

**SCHOOL OF NURSING  
COLLEGE OF HEALTH SCIENCE UNIVERSITY OF GHANA  
LEGON**

**RETENTION OF NURSES IN GHANA: PERSPECTIVES OF NURSES AT  
KORLE-BU TEACHING HOSPITAL**



**2007**

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**ANITA AFUA DAVIES**



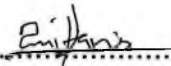
**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN  
PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF  
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**2007**



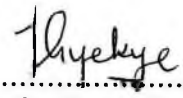
### Declaration

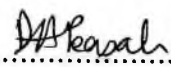
I, Anita Afua Davies hereby declare that this is my original work, which I have produced during the conduct of a research project. References made from other researchers have been duly acknowledged. None of the materials contained in this thesis have been presented either wholly or partially to any institution for any degree.

  
.....  
Anita Afua Davies  
Candidate

WE THE UNDERSIGNED ACCEPT THIS THESIS AS CONFORMING TO THE  
REQUIRED STANDARD.



  
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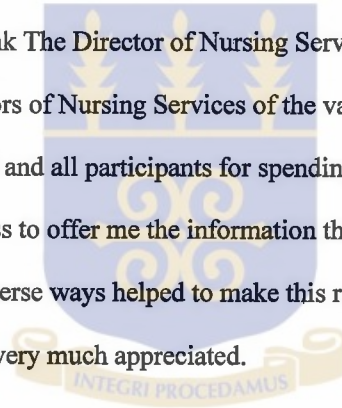
  
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### **Dedication**

I dedicate this work to Jesus Christ my Saviour, Strength and all, to my mother, my sisters, niece and nephews, for their love care and support. Colleen- Charlotte, Jojo and Edem, this is for you.

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### **Abstract**

A qualitative approach which is exploratory in nature was used to explore retention of nurses in Ghana: perspectives of nurses at Korle-Bu Teaching Hospital. The research sought to explore what had made nurses stay in Ghana and what these nurses believe will enhance retention of nurses in Ghana. Eleven participants were interviewed including a nurse administrator. The inclusion criterion was nurses who had worked in Ghana for at least ten years. The analytic strategy was content analysis and after verbatim transcription, checking, correcting and coding, personal convictions, monetary benefits and improved working conditions were found to be the reasons why nurses had been retained in Ghana. Personal convictions should be exploited in order to retain nurses. The Ghana Registered nurses Association should ensure that nurses are well paid. This they can do by lobbying. Ministry of Health should improve upon the working conditions of nurses.

## **CHAPTER ONE**

### **Introduction**

#### **1.1 Background**

There is a shortage of nurses worldwide, which has led to increased opportunities for international mobility within the nursing profession. The increasing number of nurses as well as other health professionals who migrate to wealthier nations has had devastating effects on countries still classified as low resource or low income. (Buchan, 1996, 2000; Buchan, Parkin & Sochalski, 2003; Muula, Mfutso- Benjo, Makoza & Chatipwa, 2003; Oulton, 2004; Pang, Langsang & Haines, 2002; Pearson, 2004).

This is in response to huge demands emanating from high income countries. The demands for health care professionals increased in these countries due to shifts in demographic characteristics such as the aging of their population and influxes of immigrants and refugees as well as increased insight into acute care settings. These population trends occurred at a time when there was an exponential increase in career choices for those who are entering post secondary education and/or the labour force. This led to a reduction within high income countries of attracting recruits into professional nursing careers. In view of the increased demand for health professionals including nurses globally, nurses from lower income countries, especially countries in Africa, are being recruited at increased rates to fill the human resource deficit in higher income countries.

African nurses are being recruited at increasing rates by European and North American countries at a time when the African continent is facing a health crisis.

This crisis is being caused by a number of events that occurred in the past two decades. These include the emergence of relatively new disease conditions such as Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and Ebola fever as well as resurgence in other diseases such as tuberculosis, malaria, sickle cell disease, hypertension, diabetes mellitus and guinea worm (Unpublished paper, Adika-Bensah & Attah-Tuffour, 2004). This has also led to high levels of morbidity and mortality over the centuries. Linked to these events are changing lifestyles including migration to urban areas with its attendant overcrowding and loss of role models. Other behaviours, affecting individual and community health status, such as the ingestion of “fast foods” and abuse of substances such as tobacco, alcohol and drugs, have become more apparent.

