinics the box was overflowing, pierced or broken, and in 8 clinics (3%) there was no safety box, but another container was being used. Sharps and contaminated waste are disposed mainly by burning and burying (in 42% of facilities), but also by burning in an incinerator (33%), or throwing in trash/open pit (14%). The surveyors also viewed the disposal site for sharps and contaminated waste. They noted that in 23% of facilities the sharps waste and the contaminated waste was visible and not protected.

## 2.3. Services

### 2.3.1. Services available

Clinics were surveyed about the services they offer in order to assess the consistency of care across facilities. Table 10 shows the services that facilities provide both in the facility and as an outreach service. Nearly all of the facilities offer immunization and growth monitoring as well as maternal care and family planning. Very few facilities offer dental care, HIV/AIDs counseling and testing or nutrition supplementation advice. 64% of facilities routinely admit patients for treatment.

Table 10. Services provided at facilities

Service	% facilities that have these services	Average number of days in the past month of service in the facility	Average number of days in the past month of service as an outreach service
Immunization	99.21%	4.64	2.26
Growth monitoring	99.21%	15.06	2.5
Treatment of sick children	98.82%	22.24	3.03
Antenatal care	100%	7.59	2.07
Family planning	94.49%	14.41	2.36
Treatment of STIs/STDs	87.80%	11.39	1.4
Wound care	88.98%	10.79	1.2
Deliveries	98.03%	9.18	0.77
Dental care	1.97%	0.38	0.13
HIV/AIDs counseling and testing	33.07%	9.67	1.36
Health education	95.67%	11.58	2.4
Post natal care	99.21%	9.69	1.31
Nutrition supplementation	30.31%	5.6	0.47
Training of nursing aides	7.09%	3.25	1.2
Training of community health workers	21.26%	2.44	0.84
Training of TBAs	12.99%	3.15	0.71

### 2.3.3. *Charges*

Table 11 shows the charges applied to services by clinics. Just 1 clinic charges illegal fees for children under 5 and pregnant/lactating women. A very small number of clinics charge other people for services. In addition to the services in the table below, no facilities charge under 5's for penta, BCG, measles, or polio vaccinations or pregnant or lactating women for family planning consultation or delivery and delivery materials. Other charges for under 5's include fines when immunization cards are lost, and pregnant women are sometimes charged for materials that aren't available. 9% of facilities charge patients for medical supplies when they are out of stock, and 11% of facilities require that patients bring something for medical visits at the facility. These items are generally delivery sheets, but also exercise books, burned palmoil, and soap, amongst others.

Table 11. Charges applied to services by clinics

Service	Population group	Number of clinics charging	Average amount (Le)	Service	Population group	Number of clinics charging	Average amount (Le)
<b>Registration or records</b>	Children under 5	1	2,000	<b>Outreach fee</b>	Children under 5	0	4,366
	Pregnant women	1	2,000		Pregnant women	0	
	Lactating mothers	2	2,000		Lactating mothers	0	
	Other people	34	2,234		Other people	59	
<b>Consultation</b>	Children under 5	1	5,000	<b>Outpatient</b>	Children under 5	0	4,750
	Pregnant women	1	10,000		Pregnant women	0	
	Lactating mothers	1	7,000		Lactating mothers	0	
	Other people	37	3,500		Other people	41	
<b>Medication</b>	Children under 5	1	5,000	<b>Laboratory tests for malaria</b>	Children under 5	1	n/s
	Pregnant women	0			Pregnant women	0	
	Lactating mothers	0			Lactating mothers	0	
	Other people	197	6,920		Other people	9	3,500
<b>Laboratory exams</b>	Children under 5	0		<b>Laboratory tests for TB</b>	Children under 5	0	1,000
	Pregnant women	0			Pregnant women	0	
	Lactating mothers	0			Lactating mothers	0	
	Other people	3	2,666		Other people	1	
<b>Admission fee</b>	Children under 5	1	5,000	<b>Injections/ syringes</b>	Children under 5	1	2,000
	Pregnant women	1	5,000		Pregnant women	1	3,000
	Lactating mothers	0			Lactating mothers	1	3,000
	Other people	20	7,205		Other people	91	3,159

All clinics said that they had heard of the policy for free health care. When asked what they thought this policy was, 44% said that it was free medical treatment for under-fives; free supply of bed net to pregnant women/lactating mothers, free medical treatment for pregnant women/lactating mothers. A very small number of facilities thought that it was just a free supply of bed net to pregnant women, and medical treatment for pregnant/lactating women, and the remainder gave a response very close to the definition of the free health care policy. Clinics had heard about the free health care policy from a variety of sources, 42% heard through the media, 41% heard from the District Health Management Team, 10% had heard from the ministry of health aide, and the remainder through the district medical officer, friends and family and NGOs.

#### ***2.3.4. Information availability***

When the facility staffs were asked about information availability, 83% of facilities claim to provide information publicly on the services provided. 90% of facilities claim to provide public information on new deliveries of drugs. 82% of facilities say that they provide information to the community/patients on their rights and obligations at government health facilities and 97% of facilities claim to provide information on family planning to the community. However, when the surveyors observed the clinics, they found that only 67% of facilities visibly posted the services provided by staff and just 37% of facilities had information visibly posted on drug deliveries. In addition, opening hours were posted in 33%, 13% showed information on PHC fund received, 25% had patients' rights visibly posted and 48% of facilities illustrated clearly information about free services.

As can be seen in table 12, the most common form of information dissemination is through spreading the information verbally through staff and patients. Frequently used forms of information dissemination are also posting the information in the waiting room or outside the clinic or through the HMC or local council.

Table 12. Source of information

Information source	% clinics providing information on services provided in this manner	% clinics providing information on new drugs in this manner	% clinics disseminating information on patients' rights in this manner
Chief	0.39%	0.79%	0.00%
Health education	0.00%	0.00%	0.79%
Meetings	1.18%	0.00%	0.79%
Outreach visits	0.79%	0.39%	0.00%
Posted in the villages	10.24%	8.27%	7.87%
Posted in the waiting room	35.83%	9.84%	18.11%
Posted outside the clinic	24.02%	9.06%	10.63%
Spread verbally by staff and patients	66.14%	76.77%	74.02%
Through HMC	42.52%	49.61%	39.76%
Through local council/religious	28.74%	32.28%	26.77%
Town crier	1.97%	1.18%	0.39%
Village development committee	0.39%	0.39%	0.79%

96% of facilities said that they know patients/communities rights and obligations at a government health facility. However, at free recall, as shown in table 13, 84% of clinics said that free health care for pregnant/lactating women and under 5's was a right, and just 18% of clinics said that patients had the right to receive information on the drugs received at the health facility.

Table 13. Patients' rights as recalled by health facility staff

Patients' right	% clinics mentioning patients' right at free recall
Free health care for pregnant/lactating mothers and under 5s	83.86%
Right to confidential treatment	59.45%
Polite treatment to the patient without discrimination	57.48%
Should be attended to within one hour	33.46%
Right to receive information on the drugs received at the health facility and how they are utilized	17.72%

## 2.4. Clinic resources

### 2.4.1. Clinic infrastructure

The survey team observed the cleanliness of the clinic as they found it. In 90% of facilities, the floor was swept with no obvious dirt or waste, and 93% had clean counter, tables and chairs. Just 8 clinics have a mud floor, the rest are cement or tiles. 13 have mud walls, 1 wood, and the remainders are cement. In 96% of clinics the roof is made out of corrugated iron/zinc, 2% out of cement, the remainder from straw or plastic. The roof was in good condition in 83% of clinics.

Only 10% of clinics have functional electric lighting, with solar panels as the main electric sources. Just 1 clinic surveyed is connected to the national power grid. The majorities of facilities get their water from a protected/mechanical well (75%), with the remainder from rivers, unprotected wells, or piped water. 68% of water sources are located within 100 meters of the facility. 21% of facilities' water was not working at the time of the questionnaire, and just over half of supplies are reported as being very regular.

82% of health facility have not built additional units or made renovations to the maternity ward in the past 6 months. The majority of renovations that have happened have been initiated by the government (58%), with a significant number from NGOs (13%). The water source has been renovated in the past 6 months in 7% of facilities. These renovations were mainly carried out by NGOs (64% of renovations/constructions), and the government (21%). Staff houses were constructed in 3% of facilities, and renovated in 8%, mainly by the government (38%), and the community (17%). The source of electricity was constructed in 1% of facilities and renovated in a further 1% of cases. This was done by a variety of people; government, private companies, cost recovery funds, facility funds and local councils.

### 2.4.2. Equipment

Table 14 below gives the equipment in the clinics at the time of the survey. As can be seen, less than half of the clinics have treatment guidelines in stock, with just 2% of clinics having treatment guidelines for TB. However, 89% of clinics have a thermometer, and 84% have an infant weighing scale.

Table 14. Equipment that clinics have at time of survey

Equipment	% the 254 clinics that have the equipment
Drip stand	40.16%
Infant weighing scale	84.25%
Adult weighing scale	83.86%
Thermometer	89.37%
Sphygmomanometer	68.50%
Stethoscope	82.28%
Couch and stool for gynecological exam	15.35%
Gynecological speculum	18.11%
Spotlight source	15.35%
Fetal stethoscope	83.86%
Mucous extractor	65.35%
Guidelines for diagnosing HIV/AIDs	24.80%
Standard treatment guideline for malaria	49.21%
Standard treatment guideline for ARI	22.05%
Standard treatment guidelines for G&V	7.09%
Standard treatment guidelines for TB	1.57%
Clinical guidelines for diagnosing and treating STIs	11.02%
Clinical guidelines (general)	24.41%

### 2.4.3. Drugs

#### 2.4.3.1. Medication

In addition to checking the stocks of medicines, the survey teams also checked the organization and storage conditions of medicines. Medicines were found to be off the floor in 85% of facilities, and were found to be well organized in 88% of clinics, even arranged by expiry date in 62% of clinics. They were found to be stored in a clean room in 85%, and in a room with a lockable door in 96% of clinics. Stock cards are used in 93% of clinics, and these were up to date in 84% clinics. Table 15 shows the stock of oral drugs currently and in the past 6 months as well as donations. Table 16 shows the injections available at the clinic. As can be seen, the most commonly stocked oral drugs are antibiotics (such as Amoxicillin and Metronidazole), de-worming pills (such as Mebendazole), oral contraceptives and vitamins. Less commonly stocked are tuberculosis treatments (Isoniazid and Ethambutol), amongst others. In the past 6 months, on average, clinics have received more iron, vitamin, anti-inflammatory pills and antibiotics for free, and received very few tuberculosis and anti-retroviral medications. The most commonly stocked injections are vitamins, hormonal and contraceptive, with very few injectable antibiotics stocked.

Table 15. Oral drugs in stock at the clinics

Drug	% of clinics with drug in stock	% of clinics with drug in stock in past 6 months	% of clinics with drug out of stock in past 6 months	Average number of tablets received free in past 6 months	Average number of tablets received in past 6 months
Amodiaquine-artemisinin	25.30%	70.37%	49.21%	274.36	313.49
Amoxicillin	69.72%	81.25%	35.63%	1562.43	1523.99
Aspirin	41.11%	59.18%	42.86%	522.59	557.1
AZT/ziduvudine	6.35%	15.25%	23.53%	15.28	11.86
Ciprofloxacin	22.92%	51.55%	39.66%	134.84	136.02
Cotrimoxazole	67.86%	71.95%	33.92%	1459.88	1506.95
Doxycycline	26.09%	38.71%	31.82%	184.53	169.03
Ethambutol	3.97%	13.81%	33.33%	4.03	0.01
Chloroquine	3.57%	10.70%	33.33%		
Ibuprofen	8.70%	23.91%	36.36%	127.55	130.84
Isoniazid	1.20%	10.53%	25.00%	36.28	32.47
Mebendazol	76.59%	62.71%	34.72%	402.26	392.77
Metronidazole	78.66%	72.22%	31.19%	1512.58	1561.92
Nevirapine	5.18%	10.17%	21.43%	9.55	0.59
Oral contraceptive pill with progesterone	74.31%	49.23%	21.39%	135.18	115.29
Oral contraceptive pill combined	73.31%	50.77%	24.06%	101.11	101.81
Paracetamol	35.18%	65.64%	43.82%	1012.23	1056.58
Quinine	34.39%	53.66%	43.02%	215.14	217.29
Pyrazinamide	5.20%	15.25%	13.33%	2.41	2.01
Rifampicin	2.39%	13.06%	50.00%	27.16	27.24
Sulphadoxine/pyrimethamine	61.11%	63.27%	33.77%	357.31	372.42
Tetracycline	10.67%	19.56%	48.15%	22.82	44.26
Oral rehydration salts	65.22%	89.89%	30.49%	302.25	294.53
Iron	64.82%	67.42%	35.58%	1785.77	1833.49
Vitamin A	70.63%	40.00%	32.58%	315.78	315.17
Multivitamin	34.39%	45.73%	47.73%	453.41	459.45
Erythromycin	24.51%	42.63%	56.45%	64.98	68.37

Table 15. Injections in stock at the clinic

<b>Injection</b>	<b>% clinics with injection in stock</b>	<b>% clinics with injection in stock in past 6 months</b>	<b>% clinics with injection out of stock in past 6 months</b>
Ampicillin injection	16.21%	24.17%	40.00%
Benzylpenicillin IM	21.34%	27.41%	44.44%
Diazepam injection	64.43%	35.96%	33.33%
Ergometrine injection	72.22%	25.71%	30.22%
Gentamycin IM	21.03%	34.34%	33.33%
Magnesium sulfate injection	82.61%	37.21%	29.33%
Oxytocin/syntocin injection	65.87%	41.86%	34.34%
Streptomycin injection	6.37%	10.64%	35.29%
Quinine IM	56.13%	53.64%	28.37%
Injectable contraceptive	65.08%	47.13%	21.95%
Normal saline for infusion	56.75%	39.81%	28.47%
Dextrose saline for infusion	64.03%	37.36%	31.06%
IV giving set	81.75%	38.3%	27.32%

19% of clinics report that they have received more drugs over the past 6 months, 67% less, and 15% report no change. The facilities put this change down to an increased/decreased supply from the district (90%), the fact that they are requesting more/less drugs (85%), as well as changes in distribution from the NMS (81%), changes in funds from the government (78%). Drug stock outs have been reported to increase in 44% of clinics, and decrease in 40%. These changes are again put down to increased/decreased utilization in 97% of clinics, 96% put it down to an increased/decreased supply from the district and to changes in reporting in 78% of clinics.