In addition, political structures are facing economic difficulties leading to the very low funding of social services, which includes the health services. These economic difficulties have led to the deterioration of health service infrastructure while these same economic issues are leading to an increased demand for healthcare services as the health status of the population declines. For example, there are increases in the numbers and severity of those experiencing malnutrition or acquiring infectious diseases such as HIV/AIDS. These healthcare crises in Africa are examples of morbidities that will lead to escalating health care costs. To further compound these problems, retention of staff in the health sector, especially the retention of nurses becomes increasingly difficult.

Retention of nurses is a delicate issue in that one wonders whether one can ask nurses to function in conditions which are deplorable. Can nurses be forced to stay in their country when high income countries are recruiting them and offering them attractive contracts, predictable hours and better working conditions? Ethically and

morally, is it right for high income countries to exploit lower income ones by exporting nurses trained in these countries to nursing positions abroad? Is it possible for low income countries to be remunerated for sending personnel abroad? Or must there be an arrangement whereby every nurse in a low income country is exposed to working in good conditions for some years and then made to return to their native country?

Nursing as a human resource increased by about 1,000 in Ghana during the years 1999 to 2003. The total numbers were 11,659, 14,315, 11,876, 12,068 and 12,647 respectively (Statistics on nursing personnel for Ghana Health Service, 1999 to 2003). The figures may be rising probably because attempts are being made to retain the nurses. Like other Sub-Saharan African countries, Ghana is experiencing a significant loss of nurses to the United Kingdom, United States and other western nations (Amoa, 2000; Sagoe, 2000). It was revealed that 200 nurses emigrated from Ghana in the first two weeks of January 2003 ([myjoyonline.com](http://myjoyonline.com), January 28, 2003). This migration is significant in human terms in that each migrating African who received nursing education in their country is equivalent to a loss of \$184, 000 US to that country (Federation for American Immigration Reform: Brain Drain, 2004).

It is estimated that 2,972 nurses left Ghana in 2001 and 3,534 in 2002. Most went to the United Kingdom and USA (Buchan, Parkin and Sochalski, 2003). In the *Nursing and Midwifery Council, United Kingdom (NMC)* statistics it is indicated that 195 Ghanaian nurses were registered in the UK in March 2001 (Buchan, Parkin, and Sochalski, 2003). In an integrated Regional Information Network (IRIN) interview with the immediate past president of Ghana Medical Association, Mr. Plange-Rhule it was revealed that health professionals have been steadily leaving Ghana over the last decade (Unpublished paper, Adika-Bensah & Attah-Tuffour, 2004). In some

hospitals, wards that accommodate 40 patients and ideally have 6 or 7 nurses on day shifts must now make do with one nurse and one nurse-aid (i.e., a non-professional). Ghana had about 20,000 nurses in 1996 (Unpublished paper, Adika-Bensah & Attah-Tuffuor, 2004). Dr. Plange-Rule asks the question, "Where have they gone?" He describes the situation as frightening.

Much is already known about the reasons why nurses and other health professionals choose to leave their countries of origin for opportunities in wealthier nations. The situation can be likened to osmosis, whereby those in stronger nations attract those in weaker nations. However, there are nurses who, given a choice, would decide to remain in their native countries in any event. It may be helpful to understand more about why these nurses choose to stay. Thus, the focus of this research study will be to ask this question and what these nurses believe would enhance retention of members of their profession?

## **1.2 Statement of the problem**

Low income countries are faced with many challenges including much of the population living below the poverty level and also having compromised health status with high morbidity and mortality rates, overpopulation, corruption and threats of violence. The health status of the population is of particular concern and one that requires the knowledge and skills of professional nurses. The challenge is not only to educate nurses in Ghana but also to retain them.

Korle-Bu Teaching Hospital requires 1500 nurses to function effectively but the nursing strength from 1999 to 2004 was 1,025, 971, 969, 1,031, 1,032 and 1,038 respectively (Korle-Bu Teaching Hospital, 2000 to 2005). This figure is not up to the required 1,500 nurses. What can be done to address working conditions for professional nurses so that they remain committed to practising in Ghana rather than

looking for opportunities outside their country? This is a problem that must be attended to with all seriousness so that health services function effectively.

### **1.3 Purpose of the Study**

The purpose of this study is to explore perceptions of nurses at Korle-Bu Teaching Hospital about their working conditions, why they continue to practise nursing in Ghana, and what they believe would enhance retention of nurses in their specific setting.

### **1.4 Objectives**

1. To describe what motivates nurses to remain at Korle Bu Teaching Hospital.
2. To explore strategies that will enhance the retention of nurses in Ghana.