#### 2.4.3.2. Vaccinations

45% of facilities routinely store vaccines, the remainders pick the vaccines up from other facilities or have them delivered when provided with other services. Out of these clinics, 93% have a refrigerator powered by solar panel electricity to store the vaccine. Out of clinics routinely storing vaccines, over 90% of them have tetanus, penta, yellow fever, polio, measles and BCG vaccines in stock.

Table 16. Clinics with vaccinations in stock

Vaccination	% clinics routinely storing vaccines with these vaccines in stock
Tetanus	97.37%
Penta	95.61%
Yellow fever	95.61%
Polio	94.74%
Measles	93.86%
BCG	90.35%

In just 5% of these clinics, the BCG vaccines had expired. 81% of these clinics have 5 or more syringes of all sizes in stock. 84% of these clinics have blank individual child immunization cards in stock, and 88% have immunization tally sheets in stock.

#### 2.4.4. Medical supplies and bed nets

Table 17 shows the reported medical supplies available at the clinics. 85% of clinics have condoms available, but report that in the past 6 months, only 49% of clinics have had them in stock. The majority of clinics have antiseptic and sterile bandages in stock.

Table 17. Medical supplies available at the clinics

Medical supplies	In stock	In stock in past 6 months	Out of stock in past 6 months
Condom (male)	85.38%	48.65%	21.50%
Sterile bandages or gauze	55.73%	55.86%	28.37%
Antiseptic	70.75%	47.95%	31.28%
Disposal gloves	77.78%	59.65%	33.67%
Mosquito nets	38.49%	40.38%	40.63%
Cord ties/cord clamps	79.05%	43.40%	22.50%
Blank partographs	81.03%	35.42%	26.47%
Safety boxes for disposal of needles	97.23%	71.43%	22.45%
Swab sticks for STI specimen	10.67%	16.44%	29.63%
Suture material	59.92%	42.16%	25.17%

The facilities' main source of drug supplies, injections and medical supplies are the district medical office.

63% of facilities report to have distributed mosquito nets in the past 6 months. 71% of facilities were confident that they had enough nets for all those that were entitled to one (although only 38% have the nets in stock as shown in table 17), and in just 1% of facilities the recipient paid for the net. Table 18 illustrates that nets are predominantly provided to pregnant women and children under 5.

Table 18. Bed net distribution by clinics

<b>Population group</b>	<b>% facilities providing bed nets to the population group</b>
Pregnant women	52.76%
Children under 5	46.46%
Lactating mothers	46.46%
Institutional delivery	42.91%
Children coming for Penta 3/vitamins	2.36%
Household	1.97%
Everyone	1.18%

## 2.5. Records

The surveyors requested to see a map of the catchment area of the health center. 87% of clinics had a map showing major communities, but 14 (6%) clinics had no map. They also asked to see a document reporting the total estimated population in the catchment area. This was prominently displayed in 82% of clinics, but there were no estimates in 11 (4%) clinics. The mean estimated population in the catchment area is 3,764, including 242 infants (0-12 months) and 217 pregnant women. The DHIS and clinic register monthly report was available in 99% of clinics, and ICS tally sheet in 98% of clinics. The average figures given in these records are shown in table 19.

Table 19. Records of key activities in the clinic

Indicator	Average number recorded in records		
	DHIS	Clinic record	Tally sheet
Children under 5 with fever in last 2 weeks at times of measles vaccine	46.47	47.95	116.4
Children under 5 with diarrhea in last 2 weeks at time of measles vaccine	11.47	12.41	27.57
BCG vaccine, 0-11 months	26.75	27.71	30.36
Penta-3 vaccine, 0-11 months	24	25.17	27.98
Penta-3 vaccine, 12-59 months	1.11	1.39	1.32
Measles vaccine, 0-11 months	22.11	22.24	24.85
Measles vaccine, 12-59 months	1.36	1.81	1.78
First antenatal visits	25.21	26.27	29.59
Second antenatal visits	25.63	26.62	28.62
Third antenatal visits	20.89	20.60	18.76
TT2+ for pregnant women	34.44	36.53	35.68
Total number of outpatients	436.22	440.76	429.47
Total number of outpatients over 5 years	180.68	168.89	189.51
Total number of outpatients under 5 years	268.5	281.4	299.38
Total number of deliveries	17.99	18.43	20.98
Total number of antenatal care patients	85.23	83.99	98.89
Total number of people seeking family planning services at the facility	62.95	60.46	60.41
Number of maternal deaths in childbirth	0.02	0.32	0.4
Number of deaths in children under 5	0.73	0.71	7.28
Estimated number of children under 5 in catchment area	550.23	573.92	558.95
Number of children completing routine schedule of vaccinations by 1 year	28.74	32.35	28.87
Number of assisted deliveries	7.93	7.70	9.57
Number of diarrheal cases in children under 5	24.13	22.68	
Number of recorded malaria cases in children under 5	116.95	117.56	124.54

## 2.6. Staffing and support

31% of facilities have had staff leaving in the past year. Most staff were dismissed for selling drugs or syringes to patients, due to a lack of respect for autonomy or for further studies. The majority of staff transferred were done so due to a routine transfer. When asked directly about whether a member of staff has been found not doing their job in the past 6 months, just (16 clinics) 6% said there was. 41% of clinics report a shortage of staff in the past 6 months, and 48% of facilities had an average of 2.4 vacancies at the time of the survey. The most common position not filled at the time of the survey was a maternal and child health aide, as seen in table 20.

Table 20. Positions available in clinics at time of survey

Position	Number of facilities looking for following positions
Maternal and child health aide	62
Vaccinator	47
Volunteer	10
TBA	6
Enrolled nurse	5
Endemic disease control unit assistant	4
Community health officer	2
Registered nurse	2
Midwife	1

Table 21 shows that the most common training that facility staff receive is on malaria treatment. Only 40% of facilities have staff trained on the treatment of STIs, and only 62% of facilities have trained staff on immunizations. The training is mainly provided by the DHMT.

Table 21. Staff training

Training type	% facilities with trained staff	Average number of staff receiving at least 2 days training	Training mainly provided by
Malaria treatment	87.30%	1.46	DHMT
Management of sick children	68.77%	1.59	DHMT
Safe motherhood	64.29%	1.44	DHMT
Immunizations	62.06%	1.49	DHMT
Treatment of STIs	39.76%	1.41	DHMT

The majority of clinics had been visited within 2011 by the MoHS, local council and DHMT. 82% of facilities are monitored regularly by HMC monitors, and 59% are monitored by the local council. 85% of facilities have an HMC, holding an average of 4.64 meetings in the past 6 months. Supervisors from outside the facility provided support mainly on checking the registers and other records. As can be seen in the table below, very few clinics have received feedback on the staff or clinic.

Table 22. Support clinics receive

Type of support	% clinics receiving support
Check registers and other records	86.61%
Discuss technical protocols and practices and teach or answer questions on technical issues	57.09%
Observe staff managing sick children	55.91%
Observe individual staff providing services	51.18%
Provide any feedback on performance of staff	33.46%
Provide written report of the supervisory visit	27.56%

92% of facilities have never had a conflict with the community. The disputes that did occur were mainly because of disrespect of facility staff by the community and shortages of drugs. These conflicts were settled by mediation by chiefs and the village development committee in the majority of cases.

## 2.7. Challenges faced

The tables below provide information on some of the challenges faced by clinics and some suggested potential improvements. The most common challenge faced is deficient equipment and drugs, as well as inadequate funding and staff shortages. Staff have had issues of salary delays in 12% of facilities. Interestingly, the presence of illegal practitioners and supply issues were not frequently mentioned as a problem for the clinics. The majority of the facilities felt that they would contact the DMO/DHMT with any problems, and slightly fewer mentioned the government as a source of help. Potential improvements commonly mentioned were better equipment and drugs, an improved incentive system, as well as better infrastructure.

Table 23. Challenges faced by clinics

Challenge faced	% clinics reporting this as a major challenge
Deficient equipment and drugs	56.69%
Inadequate funding/budget	43.70%
Staff shortages	36.22%
Lack of community mobilization skills	23.62%
Poor clinic management	13.78%
Difficult to reach	12.99%
Not enough authority to influence decisions	12.20%
Lack of staff skills	10.63%

Table 24. Potential improvements to clinics

Potential improvement	% clinics reporting this as a potential improvement
More supplies stock	50.39%
Better incentives (salary, promotions)	50.00%
Better equipment	43.70%
Better building/infrastructure	40.16%
Transport for patients being referred	25.59%
Staff quarters	23.23%
More knowledge training	16.54%
Less workload/more staff	15.35%
Performance-based financing	10.63%

In order to assess the impact of any challenges faced, the facility staff reported their satisfaction with the facilities. 28% are very satisfied, 17% somewhat unsatisfied, and 12% very unsatisfied. When asked how the clinic staff felt about the level of community participation, just 2% responded that they were very unsatisfied, with 49% somewhat satisfied and 38% very satisfied. 46% of staff reported themselves to be very satisfied with the health of members of the community, with just under 1% very unsatisfied. Staff felt that over the past 6 months, most facilities had become a little better, with very few worsening. The majority of staff feel satisfied with their jobs over the past 6 months, and reported an average monthly pay is 541,701 Le (although 17 facilities reported staff earning nothing) and a maximum of 5,000,000 Le<sup>1</sup>.

<sup>1</sup> Using an exchange rate of 1USD = 4,300 Le, the average monthly pay for clinic staff is 126USD, with a maximum wage of 1,162USD per month

### 3. User Feedback Questionnaire

7,600 people were sampled with a user-feedback questionnaire to collect information on recent health episodes, and feedback on service provision. 7,423 respondents completed a survey on their clinic use throughout the 4 intervention districts, as illustrated in table 25.

Table 25. Number of individuals surveyed throughout intervention districts

District	Number of users surveyed
Bo	1,826
Bombali	1,705
Kenema	1,882
Tonkolili	2,010

#### 3.1. Political engagement

87% of users have heard about local councils and in the past year 21% have talked with the local councilor. When asked what they thought the government in Freetown would do with 500 million Leones<sup>2</sup> to complete a project, just 4,980 individuals responded to this question, and 26% of these respondents felt that they would take all of the money, while 19% felt that they would do a great job. 89% of respondents have a voters' registration card, 84% voted in the last local council elections, and 94% voted in the last presidential elections.

#### 3.2. Household Mortality

An average of 0.44 under 5's died in each household in the past 6 months, 61% of households had no deaths (n= 1,356). Households that responded (n=946) had on average 0.05 maternal deaths in the past 6 months and 95% of households had no maternal deaths.

#### 3.3. Healthcare services

##### 3.3.1. Clinic use

A target clinic user was surveyed from the households sampled above giving a sample size of 3,360.

15% of the users are under 1 year old, and the average age of user is 19.86. 51% of users were pregnant when they last visited the clinic (670 out of n=1,317). 10% of respondents (n=1,703) last visited the clinic for an ANC visit, 6% for illness/injury of under 5's, 5% for under 5 immunizations, 5% for growth monitoring, 4% for a PNC visit and less than 1% for child birth. The user visited the clinic on average 2.21 times (n=1,703) in the last month. 13% of users said that there was no staff present in their visit in the last month, with 15% of these visits being outside regular hours.

---

<sup>2</sup> 116,279USD

### 3.3.2. Medicine and charges

84% of users were told they needed medicine the last time they visited the clinic, and in 87% of these cases the medicines were in-stock and available at the clinic. 28% of users paid an average of 11,771 Le<sup>3</sup> last time they visited the clinic. The most frequently charged for medical item was paracetamol, and the least frequently charged was a condom. The majority of users felt that the charges were affordable, just 2% (64 users) felt that the charges were very unaffordable.

Table 26. Charges applied in target clinic

Medical item	% users reporting a charge for the following
Paracetamol	18.66%
Oral Rehydration Salt	10.38%
Amoxicillin	10.16%
ACT	8.96%
Ibuprofen	7.92%
Quinine	7.07%
Tetanus Toxoid	1.22%
Polio Vaccine	0.95%
Pentavalent Vaccine	0.95%
Measles Vaccine	0.92%
Yellow Fever Vaccine	0.92%
RHZT	0.51%
Condom (male or female)	0.09%

### 3.3.3. Reported problems

In the past month just 8% of users have had problems with the clinic. The vast majority of these problems were due to drugs not being available, but there were also a significant number of users with problems relating to staff absenteeism or unpleasant behavior from staff. The last time the user visited the clinic, most were very satisfied with the building, the care and the cleanliness of the clinic. Just 5% of users were very unsatisfied with the building, 2% with the care, and less than 1% felt that the clinic was very dirty. 79% of users felt that the clinic staff were very polite and respectful during their last visit, and 93% of users reported that they would use the same clinic next time.

As can be seen in table 27, the most common reason for not using the clinic (other than not being sick) is that drugs or equipment are not available. The cost is also cited as a reason, as well as it being difficult to reach and staff absenteeism. A small number of households do not use the clinic as they believe that it is only for women and children, or because they don't know about the clinic.

---

<sup>3</sup> 2.74USD

Table 27. Reasons for non-use of the target clinic

Reason for not visiting the clinic	% of total respondents citing this as a reason for not visiting the clinic
Not sick	39.34%
Drugs or equipment not available	5.51%
Cost	5.24%
Difficult to reach	2.06%
Staff not available	1.68%
Not happy with the clinic	1.45%
Drug peddler/self-treatment/traditional healer used	0.9%

## 4. Household Questionnaire

2,540 individuals were sampled to complete the extensive household questionnaire, based on the National Public Services panel survey, to assess access to public services, current health and educational status and income/assets. Out of the 2,540 respondents in the design, 2,519 responses were obtained.

Table 28. Individuals surveyed across intervention districts

District	Number of respondents
Bo	621
Bombali	578
Kenema	646
Tonkolili	674

### 4.1. Household resources

The households were questioned about their resources. It was found that very few households own a generator, refrigerator, television, electric fan or form of transport. Interestingly, just 19% of households own mobile telephones, whereas 56% own a radio.

Table 29. Household resources

Item	% households owning item	Average number per household	Min	Max
Radio	55.56%	0.63	0	11
Watch/clock	36.58%	0.47	0	120
Umbrella	34.91%	0.45	0	11
Large cooking pot	28.28%	0.5	0	22
Mobile telephone	19.38%	0.25	0	9
Bicycle	9.02%	0.098	0	3
Motorcycle	2.70%	0.029	0	3
Generator	1.19%	0.097	0	108
Television	1.11%	0.012	0	2
Electric fan	0.60%	0.0079	0	3
Landline	0.44%	0.048	0	2
Boat with no motor	0.40%	0.0044	0	2
Car/truck	0.32%	0.082	0	3
Refrigerator	0.28%	0.0028	0	1
Animal drawn cart	0.08%	0.0016	0	3
Motorboat	0.04%	0.0012	0	3

Less than 1% of households are connected to national power authority electricity, and 98% of households use wood as fuel for cooking. 58% of households cook in a separate building on an open fire,

21% cook outdoors on an open fire, and 12% cook in the house on an open fire. 26% of houses have a separate room for a kitchen.

79% of households have an earth floor and 20% a concrete floor. Most houses have a corrugated iron roof (66%), and the majority of the remainder have thatch roofs (34%).

97.62% of households claim to have no rent on their houses, and of the remainder, the average rent paid per month is 175,640 Le<sup>4</sup>.

## 4.2. Consumption

As can be seen in table 30 households tend to spend the largest amount of money per week on tobacco. They also spend a significant amount of money per week on bacon, rice, salt and alcohol. Relatively small amounts of money are spent on bread and fresh fish. In a month, households tend not to spend a significant amount more on things such as transport, school fees, clothes and medical services than they spend in a week on individual food items.

Table 30. Household consumption

Item consumed	Average amount spent in Le in the past week	Item consumed	Average amount spent in Le in the past month	Item consumed	Average amount spent in Le in the past year
Bread	83,077	School fees	319,672	Television	357,797
Rice	283,211	Transport	369,910	Motorbike	502,705
Bacon	399,950	Fuel	290,810	Bicycles	562,600
Fresh fish	142,568	Cotton	383,465	Radio	451,579
Palm oil	173,155	Readymade clothes	383,465		
Palm wine	215,432	Medical services	372,639		
Alcohol	285,698	Medications	357,659		
Nonalcoholic drinks	329,768				
Ground nuts	214,727				
Cassava	206,458				
Salt	283,929				
Pepper	247,505				
Vegetable	207,935				
Tobacco	419,575				
Soap	294,207				
Telephone top-up	250,765				

<sup>4</sup> 40.85USD

The most common items that households consume are shown in table 31, and the most frequently consumed items from their own harvest are cassava roots and chicken. Very few households consume yams from their own harvest, and just 8% consume rice from their own harvest.

Table 31. Household consumption from own harvest

Item consumed	% of households consuming from own harvest in past week	Item consumed	% of households consuming from own harvest in past month
Rice	8.34%	Chicken	16.10%
Cassava Roots	19.24%	Fresh cow meat	0.16%
Yams	2.07%	Other domestic meat	1.47%
Fish	5.20%	Wild meat	5.32%

### 4.3. Water and sanitation

The main source of drinking water for many households (42%) is a mechanical well. However, many households (34%) do use surface water as their main source of drinking water. Just 2% of households pay for this water, whereas 55% would be prepared to pay for the supply of clean and safe water. When asked if they could always get water from this source in the past year, 43% of households said that they could not get water during the dry season. A small proportion of households do something to the water before drinking it, the majority add bleach.

Most households (90%) dispose of their waste in the bush. 28% of households use a ventilated improved pit latrine, 30% use an open pit, and 24% have no facility, they just use the bush. In 40% of households, more than 5 households use this latrine, whereas only 19% of households are the only household using the toilet facility.

### 4.4. Community engagement and awareness

#### 4.4.1. Political engagement

Households were asked which positions of power and authority they had confidence in. Table 32 illustrates that respondents have the most confidence in clinic staff and the magistrate's court. Not many respondents have confidence in traditional healers, Diba and the Mori-man.

Table 32. Respondents' confidence in positions of authority

Organization	Confidence				
	A great deal	Quite a lot	Not very much	None at all	Never came into contact with
The magistrate's court	61.06%	25.59%	7.23%	3.30%	2.82%
The central government	32.84%	32.84%	21.06%	11.27%	1.99%
Political parties	43.38%	35.73%	11.72%	4.78%	4.39%
NGOs/donor projects	39.60%	37.97%	14.86%	5.42%	2.15%
Clinic staff	63.73%	26.51%	6.45%	3.18%	0.12%
Traditional healers/herbalists	24.94%	30.68%	28.01%	14.74%	1.63%
Diba/soweh mammy	25.66%	24.54%	25.22%	20.96%	3.63%
Mori-man/Karamoko	19.24%	16.29%	20.99%	38.83%	4.66%

25% of respondents have spoken to the paramount chief in the past year, and 56% think that the paramount chief listens to what people in the town say. When asked what they felt the paramount chief would do with 500 million Leones to complete a project, 15% of them feel as though the paramount chief would do a good job, whereas 25% feel as though the paramount chief would just take all of the money (n=1,705). 90% of respondents have heard about the local councils, but just 3% have visited the local council notice board. 22% of respondents have talked with the local councilor in the past year, and 29% feel that the local council listens to people in the community. Just 5% of respondents feel that if the local council was given 500 million Leones to complete a project they would do a great job, while 47% feel that they would just take all the money (n=1,763). While 18% of respondents have heard about the ward development committees, and 24% (n=457) have personally talked with a member of the WDC only 3% (n=457) have ever visited a ward notice board. 67% of respondents feel that the government in Freetown listens to the villagers. 17% of respondents (n=1,769) feel as though the government is corrupt and if given 500 million Leones to complete a project it would just take the money. Most people feel that the centralized government is less corrupt than the local government. 89% of respondents have a voter registration card, and 82% voted in the last local council elections.

#### 4.4.2. Community structure

The majority of respondents (86%) feel that people in their own community are honest and can be trusted and 81% feel that they would be willing to help out if needed. In contrast, just 57% of respondents feel that people outside their own community are honest and can be trusted, and 49% feel that people from outside their community would help if needed. 94% of household respondents feel that relationships among the community are harmonious, and 56% feel that relationships in their village are more harmonious than those in other villages. 69% of respondents feel that the recent armed conflict made the community more co-operative.

### 4.4.3. Health awareness

97% of respondents are satisfied with their families' health. However, less than half (47%) of respondents are satisfied with the public health and sanitation facilities, although, over the last year, 68% of respondents feel as though the quality of public health and sanitation have improved. Despite this lack of positive response for the state of the facilities, 83% of respondents are satisfied with the performance of public health workers, and 89% of respondents are satisfied with the cleanliness of the community.

94% of respondents consider western medicine very effective, with just 6 respondents (0.2%) considering it not effective. This is in contrast to 37% of respondents stating that traditional medicine is very effective, and 14% saying it is not effective.

Respondents were asked to say whether a number of health related statements were true or false in order to ascertain their knowledge of how to remain healthy, as shown in table 33. It was interesting to see that 80% of respondents replied that children would be malnourished if the women engages in infidelity after the birth of the child, and 23% said that vaccines prevent women from having children. However, in some respects, respondents had very good health knowledge, as exemplified by 91% saying that sleeping under a bed net makes it less likely that they will get malaria and 90% know that washing hands and utensils prevent diarrhea.

Table 33. Household health knowledge

Health statement	% saying true	% saying false	% don't know
Sugar causes diabetes	57.65%	6.56%	35.79%
Children are malnourished if a woman engages in infidelity after the birth of the child	79.51%	9.61%	10.89%
Sleeping under a bed net makes it less likely that you will get malaria	91.17%	5.13%	3.70%
Washing hands and utensils prevents diarrhea	90.12%	4.06%	5.81%
Local alcohol kills tapeworm and heals wounds	12.50%	36.46%	51.04%
Vaccines prevent women from having children	23.40%	41.70%	34.90%

98% of household members said that they wash their hands every day. When given free recall on the question asking if the household knows one way to prevent malaria, most people (63%) cited sleeping under a bed net, 17% said a clean environment, and 94% of households had a mosquito net hanging over the sleeping area in the household.

Just over a quarter of households use mosquito nets for other reasons as seen in table 34, the most common being as a bed cover.

Table 34. Other uses for mosquito nets

Other use for mosquito net	% households using mosquito net for other reason
No other use	73.44%
Bed cover	20.60%
Washing sponge	10.16%
Fishing	7.62%
Goal post net	3.14%
Chicken nest	2.10%
Filters for palm oil	1.47%
Bed bough	0.08%
Cover mattress	0.04%

Respondents were asked a number of questions on how they take the medicine they are given by the clinic. 89% of household respondents take medicine given to them by a nurse or doctor until it is finished, with 11% just taking it until they feel better. When given medicine by a traditional healer/herbalist, 41% of respondents take it until they feel better, 30% until it is finished and 17% don't take the medicine at all. 99% of respondents think that it is important to get a child vaccinated.

94% of households have heard about the free health care policy, and as table 35 shows, most households know that free health care applies to children under 5, and pregnant and lactating women. Most people had heard about the free health care policy through the radio, the health worker or a family member.

Table 35. Households' knowledge of population target of free health care policy

Population group	% households who think free health care is for this group
Children under 5	84.87%
Pregnant women	83.33%
Lactating mothers	77.21%
School aged children	3.29%
Other adult women	3.26%
People with disabilities	2.46%
Elderly people	2.26%
Adult men	1.71%
Everyone	0.60%
No one	0.56%

Table 36. Informant of the free health care policy

Informant	% households informed by this informant
Radio	62.05%
Health worker	51.05%
Family member/member of the community	47.24%
CHB/VDC/VHC/HMC	2.58%
NGO/CBO/CSO	2.02%
Councilor/politician	1.47%
Television	0.32%
Chief	0.12%
Newspaper	0.04%

## 4.5. Healthcare

Most households (69%) seek care at the maternal and child health care post when a member of the household is sick, and 22% seek care at the community health post. Very few households said that they seek care with a spiritual healer or traditional doctor. Just 12 households (0.5%) said that they never seek western medical assistance (in contrast to 26% who never seek traditional health assistance). 34% of households seek health assistance from a religious body.

### 4.5.1. Western medicine

The average distance to the nearest western clinic is 1.41 miles, of which patients usually travel by foot. When households were asked why they generally go to the described western clinic, 64% responded that it was due to the distance and 20% said it was due to the availability of drugs there. Other reasons cited were skill of staff, cost and friendliness of staff.

The majority of respondents (90%) were satisfied with the general state of the building, and 92% were satisfied with the equipment there. 97% were satisfied with the clinic cleanliness, 94% with the performance of staff at the clinic, and 94% with the care received. When households were asked what they thought had happened to the quality of the government health services in the past year, most responded that they had improved (79%), with 10% saying that there was no change. Table 37 shows that the most commonly cited problem with the health care facility was the lack of a clean toilet and shortage of medicine. Cost (most households felt that if they did pay a fee, these fees were very affordable) and illegal fee charging were not commonly cited problems, a bigger problem was absenteeism, however out of the 21% of respondents who visited the clinic outside of regular hours, 93% found the nurse/doctor present.

Table 37. Problems with the health care facility

Problem	% households citing this as a problem
Lack of proper/clean toilet facilities	61.57%
Shortage of medicine	56.41%
No clinic	34.93%
No health workers	18.86%
Clean water	11.55%
Clinic too small	0.52%
Transportation to clinic	0.40%
Nurse attitude	0.16%
Cost	0.12%
Traditional medicine	0.04%
No free health care	0.04%

35% of people with problems complained, mainly to the village headman or chief, and 18% of these problems were resolved. If people haven't complained, they said that they haven't done so as they don't know who to complain to, or feel that complaining won't do anything. Interestingly, a significant number say that if they were to complain, they would do so to the nurse/doctor. In practice however, very few people actually complaining did so to the nurse/doctor.

#### 4.5.2. Traditional medicine

Out of households seeking traditional medicine care, most seek from a traditional healer (44%) or herbalist (29%). People cite the use of the traditional doctor as a result of the low cost (32%), availability of drugs (22%), the skill of the staff (17%) and the distance to the care (16%). The traditional doctor is seen as very affordable in general.

#### 4.5.3. Religious assistance

32% of respondents seeking religious assistance do so in the church, 37% in the mosque, and 21% in their own home. The majority of people (89%) seek religious assistance due to their faith, and there are no fees in most cases.

#### 4.6. Health episodes

Overall, 34% of households don't use the target clinic, mostly because they are not happy with the clinic or it is difficult to get there.

Table 38. Reasons for non-use of clinic

Reason for not using clinic	% of non-users citing reason
Difficult to get there	11.74%
Attitude of the staff	6.92%
Staff not available	4.23%
Drugs or equipment not available	2.82%
Not happy with the clinic	17.02%
No need to health care	5.52%

#### 4.6.1. Children under 2-vaccines and growth monitoring

388 households (15% of households surveyed) have an under 2 living in the household. These households were asked questions on the child.

The majority of children seeking vaccinations or growth monitoring visited the nearest MCHP. 88% of households with a child under 2 responding to the question (n=112) said that the child had been for vaccinations, and had received one or more vaccinations on an average of 3.38 different occasions. The biggest concerns that respondents had about getting vaccinations were the distance to clinic, the issue with vaccines not being available, and sometimes the mother was reported to have refused to take the child to the clinic. Also of concern was the cost, attitude of nurse and nurse absenteeism. In addition, 25% (n=399) went to the clinic to find no vaccine was given, mainly due to vaccines being out of stock. Furthermore, 22% of people not receiving the vaccine on the day they visited the clinic did not seek further vaccinations. Just 3% of people that have been for vaccinations and growth monitoring in the past month (n=106) said that they paid for this service. All respondents felt that the nurse was attentive during the visit, but 21% (n=110) felt that the nurse didn't explain the treatment to them. 67 (out of 70 that have visited a government clinic in the past month) children under 2 have visited the target clinic in the past month.