### **1.5 Significance**

The information will provide insight into why Ghanaian nurses practise in their country and at Korle Bu Teaching Hospital in particular. It will also provide strategies to enhance the retention of nurses in Ghana, particularly at the Korle-Bu Teaching Hospital. Areas of nurses' satisfaction with their place of employment will also be identified. This is especially critical at a time when so little funding is available for health care and the largest group of health professionals (i.e., nurses) are considering other opportunities.

In the area of research, the study will go on further to support findings that have come out of other researches mostly outside the country. Since most researches have emphasized on why nurses migrate, it will serve as a source of study for up and coming nurses. Policy makers will be able to come out with strategies to retain nurses or appropriate policies to enhance the retention of nurses.

### **1.6 Operational Definitions:**

For the purpose of this study, the following terms will be defined:



**Retention of Nurses:** Nurses who have been employed at Korle Bu Teaching Hospital for at least 10 years and who acknowledge verbally that they have no plans to resign.

**Nurses: State Registered Nurses (Ghana)**

## **CHAPTER TWO**

### **Literature Review**

To explore retention of nurses within the Ghanaian health care system, it is helpful to conceptualise the issue within the context of global migration, and to understand how nurses weigh factors influencing their decision to emigrate or remain in their country. Of equal importance is the need to understand issues of specific relevance to nurses such as satisfaction with their employment, levels of remuneration for their service, and functioning in a gender-specific profession. Existing research in each of these areas was reviewed, as well as specific details about the emigration of nurses from Ghana to higher income countries.

#### **2.1 Global Migration**

Migration is a global phenomenon that is related to market forces. With worldwide shortages of nurses, recruiters are encouraging the migration of nurses across international boundaries (Buchan, 2002a; 2002b; Buchan, Parkin & Sochalski, 2003; Erlen, 2004; Finlayson, Dixon, Meadows & Blair, 2002; McKee, 1998; Pearson, 2004; Reilly, 2003; Spurgeon, 2000). Both the benefits and risks to nurses who choose new work settings as a result of international migration are well documented (Brown & Connell, 2003; Buchan, 2002b; Kale, 1995; Kline, 2003; Kumar, 2002; Makinwa-Adebusoye, 1995; Ray, 2001; Steltzer, Woods & Gasda, 2003; Xu, 2003). 'Brain drain', also known more benignly as 'brain mobility' or 'brain circulation' (Oo, 2004), is an old term that refers to the flow of skilled professionals from disadvantaged or 'developing' nations to wealthy or 'developed' nations (Marchal and Kegels, 2003; Federation for American Immigration Reform, 2004). Such migration of skilled professionals leads to a real or perceived loss of human capital in their countries of origin. This loss is considered an important factor

in an emerging health care crisis, particularly in Sub-Saharan Africa (Abergavenny, 2004; Buchan, Parkin & Sochalski, 2003; de Castella, 2003; Federation for American Immigration Reform: brain drain, 2004; Richards, 2003; Woodcock, 2004). Before discussing previous research about forces that affect a nurse's decision to migrate and 'brain drain' in detail, an overview of the extent of the loss of nurses and other health professional human capital in low income countries, in general, and in Ghana, in particular, will be provided.

## **2.2 Significance of migration from low to high income countries**

International migration of skilled professionals including health professionals is not new (Makinwa-Adeboysaye, 1995; Mejia, 1978). Cyclic variations in the availability of health professionals in richer countries, marked by sporadic shortages, create conditions that facilitate migration of skilled professionals, including nurses, from disadvantaged to more advantaged countries.

The emerging health care crisis in Sub-Saharan Africa is fuelled by significant health professional shortages in the United Kingdom (UK), United States (US), Canada, and Australia. In the UK, the nursing shortage experienced since 1998 is considered the most critical in 25 years (McKee, 1998). For example, by 2004 about 10,000 additional nurses and doctors were being recruited to the UK alone (Abergavenny, 2004; Finlayson, Dixon, Meadows & Blair, 2002). These shortages of skilled health care professionals are widely believed to be threatening the quality of health care providers everywhere (Buchan, Parkin & Sochalski, 2003; McKee, 1998; Pang, Langsang & Haines, 2002). International recruitment of nurses is intensive and by 2005, 7000 nurses from the Philippines were registered in the UK compared to 52 in 1999 (Abergavenny, 2004). There were reports of more than 30,000 foreign-educated nurses working in the UK in 2002 (Woodcock, 2004). It is also reported that

58 percent of all newly registered physicians in the General Medical Council (UK) in 2002 received their medical education somewhere else (Goldacre, Davidson & Lambert, 2004).