#### 4.6.2. Childbirth

244 women (10% of households surveyed) gave birth in the past year. 23% of these women attended a birth waiting home before the birth, 91% sought assistance (mostly at the closest MCHP) during labor, and 99% of women reported that they gave birth in the place that they sought assistance. 59% gave birth in the MCHP, 17% in the community health post, 3% gave birth in the community health center, 2% in their own home, 1% in the faith based clinic, 1% in the government hospital (n=228). The women not seeking assistance put it down to the distance to the clinic and the fact that there was no one there to take the woman to the clinic and the labor progressed too fast. Over half of women attending a clinic were given treatment, mostly an injection or medicine. Just 1 woman was given a caesarean section, and very few were treated through prayer, ritual herbal treatments or sacrifices. 23% of respondents report having paid for the service.

89% of mothers had no problems within the first 2 months after delivery, just 1% had severe problems, and none died (n=245). 91% of babies had no problems within the first month of their lives, but 4 babies died (2%) (n=222). 75% of women attending the clinic felt that the staff explained things to them, and all

but 3 women thought that the staffs were attentive. 3% of women are unsatisfied with the care they received. 123 (out of 142 who attended a government clinic) respondents gave birth in the target clinic and very few of these were very unsatisfied with the building and the care given in the target clinic, and just 1 person (n=12) reported paying for services at the target clinic. There was no staff present 15% of the times that women visited the target clinic (n=136), but 19% of these visits were outside regular hours.

#### ***4.6.3. Ante-natal care/Post-natal care***

162 women (6%) out of households surveyed went for ANC/PNC visits in the past month, and these women made an average of 4.80 ANC visits, and 1.86 PNC visits in the past month. Most ANC visits were made in the 8<sup>th</sup> month of pregnant, and respondents went for a PNC consultation an average of 21.72 days after the birth of the child. These visits were generally to the closest community health post or the maternal and child health care post. 13% of respondents (n=98) paid something for ANC and 5% for PNC (n=61).

62% of the women seeking ANC/PNC care (n=162) did so at a government facility, and 57.41% (as a percentage of the total visiting government facilities) of them said that they attended the target clinic. 16% of people attending the target clinic (n=97) had been there in the past month to find no staff present, and 13% of these visits were outside of regular hours. 10% of people attending the target clinic (n=96) have had problems with it, with most of these problems being the staff not being present, or unpleasant behavior from staff.

#### ***4.6.4. Ill/injured***

667 (26%) of people surveyed have had a member of the household with an illness or injury in the past month. 93% of these cases were illness and 6% were injury. 41% of people with an illness had malaria, 29% had a cough with fever and 4% had diarrhea. 48% of people with an injury had a cut, 45% a broken bone and 7% had a burn. 25% of illnesses and injuries were mild, 48% moderate, and 24% severe, with just 3% fatal. 90% of people (n=687) sought treatment, and out of those seeking treatment, 94% of respondents (n=618) attended a western clinic, and 6% attended a traditional medicine post. The most common facility to visit was the MCHP, but many people also visited the CHP, CHC government hospital and were also assisted in their own homes.

92% of people attending a western clinic (n=593) attended the nearest facility. Out of those not attending the nearest facility, reasons cited for not attending the nearest facility were that the drugs and equipment as well as staff are not available. When asked about waiting times at the clinic, 43% of people didn't have to wait at all, 38% waited for under 1 hour, and just 1% waited over 4 hours (n=609). 53% of people (n=626) were advised to make follow up visits to the same place, and people made an average of 2.48 follow up visits. 11% (n=333) were admitted into the clinic, and stayed an average of 5.37 nights. 99% of people attending a western clinic (n=332) were given a treatment. Most were given medicine or an injection and 89% (n=329) completed the treatment they were given. 69% of respondents (n=335) said that they paid for the service. Most people said that the staffs were very attentive and just 1 person (0.3%) said they were very inattentive.

Out of 347 people visiting a government clinic, 281 people visited the target clinic. Only 16 people responded to questions on satisfaction on the building and care given, and all of these but 2 were satisfied. Just 3 people said they paid for the service (out of 14 replying). 15% of people (n=202) said there was no staff when they visited the clinic, with 3% of these visits being out of hours. 7% (n=297) said that they had had problems with the clinic, with the main problems being drugs not being available, staff not present or unpleasant behavior from staff.

## 5. Summary of treatment and control clinic statistics

There were no observable differences between the two treatment and control groups in terms of illegal charges. 1 clinic in the NFA group sometimes charges children under 5, pregnant and lactating women for registration of records. A different NFA clinic charges for consultation and medication for under 5s, and 1 control clinic charges children and pregnant women admission fees. 1 control clinic charges lactating mothers for family planning treatment. 1 NFA clinic charges under 5s for malaria lab tests. 4.76% of NFA, 8.33% of control and 14.12% of CM charge patients for supplies when they are out of stock.

As shown in the table below, the NFA clinics had on average longer waiting times and more staff vacancies at the time of the survey.

Table 39. Opening times, waiting times and staff vacancies

	CM	NFA	Control
Average number of days open in past month	5.99	6.14	6.31
Average waiting time	13.6	15.54	13.76
Average number of vacancies	2.37	2.79	1.92

The following tables report the services offered by the treatment and control clinics and the drugs and injections in stock at the time of the survey.

Table 40. % clinics offering services

Services	% CM clinics offering service	% NFA clinics offering service	% control clinics offering service
Immunizations	98.82	100	99.21
Growth monitoring	98.82	100	98.81
Treatment for sick children	97.65	98.82	100
Antenatal care	100	100	100
Family planning	94.12	94.12	95.24
Wound care	90.59	89.41	86.9
STI treatment	89.41	89.41	84.52
Delivery services	98.82	96.47	98.81
HIV testing and care	30.59	37.65	30.95
Health education	94.12	97.65	95.24
Postnatal care	97.65	100	100
Nutrition supplementation services	29.41	37.65	23.81
Nurse training	9.41	7.06	4.76
Community health worker training	23.53	17.65	22.62
TBA training	14.12	12.94	11.9

Table 41. % clinics with drug in stock

Drug	% CM clinics with drug in stock	% NFA clinics with drug in stock	% control clinics with drug in stock
Amodiaquine-artemisinin	22.62%	27.06%	26.19%
Amoxicillin	64.29%	76.19%	68.67%
Aspirin	40.48%	43.53%	39.29%
AZT/ziduvudine	7.23%	10.59%	1.19%
Ciprofloxacin	17.86%	22.35%	28.57%
Cotrimoxazole	67.86%	64.29%	71.43%
Doxycycline	29.76%	28.24%	20.24%
Ethambutol	2.38%	3.53%	6.02%
Chloroquine	1.20%	4.71%	4.76%
Ibuprofen	9.52%	8.24%	8.33%
Isoniazid	0.00%	1.18%	2.41%
Mebendazol	69.05%	78.57%	82.14%
Metronidazole	79.76%	77.65%	78.57%
Nevirapine	2.38%	5.95%	7.23%
Oral contraceptive pill with progesterone	75.00%	81.18%	66.67%
Oral contraceptive pill combined	71.43%	80.00%	71.43%
Paracetamol	39.29%	27.06%	39.29%
Quinine	38.10%	38.82%	26.19%
Pyrazinamide	4.82%	5.95%	4.82%
Rifampicin	1.19%	3.53%	2.44%
Sulphadoxine/pyrimethamine	55.95%	64.29%	63.10%
Tetracycline	9.52%	11.76%	10.71%
Oral rehydration salts	65.48%	64.71%	65.48%
Iron	65.48%	65.88%	63.10%
Vitamin A	66.67%	72.62%	72.62%
Multivitamin	26.19%	37.65%	39.29%
Erythromycin	26.19%	21.18%	26.19%

Table 42. % clinics with injections in stock

<b>Injection</b>	<b>% CM clinics with injection in stock</b>	<b>% NFA clinics with injection in stock</b>	<b>% control clinics with injection in stock</b>
Ampicillin injection	19.05%	14.12%	15.48%
Benzylpenicillin IM	20.24%	18.82%	25.00%
Diazepam injection	69.05%	58.82%	65.48%
Ergometrine injection	81.93%	71.76%	63.10%
Gentamycin IM	24.10%	15.29%	23.81%
Magnesium sulfate injection	82.14%	82.35%	83.33%
Oxytocin/syntocin injection	71.43%	67.06%	59.04%
Streptomycin injection	9.52%	3.57%	6.02%
Quinine IM	53.57%	56.47%	58.33%
Injectable contraceptive	65.48%	64.29%	65.48%
Normal saline for infusion	55.95%	53.57%	60.71%
Dextrose saline for infusion	66.67%	60.00%	65.48%
IV giving set	84.52%	78.57%	82.14%

Table 43 gives the clinic records for both treatment groups and the control.

Table 43. Treatment and control group clinic record data

Indicator	Average number recorded in clinic record		
	CM	NFA	Control
Children under 5 with fever in last 2 weeks at times of measles vaccine	48.98	58.15	36.84
Children under 5 with diarrhea in last 2 weeks at time of measles vaccine	10.20	15.81	11.27
BCG vaccine, 0-11 months	31.39	28.10	23.64
Penta-3 vaccine, 0-11 months	27.95	26.47	21.08
Penta-3 vaccine, 12-59 months	2.56	1.30	0.31
Measles vaccine, 0-11 months	21.47	25.59	19.67
Measles vaccine, 12-59 months	2.17	3.06	0.21
First antenatal visits	26.92	30.88	21
Second antenatal visits	26.36	30.84	22.65
Third antenatal visits	20.57	24.41	16.79
TT2+ for pregnant women	34.69	48.32	26.73
Total number of outpatients	490.66	433.07	398.54
Total number of outpatients over 5 years	171.26	172.24	163.22
Total number of outpatients under 5 years	316.76	284.98	242.47
Total number of deliveries	19.31	19.58	16.39
Total number of antenatal care patients	83.25	99.10	69.64
Total number of people seeking family planning services at the facility	54.45	69.40	57.49
Number of maternal deaths in childbirth	0.012	0	0.94
Number of deaths in children under 5	0.51	0.71	0.90
Estimated number of children under 5 in catchment area	535.53	662.76	523.46
Number of children completing routine schedule of vaccinations by 1 year	25.42	46.20	25.34
Number of assisted deliveries	8.29	8.87	5.91
Number of diarrheal cases in children under 5	26.57	22.32	19.14
Number of recorded malaria cases in children under 5	127.64	125.81	99.47

# Chapter 4. Conclusion

The four different surveys were designed in order to enable researchers to triangulate information and ascertain the true situation of health and healthcare, as well as associated issues, such as village accessibility, consumption and education, amongst others, on the ground. The purpose of this report is to provide the stakeholders of the community monitoring and non-financial awards interventions with a picture of the baseline situation in order to provide a comparison point for the endline survey which will take place after the conclusion of the interventions.

When examining the survey responses through the lens of the eight indicators selected to evaluate the effectiveness of the interventions, it was found that there were a number of trends. Under 5 and pregnant women morbidity mortality is reported to be relatively low in the catchment communities, and almost all of the evaluation clinics offer vaccinations and maternal care. The coverage for vaccinations for babies is very good, and most women are giving birth in the facility, but the coverage for anc/pnc care has room for improvement. Overall, the clinics are found to be performing well, with very little illegal fee charging. Levels of absenteeism are relatively high (over 10%), although many clinics have staff present out of regular hours, and waiting times are very low. Staff turnover is not too significant (around 30% a year), but the number of vacancies is high, and levels of training are low. Users are fairly satisfied with the clinics' performance and staff behavior. The main problem for users seems to be the lack of drugs and equipment at the clinics. However, it was found that patients are not given much information at the clinic, both about their condition and treatment as well as about the functioning (funding etc.) of the clinic. Staff, on the other hand, did not report such satisfaction with the facilities, although they do report to be fairly satisfied with their jobs.

# Chapter 5. Ongoing Data Collection

In partnership with the World Bank and the participating NGOs, the research team has taken steps to insure the consistency of the intervention across all districts. Extensive monitoring is currently being undertaken by members of the IPA research team. Project and research associates are attending the community monitoring meetings as well as the non-financial award meetings in order to complete a detailed questionnaire on the structure and content of meetings, which is then fed back to the research and implementation team to incorporate findings into refresher training in order to ensure a consistent intervention. Project and research associates are also travelling control clinics to discretely ascertain that no control clinics are attempting to participate in either the NFA competition or community monitoring.

# References

- Ashraf, N., Bandiera, O. and Jack, K. (2011). No Margin, No Mission? A Field Experiment on Pro-Social Tasks (Working paper). Retrieved from the Harvard Business School website: <http://sticerd.lse.ac.uk/dps/eopp/eopp35.pdf>
- Banerjee, A., Deaton, A., & Duflo, E. (2004). Wealth, Health, and Health Service Delivery in Rural Rajasthan. *American Economic Review Papers and Proceedings*, 94(2): 326-330.
- Banerjee, A., & Duflo, E. (2005). Addressing Absence. *Journal of Economic Perspectives*, 20(1): 117-132.
- Basinga, P., Gertler, P., Binagwaho, A., Soucat, A., Sturdy, J., Vermeersch, C. (2010). Paying Primary Health Care Centers for Performance in Rwanda (World Bank Policy Research Working Paper 5190). Retrieved from [http://siteresources.worldbank.org/EXTDEV\\_DIALOGUE/Images/537296-1238422761932/5968067-1269375819845/Rwanda\\_P4P.pdf](http://siteresources.worldbank.org/EXTDEV_DIALOGUE/Images/537296-1238422761932/5968067-1269375819845/Rwanda_P4P.pdf)
- Bénabou, R., & Tirole, J. (2003). Intrinsic and Extrinsic Motivation. *Review of Economic Studies*, 70(3), 489–520.
- Besley, T., & Ghatak, M. (2008). Status Incentives. *American Economic Review*, 98(2): 206–11.
- Bilardi, J. Fairley, C., Temple-Smith, M., Pirota, McNamee, K., Bourke, S.,... Hocking, J. (2010) Incentive Payments to General Practitioners Aimed at Increasing Opportunistic Testing of Young Women for Chlamydia: A Pilot Cluster Randomised Controlled Trial. *BMC Public Health*, 10(70)
- Björkman, M., & Svensson, J. (2009). Power to the People: Evidence from a Randomized Field Experiment on Community-Based Monitoring in Uganda. *The Quarterly Journal of Economics*, 124(2), 735.

- Camerer, C., & Hogarth, R. (1999). The Effects of Financial Incentives in Experiments: A Review and Capital-Labor-Production Framework (California Institute of Technology Social Science Working Paper 1059). Retrieved from: <http://www.springerlink.com/content/wh218110256r8t00/>
- Chaudhury, N., Hammer, J., Kremer, M., Muralidharan, K. & Rogers, H. (2006). Missing in Action: Teacher and Health Worker Absence in Developing Countries. *Journal of Economic Perspectives* 20(1): 91-116.
- Christianson, J., Leatherman, S., & Sutherland, K. (2007). Financial Incentives, Healthcare Providers and Quality Improvements: A Review of the Evidence. London: Health Foundation, 2007.
- Frey, B., & Neckermann, S. (2010). Awards as Signals (CREMA Working Paper Series 2010-21). Center for Research in Economics, Management and the Arts (CREMA). Retrieved from: <http://www.iew.unizh.ch/wp/iewwp513.pdf>
- Huntington, D., Zaky, H., Shawky, S., Fattah, F., & El-Hadary, E. (2010). Impact of a Service Provider Incentive Scheme on Quality of Reproductive and Child-Health Services in Egypt. *The Journal of Health, Population and Nutrition*, 28(3): 273-280.
- Kohn, A. (1999). Punished by Rewards: The Trouble with Gold Stars, Incentive Plans, A's, Praise and Other Bribes. Boston: Mariner Books.
- Kosfeld, M., & Neckermann, S. (2011). Getting More Work for Nothing? Symbolic Awards and Worker Performance. *American Economic Journal: Microeconomics*, American Economic Association, 3(3): 86-99.
- Kreps, D. (1997). Intrinsic Motivation and Extrinsic Incentives. *American Economic Review Papers & Proceedings*, 87: 359-364.
- Mathauer, I., & Imhoff, I. (2006). Health Worker Motivation in Africa: The Role of Non-Financial Incentives and Human Resource Management Tools. *Human Resources for Health*, 4(24).
- Moldovanu, B., Sela, A., & Shi, X. (2007). Contests for Status. *Journal of Political Economy*, 115(2): 338-63.
- Neckermann, S., Cueni, R., & Frey, B. (2009). What is an Award Worth? An Econometric Assessment of the Impact of Awards on Employee Performance (CESifo Working Paper Series 2657), CESifo Group Munich. Retrieved from: <http://www.ifo.de/portal/pls/portal/docs/1/1186326.pdf>
- Olken, B., Onishi, J., & Wong, S. (2012). Should Aid Reward Performance? Evidence from a Field Experiment on Health and Education in Indonesia. NBER Working Paper 17892.
- Rogers, H. (2006). Missing in Action: Teacher and Health Worker Absence in Developing Countries. *Journal of Economic Perspectives*, 20: 91-116.

- Stilwell, B. (2001). Health Worker Motivation in Zimbabwe. In an unpublished report for the Department of Organization of Health Care Delivery Geneva: World Health Organization.
- Tirole, J. (1996) A Theory of Collective Reputations (with Applications to the Persistence of Corruption and to Firm Quality). *The Review of Economic Studies*, 63: 1-22.
- Van Herck, P., De Smedt, D., Annemans, L., Remmen, R., Rosenthal, M., & Sermeus, W. (2010). Systematic Review: Effects, Design Choices and Context of Pay-for-Performance in Health Care. *BMC Health Services Research*, 10(247).
- Witter, S. Zulfiqur, T., Javeed, S., Khan, A., & Bari, A. (2011). Paying Health Workers for Performance in Battagram District, Pakistan. *Human Resources for Health*, 9(23).
- Yared, A. (2009). Non-Financial Incentives for Voluntary Community Health Workers: A Qualitative Study ( Working Paper No. 1). Retrieved from the JSI Research & Training Institute, Inc. website: [http://110k.jsi.com/Resources/Docs/nfi\\_workingpaper\\_vol2.pdf](http://110k.jsi.com/Resources/Docs/nfi_workingpaper_vol2.pdf)

## **Background:**

A key part of the community monitoring intervention is the joint community and health care facility meetings. The 3 NGOs: Plan, Concern and IRC scheduled these meetings for the entire treatment group in the 4 districts of the study. Plan in Bombali, Concern in Tonkolili, and IRC in Bo and Kenema. The first round of these meetings took place between May and July 2012. The second round of these meetings took place between August and September 2012, and the third round in September/October 2012. All of the scheduled meetings for the treatment group for the first three rounds took place. The fourth round is scheduled for January 2013. The first round of interface meetings were designed to give attendants information about the state of healthcare, disseminated via a community scorecard and for mutual commitments to be made to improve services through a joint action plan addressing such areas as staff absenteeism, maternal mortality and vaccination rates. The following meetings were designed in order to assess the progress made towards targets set in the previous meetings using scoring, and create new actions and targets if necessary. The research team have been monitoring these meetings in order to ensure that there is consistency in the meetings both within and between districts therefore ensuring validity of the data from the randomized controlled trial.

## **Methodology:**

The 88 clinics in the treatment group had the interface meetings scheduled by the 3 NGOs and the research team randomly selected 50% of the first round of these meetings evenly distributed across the 4 districts to attend for monitoring purposes. As many meetings as possible were captured in round 2, but due to budget constraints only a certain number of meetings in Tonkolili and Bombali were monitored. In round 3, the clinics not attended in round 1 were monitored, so as to cover all of the clinics throughout the course of the monitoring. A questionnaire was developed by the research team in order to assess the meetings on quality and consistency and to ensure that they were in line with the design of the intervention laid out in advance. The questionnaire raised issues such as the participants in the meetings, the meeting content, the way in which the NGO facilitator interacted with participants, and the content of the compact formed. One enumerator from IPA attended each of the selected meetings to complete the questionnaire. The enumerator did not interact with the meeting in any way.

Table 1 gives the 44 meetings attended by the research team in round 1 of the community monitoring meetings. Table 2 gives the meetings attended in round 2, and Table 3 gives those attended in round 3.

**Table 1. clinic meetings monitored in round 1 in the 4 intervention districts**

<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
Gbangba	Borongoh Makarankay	Bamba Kaima	Kamasaypana
Golu	Bumban	Bongor	Kunya
Kigbai	Karina	Doujou	Magbass
Kpuabu	Kerefay Loko	Faala	Makondu
Mano Yorbo	Kolisokoh	Jormu	Mamanso Kafu
Mbundorbu	Kortuhun	Konta	Mamanso Sanka
Niayahun	Mabolleh	Majihun	Mathufulie
Njandama	Madina Loko	Nyangbebo	Mayogbo
Nyagoihun	Makaiba	Panderu	Rochain Malal
Telu	Massory	Sembehun	Ronietta
Upper Saama	Rogbin	Vaahun	Warrima

**Table 2. clinic meetings monitored in round 2 in the intervention districts**

<b>Tonkolili</b>	<b>Bombali</b>
Warrima	Kunsho
Robina	Kolisokoh
Kamasaypana	Kerefay Loko
	Masingbi Lol
	Makaiba
	Mabolleh
	Kamabaio
	Maselleh
	Borongoh Makarankay
	Masangbo Limba
	Kathantha Bana
	Kaimunday
	Masorry

**Table 3. clinic meetings monitored in round 3 in the intervention districts**

<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
Bumkaku	Kaimunday	Bambara	Bath Bana
Griema	Kamabaio	Fayiema	Kathombo
Hima	Kathantha Bana	Gandorhun	Magbass
Lowoma	Kunsho	Gbado	Magboki Road
Monpende	Mabolleh	Helegombu	Mamanso Kafu
Ngogbebu	Masangbo	Komende Luyawa	Manewa
Nyagoihun	Maselleh	London	Mathinka Lol
Sahn	Masingbi Lol	Loppa CHC	Mayossoh
Sembehun 17	Yankassa	Patama	Patifu Mayepoh
Tambama		Sandaru	Robarie
Taninahun CHP		Semewabu	Robina

## **Results:**

### *Attendance and participation*

In order for the intervention to have as large an impact as possible, as well as to ensure validity of the RCT data, the meetings aimed to have 100% representation of the catchment villages of the clinic.

As can be seen in the tables below, the representation by villages at the meetings is decreasing throughout the rounds. In round 1, 84% of meetings had a 100% representation. In round 2, 75% of meetings had 100% attendance and round 3 had 71% of meetings with 100% attendance. We have discussed with the NGO's that mobilization efforts need to be improved in the final round to improve the attendance rates and village representation in all of the districts.

**Table 4. Percentage village representation at the meetings by district in round 1**

#### **Bo**

<b>% village representation</b>	<b>Frequency</b>	<b>Percentage</b>
80	1	9
100	10	91

#### **Bombali**

<b>% village representation</b>	<b>Frequency</b>	<b>Percentage</b>
31	1	9
86	1	9
98	1	9
100	8	73

#### **Kenema**

<b>% village representation</b>	<b>Frequency</b>	<b>Percentage</b>
90	1	9
100	10	91

#### **Tonkolili**

<b>% village representation</b>	<b>Frequency</b>	<b>Percentage</b>
78	1	9
83	1	9
100	9	82

**Table 5. Percentage village representation at the meetings by district in round 2**

<b>Bombali</b>		
<b>% village representation</b>	<b>Frequency</b>	<b>Percentage</b>
77	1	8
80	1	8
83	1	8
100	10	76

<b>Tonkolili</b>		
<b>% village representation</b>	<b>Frequency</b>	<b>Percentage</b>
82	1	33
100	2	67

**Table 6. Percentage village representation at the meetings by district in round 3**

<b>Bo</b>		
<b>Percentage Attendance</b>	<b>Freq.</b>	<b>Percent</b>
74%	1	9.09
91%	1	9.09
98%	1	9.09
100%	8	72.73

<b>Bombali</b>		
<b>Percentage Attendance</b>	<b>Freq.</b>	<b>Percent</b>
69%	1	11.11
87%	1	11.11
90%	1	11.11
95%	1	11.11
100%	5	55.56

<b>Kenema</b>		
<b>Percentage Attendance</b>	<b>Freq.</b>	<b>Percent</b>
100%	11	100

<b>Tonkolili</b>		
<b>Percentage Attendance</b>	<b>Freq.</b>	<b>Percent</b>
64%	1	9.09
71%	1	9.09
82%	1	9.09
88%	1	9.09
91%	1	9.09
100%	6	54.55

As can be seen in the tables below, the meetings in Bombali had, on average, a very low health facility staff presence in round 1, which had increased by round 3. The meetings in Tonkolili had a low mean NGO staff and authority figure presence in all rounds.

**Table 7. Mean number of attendants by district and attendant type in round 1**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
Number of health facility staff present	4.64	2.00	5.18	3.45
Midwives	0.09	0.00	0.00	0.00
Maternal and Child Health Aids	1.27	1.27	1.09	1.18
State Enrolled Community Health Nurses	0.00	0.00	0.00	0.09
Community Health Assistants	0.18	0.00	0.18	0.00
Vaccinators	0.18	0.09	0.55	0.55
Health Motivators	0.64	0.09	0.00	0.00
Traditional Birth Attendants	1.45	0.45	2.27	1.18
Number of NGO staff present	5.55	8.64	6.18	5.36
facilitators	4.18	7.36	4.82	4.09
enumerators	0.73	0.00	0.82	0.18
field co-ordinators	0.55	0.82	0.55	0.73
other	0.09	0.27	0.00	0.36
Number of authority figures	1.18	2.64	1.36	0.36
Resident Chief	1.11	0.45	1.11	0.38
Councilors	0.00	0.36	0.00	0.00
DMO	0.00	1.27	0.11	0.00
Paramount chief	0.00	0.36	0.00	0.00
Parliamentarian	0.00	0.00	0.00	0.00
Community representatives	41.64	54.91	39.18	58.64
Young male	8.36	12.36	7.73	11.45
Adult male	8.36	12.36	7.82	10.64
Young female	8.36	9.82	7.91	13.73
Adult female	8.36	9.18	7.64	9.91
Traditional birth attendants	8.18	13.82	8.09	13.27

**Table 8. Mean number of attendants by district and attendant type in round 2**

	<b>Bombali</b>	<b>Tonkolili</b>
Mean number of health facility staff present	4	5.7
Midwives	0	0
Maternal and Child Health Aids	0.92	1
State Enrolled Community Health Nurses	0.23	0
Community Health Assistants	0.08	0.33
Vaccinators	0.15	1
Health Motivators	0	0
Traditional Birth Attendants	2.08	2

Mean number of NGO staff present	4.85	5.67
facilitators	4.3	5
enumerators	0	0
field co-ordinators	0.54	0
other	0.62	0.33

Mean number of authority figures	1.08	0
Resident Chief	0.77	0
Councilors	0.00	0
DMO	0.00	0
Paramount chief	0.23	0
Parliamentarian	0.00	0
Other	0.07	0

Mean community representatives	52.69	46
Young male	10.69	12.67
Adult male	10.31	5.33
Young female	10.15	5.67
Adult female	10.31	11
Traditional birth attendants	11.23	11.33

**Table 9. Mean number of attendants by district and attendant type in round 3**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
Mean number of health facility staff present	7.6	5	4.9	3.5
Midwives	0	0	0	0.09
Maternal and Child Health Aids	1.82	1.22	1.27	1.09
State Enrolled Community Health Nurses	0	0.22	0.18	0
Community Health Assistants	0.36	0.11	0.09	0
Vaccinators	0	0.11	0.64	0.55
Volunteers	1.18	0.44	0.36	0.36
Health Motivators	0	0.22	0	0
Traditional Birth Attendants	4	2.33	2.36	1.18

Mean number of NGO staff present	3.45	4.67	3.18	3
Facilitators	2.82	4	2.27	2.64
Field co-ordinators	0.55	0.22	1.73	0.18

Mean number of community representatives present	42.6	47.44	44.54	39.64
Young Male Representatives	8.25	10.25	9	8.09
Adult Male Representatives	8.13	8	9.09	8.73
Young Female Representatives	8.38	8.5	8.64	8.18
Adult Female Representatives	7.88	10.13	8.64	7.73

The tables below show mean participation in the meetings, participation equating to each individual contribution during the meeting. Generally, men made more contributions than women, and older less than younger. All of the NGOs have been reminded that they should attempt to have equal contributions from all participant groups.