The situation in the US is even more daunting, with a prediction of 400,000 vacant nursing positions in the next 10 years (Reilly, 2003). This is due in part to the expected retirement of nurses born during the post war “baby boom”, the aging and therefore greater health needs of the population as well as changing opportunities for young women and men that result in fewer being interested in professional nursing in an environment where they have many more choices. It is estimated that 4,700 nurses immigrate to the US annually and that 4 percent of the nursing workforce is foreign-educated (Reilly, 2003). Similar shortages of nurses are reported in Scotland (Buchan, 2002a), Canada (Spurgeon, 2000), Australia, Ireland, and Norway (Buchan, Parkin & Sochalski, 2003).

Shortages of nurses and other health professionals in higher income countries lead to active recruitment from lower income countries. Recruiters often offer instrumental and material support including assisting with the procurement of visas and registration as well as providing relocation costs (Buchan, Parkin & Sochalski, 2003). Health care related consequences of this recruitment in Sub-Saharan Africa in general and Zimbabwe in particular are deemed to be grave (de Castella, 2003). Approximately 18,000 nurses from Zimbabwe now work overseas. Zambia is estimated to need 15,000 physicians but have only 600. This is disturbing when it is considered that a few years ago they had 1,600 (Richards, 2003). Twenty-nine thousand Nigerian doctors are working in the US (Federation for American Immigration Reform, 2004), and 70 percent of medical school graduates from Sierra Leone reside outside their country, One third of Ethiopia’s general practitioners

worked outside their country between 1988 and 2001, leading to the closure of five departments in the Gondar Medical Science College. One-third to one-half of South African medical school graduates emigrate (Federation for American Reform: Brain Drain, 2004).

On March 8, 2004, the International Council of Nurses issued a press release announcing the initiation of the “first systematic investigation of the nursing workforce globally” (p.1) to “identify the policy and practice issues and solutions that should be considered by governments, international agencies, employers and professional associations when addressing the supply and utilization of nurses” (p. 1). The ethics of international health professional recruitment from low income countries is a concern, while it is also acknowledged that freedom of mobility is a human right ((Buchan, Parkin & Sochalski, 2003; Hinsliff, 2004; Mellor, 2003; Singh, Nkala, Amuah, Mehta & Ahmad, 2003). Facilitating international migration through legislation and visa requirement changes was also discussed (Glaessel-Brown, 1998; Rockett & Putnam, 1989). In the UK in particular, agreement to curb poaching of health professionals from certain countries has been reached (Sidley, 2004). What is clear is that the issue of international migration of health professionals is real, complex, and mired in ethical, pragmatic, and human rights issues. No straightforward solutions exist as will be seen in the discussion of the aetiology of the worldwide nursing shortages, forces influencing the decision to migrate, and issues relating to ‘brain drain’ that will be presented next.

### **2.2.1 Forces Internal and External to Ghana that Increase International Migration:**

There are forces both internal and external to a given country that affect why nurses, other health professionals, or other citizens choose to migrate (Buchan, 2002;

Kline, 2003; Xu, 2003). These are often referred to as “push and pull” forces in that there are forces that are perceived to “push” nurses away from their country of origin and also forces that “pull” or attract nurses to other higher income countries. The prospect of migration is often attractive to nurses due to conditions in their home country that “push” them toward a decision to emigrate while others feel “pulled” or drawn toward particular attractions in a specific recipient country. The “pull” forces are generally opposite to conditions that exist in their country of origin (Xu, 2003). These “push and pull” forces exert influence at the individual, institutional, national, and international levels simultaneously (Makinwa-Adeboysaye, 1995; Xu, 2003).

Factors that “push” nurses toward a decision to emigrate include low or inadequate remuneration (Brown and Connell, 2004; Buchan, 2000b; Kale, 1995; Kline, 2003; Kumar, 2002; Ray, 2001), political instability (Kale, 1995; Xu, 2003), diminished career opportunities (Brown and Connell, 2004; Buchan, 2002b), lack of opportunity for further education (Buchan, 2002b), and the threat of violence in their home country (Buchan, 2002b). Other forces leading to emigration are poor working conditions (Xu, 2003), over-supply of professionals in a particular field, under-development of the home country, inflexible labour legislation, and high crime rates (Ray, 2001). Additional adverse working conditions that influence decisions to migrate may include lack of access to modern technology or lack of professional mobility, which may be related to nepotism and favouritism (Connell and Brown, 2004).