**Table 10. Mean participation in round 1 in the meeting by attendant type and district**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
Young Women	9.40	5.82	10.56	5.64
Old Women	6.50	4.45	5.44	4.18
Young Men	12.40	12.81	14.56	16.45
Old Men	9.40	10.27	6.44	12.27
TBAs	4.80	11.36	6.90	6.45
Health Staff	7.60	10.64	7.67	12.45
Authority Figure	2.82	6.55	3.64	0.64

**Table 11. Mean participation in round 2 in the meeting by attendant type and district**

	<b>Bombali</b>	<b>Tonkolili</b>
Young Women	9.58	12.67
Old Women	5.5	6.67
Young Men	9.08	23
Old Men	6.92	1.15
TBAs	6.75	8.67
Health Staff	9.42	21.67
Authority Figure	1.08	0

**Table 12. Mean participation in round 3 in the meeting by attendant type and district**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
Young women	10.44	6.78	20.55	5.55
Old women	6.56	7.22	8.64	10.27
Young men	16.33	10.33	23.73	10.09
Old men	9.56	6.78	10.55	10.09
Traditional birth attendants	6.67	6.22	12.36	8.36
Health staff	11.89	6.22	14.82	12.64
Authority Figures	1	2.89	9.1	0.73

*Meeting content*

All of the meetings, except those in Bombali, decreased in duration throughout the rounds. They are still a significant length in round 3 though.

**Table 13. Mean duration of meetings by district in round 1**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
mean (h)	3h41	3h08	3h58	3h55
min (h)	2h30	2h24	3h	2h45
max (h)	4h57	4h45	5h	5h43

**Table 14. Mean duration of meetings by district in round 2**

	<b>Bombali</b>	<b>Tonkolili</b>
mean (h)	2h 25	2 h 57
min (h)	1 h 18	2 h 30
max (h)	4 h	3 h 19

**Table 15. Mean duration of meetings by district in round 3**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
mean (h)	2h 47	3h 17	3 h 21	3 h 19
min (h)	1 h 54	2 h 07	2 h	2 h 15
max (h)	4 h 16	4 h 10	3 h 50	4 h 15

All of the meetings, bar one in Bombali in round 1, took place on the agreed date.

The tables below list certain objectives of the meetings, and the percentage of meetings in each district that achieved these objectives. In general, the facilitators performed very well in achieving these objectives. By round 3, there were only a few discrepancies between the meetings. Facilitators have been reminded that they should assign a responsible person to every action, a time frame for achievement of each action, and use role play explain the scoring method for the compact, and that all of the meetings should result in a signed compact. It has also been decided and recommended that they do not discuss the scores from previous meetings, so as not to confuse the meetings.

**Table 16. Percentage of meetings in round 1 in each district that completed certain objectives of the meeting**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
% meetings that had a discussion addressing solutions to challenges faced by both community and health facility staff	100	81.82	100	90.91
% meetings in which a responsible person was assigned to every action	100	27.27	100	63.64
% meetings in which a time frame was established for the achievement of each action	100	63.64	100	90.91
% meetings in which the group decided how to track progress and assess the status of each action	90	72.73	90.91	90.91
% meetings in which facilitator explained the scoring method for the compact	72.73	9.09	90.91	63.64
% meetings resulting in a signed compact agreement	100	81.82	100	90.91

**Table 17. Percentage of meetings in round 2 in each district that completed certain objectives of the meeting**

	<b>Bombali</b>	<b>Tonkolili</b>
% meetings that present a compact with actions for the PHU staff	100	100
% meetings in which scoring methods are explained to PHU staff	100	100
% meetings that present a compact with actions for the community	100	100
% meetings in which scoring methods are explained to the community	100	100
% meetings in which facilitator carried out a role play to explain the scoring method	76.92	100
% meetings presenting a joint compact to both PHU staff and community	92.31	100
% meetings in which community assigned an initial score	100	100
% meetings in which PHU staff assigned an initial score	100	100
% meetings in which community and PHU staff came together to discuss the compact	100	100
% meetings in which PHU staff assigned final score for community	84.62	100
% meetings in which community assigned final scores for PHU staff	84.62	100
% meetings in which the group discussed ways to improve or maintain progress	100	100
% meetings in which there was an updated time frame for achievement of the actions established	92.31	100
% meetings in which the group decided how to track progress	92.31	100
% meetings in which the group decided how information would be fed back to the communities	92.31	100
% meetings resulting in a signed compact agreement	76.92	100

**Table 18. Percentage of meetings in round 3 in each district that completed certain objectives of the meeting**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
% meetings that present a compact with actions for the PHU staff	100	100	100	100
% meetings in which scoring methods are explained to PHU staff	100	100	100	100
% meetings that present a compact with actions for the community	100	100	100	100
% meetings in which scoring methods are explained to the community	100	100	100	100
% meetings in which facilitator carried out a role play to explain the scoring method	45.45	55.56	18.18	27.27
% meetings presenting a joint compact to both PHU staff and community	100	100	100	100
% meetings in which PHU staff and community members were separated at the start	100	100	100	100
% meetings in which community assigned an initial score	100	100	100	100
% meetings in which PHU staff assigned an initial score	100	100	100	90.91
% meetings in which community and PHU staff came together to discuss the compact	100	100	100	100
% meetings in which PHU staff assigned final score for community	100	100	100	100
% meetings in which community assigned final scores for PHU staff	100	100	100	100
% meetings in which scores from round 2 were discussed for PHU staff	45.45	77.78	36.36	18.18
% meetings in which scores from round 2 were discussed for community members	45.45	77.78	36.36	20
% meetings in which the group discussed ways to improve or maintain progress	100	100	100	100
% meetings in which there was an updated time frame for achievement of the actions established	100	100	100	100
% meetings in which the group decided how to track progress	100	100	100	90.91
% meetings in which the group decided how information would be fed back to the communities	100	100	100	90.91
% meetings resulting in a signed compact agreement	90.91	100	81.82	100

The enumerators rated the atmosphere of each meeting. In round 1 all of the meetings in Bo were rated as having a very amicable atmosphere, whilst a small proportion of the meetings in Bombali, Kenema and Tonkolili had somewhat hostile meetings. In round 2, all of the meetings observed were amicable, and in round 3, just Kaimunday in Bombali was a hostile meeting.

**Table 19. Atmosphere of the meetings in round 1 by district**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
Very amicable	100%	72.73%	72.73%	72.73%
Somewhat amicable	0	18.18%	18.18%	18.18%
Somewhat hostile	0	9.09%	9.09%	9.09%
Very hostile	0	0	0	0

**Table 20. Atmosphere of the meetings in round 2 by district**

	<b>Bombali</b>	<b>Tonkolili</b>
Very amicable	91.67%	66.67%
Somewhat amicable	8.33%	33.33%
Somewhat hostile	0	0
Very hostile	0	0

**Table 21. Atmosphere of the meetings in round 3 by district**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
Very amicable	81.82%	77.78%	100%	54.54%
Somewhat amicable	18.18%	11.11%	0	45.45%
Somewhat hostile	0	11.11%	0	0
Very hostile	0	0	0	0

## **Results from the joint compacts**

*Most common concerns and solutions from community and health staff.*

Across the 4 districts, the most common problems reported in the joint compacts are:

- Fee charged to FHC category
- Home/TBA delivery
- Irregular/incomplete vaccination
- Late arrival/referral to clinic
- Low utilization of clinic
- No birth waiting homes
- Nurse absenteeism

Poor diet/nutrition/breast feeding  
Poor road/broken bridges and long distance to clinic  
Poor sanitation/hygiene  
Poor use of bednet  
Too many child birth and increase in teenage pregnancy  
Use of quack, herbs and traditional beliefs

The most commonly cited solutions and actions for health facility staff in the joint compacts are:

Award mothers who complete vaccinations and ANC  
Discuss problems and collaborate with authority  
Encourage institutional delivery of babies  
Followup on patient adherence to medication and timely arrival  
Good attitude from nurse  
Incentivize TBAs to bring patients to clinic  
Increased outreach activities  
Inform community of when nurse is not at the clinic  
No fees charged to FHC Category  
Renovate clinic building and furniture using PBF fund  
Report quacks and defaulters to authority  
Sensitize community on environmental sanitation, balanced diet dangers of quacks and herbs  
Sensitize community on importance of bednets and breast feeding  
Sensitize community on the importance of family planning and dangers of teenage pregnancy  
Sensitize community on the importance of vaccinations, ANC, and timely arrival at the clinic  
Timely referral and escort of patients  
Work with stakeholders to provide a boat or repair broken bridges

The most commonly cited solutions and actions for the community in the joint compacts are:

Advise on teenage pregnancy and use of family planning methods  
Advocate for an added staff  
Assist nurse with cleaning and other chores  
Brush roads and repair bridges  
Community to embark on environmental sanitation  
Create laws and levy fines on defaulters of all sort  
Encourage use of clinic services  
Enforce use of bednet  
Hold meetings  
Husbands to accompany and ensures their wives and children visits the clinic for all care  
Seek early and prompt treatment  
Sensitize community on the dangers of quacks and herbs  
TBA to monitor and ensures pregnant women carry out ANC, clinic delivery and

sanitation

Town crier to announce outreach days in villages

Work towards prompt payment of PBF

In round 2 and round 3 the joint compact recorded updated actions for both the health facility and the community. The most common health facility update actions are:

Continue and enforce previous action

Continue and enforce previous action

Continue on sensitization

Continue on sensitization

Hold meetings with stakeholders

Improve in communication and information dissemination

Improve on lapses

Increase support and collaboration with staff/community

Reactivate/form new HMC

Train TBAs/Volunteers

The most common update actions for the community are:

Complain to appropriate authority

Continue and enforce previous action

Continue sensitization

Hold meetings with stakeholders

Improve on communication and information dissemination

Improve on lapses

Increase support and collaboration with staff/community

Levy fines on defaulters

Reactivate/form new HMC

Train TBA/volunteers

A key part of the meetings in round 2 and 3 are assigning scores to each action. The community assigns a score for how the health facility staff are doing in achieving the action target, and the health facility staff do the same for the community. In round 2, the mean score that the community gave to the health facility staff was 3.60 (out of 5), and in round 3, the mean score was 3.94. In round 2, the mean score that the health facility staff gave to the community was 3.24, and in round 3, 3.62.

### **Background:**

A key part of the non-financial awards intervention is the meetings that occur with the health care clinics in order to inform the clinics further about the award and ways in which they can improve their performance. The 3 NGOs: Plan, Concern and IRC scheduled the first and second round of these meetings for the entire treatment group in the 4 districts of the study. Plan in Bombali, Concern in Tonkolili, and IRC in Bo and Kenema.

The first round of these meetings took place between August and October 2012, and second between October and December 2012. All of the treatment clinics have had a meeting held by the NGOs for round 1 and round 2. Round 3 are planned for January 2013. The first round of meetings were designed to give clinics information about their current performance based on indicators that are discussed, and to create action plans to improve their performance. Each meeting following that will discuss the action points decided on in the previous meeting and ascertain whether targets have been achieved. A proportion of all of these meetings have been monitored to ensure there is consistency with both the research design and across districts/NGOs.

### **Methodology:**

Only Plan's meetings were monitored in round 1 due to resource constraints. The 19 clinics in Plan's treatment group (in Bombali) had round 1 of the meetings scheduled and the research team randomly selected 50% of these meetings to attend for monitoring purposes. A randomly selected 50% of meetings for round 2 in Bo, Kenema and Tonkolili were monitored, and the 50% not monitored in round 1 were monitored in round 2 in Bombali. A questionnaire was developed by the research team in order to assess the meetings on quality and consistency and to ensure that they were in line with the design of the intervention laid out in advance. The questionnaire raised issues such as the participants in the meetings, the meeting content, the way in which the NGO facilitator interacted with participants, and the action plan formed as a result of the meeting. An enumerator from IPA (out of 4 different individuals randomly assigned to each meeting) attended each of the selected meetings to complete the questionnaire. The enumerator did not interact with the meeting in any way.

The table below gives the meetings attended by the research team in round 1 of the non-financial award meetings. Table 2 gives the meetings attended by the research team in round 2 of the non-financial award meetings.

**Table 1. Clinic meetings attended by the research team in Round 1**

<b>Bombali</b>
Bumbandain
Gbainfay
Kagbo
Kaponkie
Madina Fullah
Maharie
Makeni Lol
Manack
Mangay Loko
Stocco

**Table 2. Clinic meetings monitored in round 2 of the NFA meetings**

<b>Kenema</b>	<b>Bo</b>	<b>Tonkolili</b>	<b>Bombali</b>
Pelewahun	Bontiwo	Fothaneh Junction	Panlap
Samai Town	Yengema	Makontande	Makarie
Tokpombu	Blamawo	Mapamurie	Maforay
Yabaima	Sembehun	Makona	Gbonko Bana
Kamboma	Mano jaiama	Makrugba	Mamaka
Sarabu	Manguama	Bake Loko	Tonkumba
Guala	Kassama	Malone	Kagbaneh
Kondebotihun	Yakaji	Kaimpkakolo	Kamakwie
Diema	Karleh	Mara	Samaya
Konabu	Benduma		
	Matru on the rail		

**Findings:**

All of the meetings that the research team attended took place on the agreed date, and all but one in round 2 (Fothaneh Junction in Tonkolili, which took place in the town hall) in or around the PHU.

As can be seen in the table below, the majority of health facility staff attending the meetings were maternal and child health aids, traditional birth attendants, vaccinators and volunteers. In a number of meetings, there were a number of health facility staff not present at the meeting. Facilitators have been reminded to attempt to have full attendance and representation at the meeting.

**Table 3. Mean number of attendees at the meetings, by attendee type**

	Round 1	Round 2			
	Bombali	Bo	Kenema	Tonkolili	Bombali
Health facility staff	4.1	2.82	5.3	4.22	6.44
Midwives	0	0	0	0	0
Maternal and child health aid	0.9	1.64	1.1	1.56	1.44
Number of state enrolled community health nurse	0	0.18	0.4	0.22	0.78
Number of community health assistants	0	0	0.3	0	0.11
Vaccinators	0.9	0	0.7	0.78	0.67
Health motivators	0.1	0	0	0	0.67
Traditional birth attendant	1.4	0.64	2.4	1.33	2.11
Volunteers	0.6666667	0.18	0.2	0	0.44
Health facility staff not at the meeting	1.1	2.45	1.6	1.56	0.89
NGO staff	2	2.09	2	3.11	2
Facilitators	2	1.73	1.9	2.67	1.89
Field co-ordinators	0	0.18	0.1	0.44	0.11

The meeting content was fairly consistent across the meetings in Bombali in round 1. 90% of PHU's were not given initial ranking position in the meeting. Only Kaponkie provided the baseline ranking for the clinic. The NGO has been informed that facilitators should be providing baseline rankings to all clinics henceforth. In round 2, 90.91% of PHU's were given initial ranking position in the meeting in Bo (just Kassama did not), 90% in Kenema (Konabu did not), 77.89% in Tonkolili (both Bake Loko and Makrugba did not), and 77.78% in Bombali (Gbonko Bana, Mamaka didn't). We have met with the NGO's again to remind them to provide all of the clinics with their baseline ranking position in the final round of meetings.

In round 1, 90% of meetings discussed the indicators for the award in some way. Only Kaponkie did not mention any of the indicators for the award. In round 2, only the meeting in Samai Town, Kenema, did not mention any of the indicators for the award. There was inconsistency as to whether the meetings discussed problems, solutions and actions, as well as timeframes and responsible individuals. This has been brought up with the NGO's as an action point for the next round of meetings.

As can be seen in the tables below, the most frequently discussed indicator is the number of women who die during pregnancy, number of children under 5 who die and staff attitude. Lesser mentioned indicators are those such as number children 12-23 months completing vaccinations by 12 months of age, number pregnant women completing 4 antenatal care visits, fees charged for maternal and under 5 health services and nurse absenteeism.

**Table 4. Meetings discussing indicators in round 1**

	<b>% meetings discussing the indicators</b>	<b>% meetings discussing problems associated with indicator</b>	<b>% meetings discussing solutions associated with indicator</b>	<b>% meetings discussing actions associated with indicator</b>
Number pregnant women that die due to pregnancy	67%	67%	67%	50%
Number children under 5 who die	56%	67%	67%	67%
Number children 12-23 months completing vaccinations by 12 months of age	33%	50%	17%	17%
Number births which occurred in health facility	44%	50%	33%	33%
Number pregnant women completing 4 antenatal care visits	22%	33%	50%	50%
Fees charged for maternal and under 5 health services	33%	33%	40%	33%
Nurse Absenteeism	33%	50%	40%	33%
Staff Attitude	67%	50%	60%	50%

**Table 5. Meetings discussing indicators in round 2**

	% meetings discussing the indicators				% meetings discussing problems associated with indicator			
	Bombali	Bo	Kenema	Tonkolili	Bombali	Bo	Kenema	Tonkolili
Number pregnant women that die due to pregnancy	66.67%	81.82%	66.67%	66.67%	66.67%	100.00%	71.43%	85.71%
Number children under 5 who die	66.67%	90.91%	66.67%	66.67%	66.67%	100.00%	71.43%	85.71%
Number children 12-23 months completing vaccinations by 12 months of age	66.67%	72.73%	55.56%	100.00%	50%	66.67%	71.43%	100.00%
Number births which occurred in health facility	33.33%	72.73%	77.78%	77.78%	0%	66.67%	57.14%	57.14%
Number pregnant women completing 4 antenatal care visits	33.33%	45.45%	55.56%	55.56%	50%	55.56%	50.00%	71.43%
Fees charged for maternal and under 5 health services	55.56%	63.64%	33.33%	66.67%	50%	66.67%	42.86%	71.43%
Nurse Absenteeism	11.11%	72.73%	22.22%	55.56%	16.67%	55.56%	28.57%	71.43%
Staff Attitude	55.56%	81.82%	33.33%	55.56%	33.33%	66.67%	42.86%	71.43%

	% meetings discussing solutions associated with indicator				% meetings discussing actions associated with indicator			
	Bombali	Bo	Kenema	Tonkolili	Bombali	Bo	Kenema	Tonkolili
Number pregnant women that die due to pregnancy	66.67%	100.00%	71.43%	85.71%	66.67%	100.00%	71.43%	85.71%
Number children under 5 who die	66.67%	100.00%	71.43%	85.71%	66.67%	100.00%	71.43%	85.71%
Number children 12-23 months completing vaccinations by 12 months of age	66.67%	75.00%	71.43%	100.00%	66.67%	87.50%	71.43%	100.00%
Number births which occurred in health facility	0%	62.50%	57.14%	57.14%	0%	62.50%	57.14%	57.14%
Number pregnant women completing 4 antenatal care visits	50%	50.00%	57.14%	71.43%	16.67%	50.00%	42.86%	71.43%
Fees charged for maternal and under 5 health services	50%	62.50%	42.86%	71.43%	66.67%	62.50%	28.57%	71.43%
Nurse Absenteeism	16.67%	50.00%	28.57%	71.43%	16.67%	50.00%	28.57%	71.43%
Staff Attitude	33.33%	50.00%	42.86%	71.43%	33.33%	50.00%	42.86%	71.43%

As Table 6 illustrates, only 78% of meetings in round 1 discussed only the key indicators. This was slightly improved in Kenema, and very much improved in Bo and Bombali in round 2, but was the same in Tonkolili. Some of the meetings discussed the community monitoring intervention, and some meetings made promises about the award. This deviation from the appropriate meeting agenda has been discouraged.

**Table 6. Issues discussed during the meeting**

Issues Discussed During The Meeting	Round 1	Round 2			
	Bombali	Bo	Kenema	Tonkolili	Bombali
Community monitoring meetings	44.40%	18.18%	20.00%	11.11%	0%
Make promise about the award	11.10%	18.18%	30.00%	11.11%	0%
Politics and the election	0	0	0	0	0
Only the key indicators	77.80%	100.00%	90.00%	77.78%	100%

In general, the meeting facilitators seemed to present themselves very well, with the majority (77%) of meetings in round 1 rated by the research team as very amicable, with the remainder somewhat amicable and all of the meetings in round 2 rated by the research team as very amicable.

**Table 7. Percentage of meetings in round 1 in which the facilitator presented the challenges the health facility staff face in a neutral manner, spoke in a respectful way and an understandable language**

	Present the challenges the PHU faces in a neutral manner	Spoke in a way that was respectful of the thoughts and feelings	Spoke in a clear and understandable language
Sometimes	11.10%		
Frequently		11.10%	22.20%
Always	88.90%	88.90%	77.80%

**Table 8. Percentage of meetings in round 2 in which the facilitator presented the challenges the health facility staff face in a neutral manner, spoke in a respectful way and an understandable language**

	Present the challenges the PHU faces in a neutral manner				Spoke in a way that was respectful of the thoughts and feelings			
	Bo	Kenema	Tonkolili	Bombali	Bo	Kenema	Tonkolili	Bombali
Frequently	9.09%	40%	22.22%	11.11%		20%	22.22%	
Always	90.91%	60%	77.78%	88.89%	100%	80%	77.78%	100%

<b>Spoke in a clear and understandable language</b>				
	<b>Bo</b>	<b>Kenema</b>	<b>Tonkolili</b>	<b>Bombali</b>
Frequently		40%	11.11%	11.11%
Always	100%	60%	88.89%	88.89%

The research team was pleased to see that 100% of meetings in round 1 checked had a poster. However, some clinics in round 2 didn't have a poster. Namely, the clinics of Benduma and Matru on the rail in Bo, Diema in Kenema, and Fothaneh Junction in Tonkolili. The theme (Respect Pass Money) was not cited in the meetings in Tokpombu and Pelewahum in Kenema. Just 40% of meetings in round 1 in Bombali, and 36.36% of meetings in Bo, 50% of meetings in Kenema, 55.56% of meetings in Tonkolili, and 100% meetings in round 2 facilitators talked about honesty and risk of over reporting by the clinic. The NGOs have been reminded that this should be emphasized by all facilitators in order to prevent false reporting of information by the clinic, and that it should be communicated that the research team will be auditing the information provided by the clinic and triangulating it with user feedback.

## **Background:**

A key part of the community monitoring intervention is the joint community and health care facility meetings. The 3 NGOs: Plan, Concern and IRC scheduled the fourth round of these meetings for the entire treatment group in the 4 districts of the study. Plan in Bombali, Concern in Tonkolili, and IRC in Bo and Kenema.

The fourth round of these meetings took place in January/February 2013. This fourth round of meetings was designed in order to assess the progress made, and make new milestones towards the actions as specified in the first and second meeting's joint action plan. As the final meeting in the intervention, it also focused on discussing the sustainability of any progress made, and action plans in the future. The research team has been monitoring the meetings in order to ensure that there is consistency in the meetings both within and between districts therefore ensuring validity of the data from the randomized controlled trial. Here follows the results of the monitoring of the fourth round of community monitoring meetings.

## **Methodology:**

The 85 clinics in the treatment group had round 4 of the interface meetings scheduled by the 3 NGOs. The research team randomly selected 50% of these meetings evenly distributed across the 4 districts to attend for monitoring purposes. A questionnaire was developed, and iterated each round in response to feedback from the IPA enumerators in the field and by the World Bank, by the research team in order to assess the meetings on quality and consistency and to ensure that they were in line with the design of the intervention laid out in advance. The questionnaire raised issues such as the participants in the meetings, the meeting content, the way in which the NGO facilitator interacted with participants, and the content of the compact formed. An enumerator from IPA (out of 10 different individuals randomly assigned to each meeting) attended each of the 39 selected meetings to complete the questionnaire. The enumerator did not interact with the meeting in any way.

Table 1 gives the meetings attended by the research team in round 4 of the community monitoring meetings.

**Table 1. clinic meetings monitored in the intervention districts**

<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
Bumkaku	Bumban	Bongor	Foindu
Grima	Kaimunday	Fayiema	Kunya MCHP
Kigbai	Kamabaio	Gbado	Magboki Road
Njandama	Kolisokoh	Komende Luyawa	Manewa
Lowoma	Kortuhun	London	Mathinka Lol
Mbundorbu	Maselleh	Loppa	Mayogbor
Nianyahun	Masingbi Lol	Patama	Mayossoh
Sahn	Massory	Sandaru	Robarie
Sembahun		Semewabu	Robina

Upper Saama Yambama		Vaahun	Ronietta
------------------------	--	--------	----------

## **Results:**

### *Attendance and participation*

In order for the intervention to have as large an impact as possible, as well as to ensure validity of the RCT data, the meetings aimed to have 100% representation of the catchment villages of the clinic.

Overall, 79% of meetings had 100% village representation. This is an improved representation from round 3 (71%), but still lower than round 1 (85%). In Bombali and Tonkolili, the percentage attendance was much lower than that of the other districts. However, in Kenema, 100% of the meetings had 100% attendance (which also happened in round 3).

**Table 2. Percentage village representation at the meetings by district**

#### Bo

Percentage Attendance	Freq.	Percent
80%	1	9.09
89%	1	9.09
100%	9	81.82

#### Bombali

Percentage Attendance	Freq.	Percent
70%	1	12.50
71%	1	12.50
98%	1	12.50
100%	5	62.50

#### Kenema

Percentage Attendance	Freq.	Percent
100%	10	100

#### Tonkolili

Percentage Attendance	Freq.	Percent
50%	1	10
86%	1	10
94%	1	10
100%	7	70

The table below gives the breakdown of mean number of attendants into further sub-categories of attendant.

**Table 3. Mean number of attendants by district and attendant type**

	Bo	Bombali	Kenema	Tonkolili
Mean number of health facility staff present	6.36	4.13	4.8	3.7
Midwives	0.09	0	0	0
Maternal and Child Health Aids	1.45	1.5	1.3	0.7
State Enrolled Community Health Nurses	0.09	0	0.1	0.2
Community Health Assistants	0.27	0	0	0
Vaccinators	0.09	0.125	0.5	0.6
Volunteers	0.72	0.625	0.1	0.2
Health Motivators	0.45	0	0.1	0
Traditional Birth Attendants	2.55	1.75	3	2.8

Mean number of NGO staff present	3.64	3.75	3.9	4.5
Facilitators	2.82	3.5	2.7	3.5
Field co-ordinators	0.64	0.125	0.8	0.8

Mean number of authority figures present	0.82	1.125	1.3	0.5
Resident chief	0.55	0.625	1.9	0.5
Councilors	0.09	0	0	0
DMO/DHMT	0	0	0	0
Paramount/section chief	0.09	0.125	0	0
Parliamentarian	0	0	0	0
VDC chairman	0.09	0	0	0

Mean number of community representatives present	42.45	58.63	39.2	46.9
Young Male Representatives	8.64	13.29	8.2	9.5
Adult Male Representatives	8.55	9.29	7.8	9.6
Young Female Representatives	8.55	11.71	8.1	9.2
Adult Female Representatives	8.55	10.14	7.2	9.3

Table 4 shows mean participation in the meetings, participation equating to each individual contribution during the meeting. It appears that in Tonkolili the health staff made contributions than any other group. In Bombali, older participants appeared to make fewer contributions.

**Table 4. Mean participation in the meeting by attendant type and district**

	Bo	Bombali	Kenema	Tonkolili
Young women	32.7	10	20.56	18.7
Old women	32.2	8.67	17.78	19.1
Young men	32.8	13.29	18.89	17
Old men	34	10.17	21.89	24.7
Traditional birth attendants	27.2	12.33	18.89	25.6
Health staff	30.6	7.29	18.67	13.6
Authority Figures	0	2.75	7.9	0.8

### *Meeting content*

Overall, meetings took an average of 3h 59 with a maximum of 6h 15 and a minimum meetings time of 1h 24. These meetings were the longest out of all of the rounds, in particular in Kenema.

**Table 5. Mean duration of meetings by district**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
<b>mean (h)</b>	3h 43	3h 05	5h 22	3h 35
<b>min (h)</b>	2h 45	1h 38	4h 20	1h 24
<b>max (h)</b>	4h 55	4h 30	6h 15	5h 47

### *Facilitator*

Several indicators given below measured the behavior of the facilitator in the meetings. The tables below provide information on the percentage of meetings in each district in which the facilitator behaves in an appropriate manner.

Table 6 and Table 7 show that a moderate percentage of facilitators succeeded in always allowing all voices to be heard, and few facilitators encouraged quiet participants to be active in the conversation.

**Table 6. Percentage of meetings in which facilitator led the group in a way to allow all voices to be heard.**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
<b>Never</b>	0	12.50	0	0
<b>Seldom</b>	0	0	0	0
<b>Sometimes</b>	9.09	0	10.00	0
<b>Frequently</b>	36.36	37.50	0	20.00
<b>Always</b>	54.55	50.00	90.00	80.00

**Table 7. Percentage of meetings in which facilitator encouraged quiet participants to be active in the conversation.**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
<b>Never</b>	18.18	12.50	10.00	10.00
<b>Seldom</b>	9.09	0	10.00	30.00
<b>Sometimes</b>	18.18	0	50.00	30.00
<b>Frequently</b>	18.18	50.00	20.00	0
<b>Always</b>	36.36	37.50	10.00	30.00

Table 8 and Table 9 show that the facilitators usually spoke in a respectful, understandable way.

**Table 8. Percentage of meetings in which the facilitator spoke in a way that was respectful of the thoughts and feelings of all participants**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
<b>Never</b>	0	0	0	0
<b>Seldom</b>	0	0	0	0
<b>Sometimes</b>	0	0	0	0
<b>Frequently</b>	0	0	90	0
<b>Always</b>	100	100	100	100

**Table 9. Percentage of meetings in which facilitator spoke in a clear, understandable language.**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
<b>Never</b>	0	0	0	0
<b>Seldom</b>	0	0	0	0
<b>Sometimes</b>	0	0	0	0
<b>Frequently</b>	0	0	10	10
<b>Always</b>	100	100	90	90

The enumerators rated the atmosphere of each meeting. It can be seen that almost all of the meetings had an amicable atmosphere.

**Table 10. Atmosphere of the meetings by district, given in percentage**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
<b>Very amicable</b>	100.00	87.50	80.00	90.00
<b>Somewhat amicable</b>	0	12.50	20.00	10.00
<b>Somewhat hostile</b>	0	0	0	0
<b>Very hostile</b>	0	0	0	0

Our enumerators also looked for the scorecard initially given to clinic was still in the clinics for reference and found that the scorecard was still present in 44.44% of the clinics.

Table 11 lists certain objectives of the meetings, and the percentage of meetings in each district that achieved these objectives. In general, all of the facilitators performed very well in achieving these objectives.

Only Ronietta in Tonkolili PHU staff didn't assign an initial score for community members' progress. Only London in Kenema community members didn't assign a final score for the PHU staff. Only Ronietta in Tonkolili didn't discuss how communities and PHU staff were to sustain progress in the absence of the NGO

staff. There was a split as to whether facilitators mentioned the scores from the previous meeting.

Our enumerators also looked for the scorecard initially given to clinic was still in the clinics for reference and found that the scorecard was still present in 44.44% of the clinics.

**Table 11. Percentage of meetings in each district that completed certain objectives of the meeting**

	<b>Bo</b>	<b>Bombali</b>	<b>Kenema</b>	<b>Tonkolili</b>
<b>% meetings that present a compact with actions for the PHU staff</b>	100	100	100	100
<b>% meetings in which scoring methods are explained to PHU staff</b>	100	100	100	100
<b>% meetings that present a compact with actions for the community</b>	100	100	100	100
<b>% meetings in which scoring methods are explained to the community</b>	100	100	100	100
<b>% meetings in which facilitator carried out a role play to explain the scoring method</b>	100	100	100	100
<b>% meetings presenting a joint compact to both PHU staff and community</b>	100	100	100	100
<b>% meetings in which PHU staff and community members were separated at the start</b>	100	100	100	100
<b>% meetings in which community assigned an initial score</b>	100	100	100	100
<b>% meetings in which PHU staff assigned an initial score</b>	100	100	100	90
<b>% meetings in which community and PHU staff came together to discuss the compact</b>	100	100	100	100
<b>% meetings in which PHU staff assigned final score for community</b>	100	100	100	100
<b>% meetings in which community assigned final scores for PHU staff</b>	100	100	90	100
<b>% meetings in which scores from round 3 were discussed for PHU staff</b>	36.36	87.50	60.00	30.00
<b>% meetings in which scores from round 3 were discussed for community members</b>	45.45	87.50	70.00	30.00
<b>% meetings in which the group discussed ways to improve or maintain progress</b>	100	100	100	90

<b>% meetings in which there was an updated time frame for achievement of the actions established</b>	81.82	100	90	100
<b>% meetings in which the group decided how to track progress</b>	100	100	100	100
<b>% meetings in which the group decided how information would be fed back to the communities</b>	90.91	100	100	100
<b>% meetings resulting in a signed compact agreement</b>	100	100	100	100
<b>% meetings discussing how to sustain progress without with NGO's facilitating future meetings</b>	100	100	100	90
<b>% meetings in which the facilitator mentioned that it was the last meeting</b>	100	100	100	100

## Monitoring of Round 3 Non-Financial Award Meetings

### Background:

A key part of the non-financial awards intervention is the meetings that occur with the health care clinics in order to inform the clinics further about the award and ways in which they can improve their performance. The NGOs: Concern and IRC scheduled the second round of these meetings for the treatment group in 3 districts of the study. Concern in Tonkolili, and IRC in Bo and Kenema and Plan in Bombali.

The third round of these meetings took place between October and November 2012. These meetings were designed to give clinics information about their current performance based on indicators that are discussed, and to create action plans to improve their performance. As the final meeting before the competition is over, and clinics are measured on their performance, the clinics are told of the dangers of over reporting as well as discussions on how to sustain improvement in the absence of the competition. The research team has monitored the third, and final round of these meetings in order to ensure that there is consistency in the meetings within the district. Here follows the results of the monitoring of the third round of community monitoring meetings.

### Methodology:

The clinics had round 3 of the meetings scheduled and the research team randomly selected 50% of these meetings to attend for monitoring purposes. A questionnaire was developed by the research team in order to assess the meetings on quality and consistency and to ensure that they were in line with the design of the intervention laid out in advance. The questionnaire raised issues such as the participants in the meetings, the meeting content, the way in which the NGO facilitator interacted with participants, and the action plan formed as a result of the meeting. An enumerator from IPA (out of 6 different individuals randomly assigned to each meeting) attended each of the randomly selected meetings to complete the questionnaire. The enumerator did not interact with the meeting in any way.

**Error! Reference source not found.** gives the meetings attended by the research team in round 3 of the non-financial award meetings.

**Table 1. Clinic meetings attended by the research team**

<b>Kenema</b>	<b>Bo</b>	<b>Tonkolili</b>	<b>Bombali</b>
Gbangeima	Feiba	Bassia	Bumbadain
Gendema	Fengehun	Fothaneh Bana	Gbonkobana
Giema	Griema	Komrabai Station	Kagbo
Koagbema	Kambawama	Magbanabom	Kaponkie
Kokoru	Kassie	Magbeassa	Maforay
Mano Jeigbla	Kpangbalia	Makoba Bana	Maharie
Ndiegboiya	Mendewa	Makonkorie	Makarie

Ngiewahun	Ngolahun	Makrugbeh	Panlap
Njelehun	Niagorehun	Mamaka	Stocco
Potehun	Sengehun	Mapamurie	Tokomba
Tawahun	Teibor	Masoko	
Woyama		Masumana	
		Mathonkora	
		Rokimbi	

All but one (Bassia in Tonkolili) of the meetings that the research team attended took place on the agreed date, and all but Bassia took place in or around the PHU. The meeting duration varied, with the longest lasting for 5 hours, and the shortest just 30 mins. The meetings were noticeable shorter in Tonkolili than in the other districts.

**Table 2. Meeting duration**

	Kenema	Bo	Tonkolili	Bombali
<b>Mean</b>	2 h 07	2 h 25	49 mins	1 h 51
<b>Minimum</b>	1 h 03	48 mins	30 mins	1 h 08
<b>Maximum</b>	5 h	5 h	1 h 20	4 h

As can be seen in the table below, the majority of health facility staff attending the meeting was maternal and child health aid, traditional birth attendants and vaccinators. In a number of meetings, there were a number of health facility staff not present at the meeting.

**Table 3. Mean number of attendees at the meetings, by attendee type**

	Bo	Kenema	Tonkolili	Bombali
Health facility staff	5.18	4.46	3.5	4.9
Midwives	0	0	0	0
Maternal and child health aid	1.82	1.38	1.07	1.4
Number of state enrolled community health nurse	0	0.15	0.14	0.1
Number of community health assistants	0.36	0.15	0.07	0.3
Vaccinators	0.09	0.38	0.78	0.5
Health motivators	0.18	0.23	0	0.5
Traditional birth attendant	1.27	1.85	0.86	1.6
Volunteers	0.09	0	0.43	0.4
Health facility staff not at the meeting	2.09	1.54	3	2.4
NGO staff	2	2.08	3.57	2
Facilitators	1.36	1.46	2	1.8
Field co-ordinators	0.64	0.46	0	0

85.42% of meetings had the same in charge nurse at the previous meeting. 95.83% of PHU's were given initial ranking positions at this meeting.

Only the meeting in Feiba, Bo, did not mention any of the indicators for the award. There was inconsistency as to whether the meetings discussed problems, solutions and actions, as well as timeframes and responsible individuals. As can be seen in the tables below, the most frequently discussed indicators are the number of women who die during pregnancy and number of children under 5 who die. Lesser mentioned indicators are those such as number pregnant women completing 4 antenatal care visits, fees charged for maternal and under 5 health services and nurse absenteeism.

**Table 4. Meetings covering key points**

	<b>Bo</b>	<b>Kenema</b>	<b>Tonkolili</b>	<b>Bombali</b>
<b>% meetings discussing the indicators</b>	90.91%	100%	100%	100%
<b>% meetings discussing problems associated with indicator</b>	90%	92.31%	92.86%	100%
<b>% meetings discussing solutions associated with indicator</b>	81.82%	76.92%	100%	90%
<b>% meetings discussing actions associated with indicator</b>	81.82%	69.23%	92.86%	70%
<b>% meetings assigning timeframes to the action</b>	100%	100%	57.14%	100%
<b>% meetings assigning responsible individuals to the action</b>	90.91%	100%	92.86%	100%
<b>% meetings in which facility staff was making progress on their action points</b>	71.73%	92.31%	100%	100%

**Table 5. Meetings discussing indicators**

	% meetings discussing the actions associated with indicator				% meetings discussing problems associated with indicator			
	Bombali	Bo	Kenema	Tonkolili	Bombali	Bo	Kenema	Tonkolili
Number pregnant women that die due to pregnancy	90%	100%	84.62%	92.86%	70%	88.89%	91.67%	92.31%
Number children under 5 who die	90%	100%	84.62%	92.86%	60%	88.89%	75%	92.31%
Number children 12-23 months completing vaccinations by 12 months of age	80%	70%	46.15%	64.29%	80%	77.78%	66.67%	69.23%
Number births which occurred in health facility	50%	50%	46.15%	50%	60%	33.33%	33.33%	61.54%
Number pregnant women completing 4 antenatal care visits	50%	50%	53.85%	57.14%	70%	33.33%	75%	53.85%
Fees charged for maternal and under 5 health services	30%	40%	46.15%	57.14%	30%	22.22%	50%	15.38%
Nurse Absenteeism	50%	60%	38.46%	28.57%	50%	44.44%	25%	7.69%
Staff Attitude	50%	70%	53.85%	28.57%	50%	77.78%	33.33%	7.14%

	% meetings discussing solutions associated with indicator				% meetings discussing actions associated with indicator			
	Bombali	Bo	Kenema	Tonkolili	Bombali	Bo	Kenema	Tonkolili
Number pregnant women that die due to pregnancy	66.67%	88.89%	100%	84.62%	66.67%	88.89%	100%	92.31%
Number children under 5 who die	55.56%	66.67%	100%	84.62%	66.67%	66.67%	100%	84.62%
Number children 12-23 months completing vaccinations by 12 months of age	77.78%	77.78%	60%	69.23%	88.89%	77.78%	55.56%	69.23%
Number births which occurred in health facility	66.67%	33.33%	40%	61.54%	44.44%	44.44%	44.44%	44.44%
Number pregnant women completing 4 antenatal care visits	77.78%	33.33%	70%	46.15%	66.67%	33.33%	55.56%	53.85%
Fees charged for maternal and under 5 health services	33.33%	100%	60%	7.69%	11.11%	100%	55.56%	7.69%
Nurse Absenteeism	44.44%	22.22%	20%	7.69%	44.44%	22.22%	22.22%	7.69%
Staff Attitude	44.44%	55.56%	40%	7.69%	44.44%	44.44%	33.33%	7.69%

**Table 6. Issues discussed during the meeting**

<b>Issues Discussed During The Meeting</b>	<b>Bo</b>	<b>Kenema</b>	<b>Tonkolili</b>	<b>Bombali</b>
Community monitoring meetings	100%	100%	100%	90%
Make promise about the award	0	0	0	0
Politics and the election	0	0	7.14%	10%
Only the key indicators	81.82%	100%	100%	90%

As Table 6 illustrates, there were meetings in both Bombali and Tonkolili that did not discuss only the key indicators. One meeting in Bombali also discussed the community monitoring intervention, although fewer than in the previous round, and no meetings made promises about the award.

In general, the meeting facilitators seemed to present themselves very well, with all of the meetings rated by the research team as very amicable, and the facilitators presenting the challenges that the PHU faces in a neutral manner, speaking in a way that was respectful of the thoughts and feelings of the staff, and speaking in an understandable language.

The research team is concerned that some clinics did not feature a poster. Namely, the clinics of Masoko and Rokimbi in Tonkolili. The theme (Respect Pass Money) was cited in all of the meetings, but the meeting in Sengehun in Bo did not discuss what type of award was to be given. Kpangbali, Feiba and Mendewa in Bo and Rokimbi in Tonkolili didn't talk about honesty and risk of over reporting by the clinic. All of the facilitators said that it was the last meeting but that the competition would continue.