Forces that “pull” nurses toward migration to another country mirror the “push” factors. They include opportunities to develop professionally, gain autonomy, participate in decision-making, become part of a decentralized style of management, and experience flexible employment possibilities (Buchan, 2000b). Other forces are

higher remuneration (Buchan, 2002b) and the opportunity to reunite with family members who have migrated earlier (Makinwa-Adeboysola, 1995).

The migration of highly skilled professionals from low to high income countries is referred to as “Brain Drain” (Scott, Whelan, and Zwi, 2004). Low income countries are losing those that they can ill afford to lose; those who are skilled and educated, perform crucial services that contribute to the health and economy of their country, and create new jobs for others. For example, African scientists and engineers are being lost at an alarming rate. There are more African scientists and engineers working in the United States than in all of Africa, leaving the entire African continent of 600 million people with just 20,000 scientists and engineers (Federation for American Immigration Reform, 2004).

Prospects for economic development in the lower income countries are worse than they were when serious concerns about “brain drain” were first raised in the 1970s. There is still a lack of comprehensive and reliable information about migration patterns, numbers and related issues. This prevents those in a low income country from accurately monitoring and identifying the impact of the loss of skilled professionals and inhibits the development of effective policy (Martineau, Decker & Bundred, 2004).

The Director-General of the World Health Organization (WHO), Dr. Lee Jong-Wook, expressed concern that brain drain from Africa is severely limiting the ability of health workers to combat the HIV/AIDS epidemic and achieve any substantial progress towards the Millennium Development Goals (Scott, Whelan, Dewdney & Zwi, 2004). The extent of the problem was outlined earlier in this proposal. The flight of trained health personnel from lower to higher income countries leaves in its trail a depleted workforce. Overworked and tired nurses have few

incentives to enable them work productively and there is little motivation to remain in their home country if opportunities to leave are presented. Salaries can be increased only within the limits of the resources available to these low income countries (Patel, 2003).

“Brain drain” is likely to continue as it is driven primarily by economic considerations; it is however important to consider that opportunities to work in different societies can be a rich experience with benefits that go beyond financial gain. For this reason, creating new barriers to the movement of peoples between countries is not appropriate. According to Patel (2003), acknowledgement is needed and institutions in high income countries have an ethical obligation to facilitate the return of health professionals to lower income countries. However, because these decisions are economically driven, it seems unlikely that many institutions will voluntarily facilitate this return of health professionals. What seems undeniable is that new strategies are needed to decrease “brain drain” and reduce patterns of migration that are costly to countries already disadvantaged, who in very real terms, are subsidizing the development of the work force in more advantaged societies.

One strategy that has been suggested to decrease “brain drain” is to train less qualified personnel within the poorer countries. The rationale is that such workers will have fewer incentives to migrate, as their qualifications will not be recognized internationally (Dovlo, 2004; Levy, 2003; Martineau, Decker & Bundred, 2004). Such suggestions are unacceptable to health professionals in disadvantaged countries, who have justifiable ethical and human rights concerns as counter arguments.

Alternatively, while low income countries do invest in training health professionals, there are limited professional development opportunities or career pathways, as systems tend to be cumbersome and highly bureaucratized to accommodate the sheer



numbers that must be served (Damodaran, 2004). Perhaps structural changes in the organization and support of health professionals in some low income countries can enhance retention of these much-needed and highly educated professionals, particularly in the health sector. This may be more possible in politically stable countries such as Ghana.

### **2.3 Attraction and Retention of Nurses**

In times of nursing shortage, the attraction of qualified persons into nursing and the retention of these nurses, both in the profession and in the workplace, are challenging. What attracts people to a particular profession is also what encourages them to stay. This includes opportunities to develop professionally, gain autonomy, and participate in decision making, while being adequately rewarded (Buchan, 2002).

Some nurses suggest that the television programme *Emergency Room (ER)* is partially responsible for the nursing shortage. Nurses are depicted as subservient to doctors, thus making nursing a less attractive career choice than other more autonomous professions (Centre for Nursing Advocacy, 2004). Remuneration, workplace satisfaction and autonomy, opportunities for career mobility, and the availability of alternative employment possibilities are factors often cited in the literature as important for both the attraction and retention of nurses (Finlayson, Dixon, Meadows & Blair, 2002). Each of these factors will be discussed.

#### **2.3.1 Remuneration:**

While globally the remuneration of nurses in relation to other equivalent professions varies widely, a perceived lack of equity in financial status affects the ability of health administrators to attract and retain nurses. In the UK, nurses' salaries have improved through a series of annual increases and special allowances. This event will be used to illustrate the concern. In 2001 nurses received a basic pay

increase of 3.7 per cent. Senior nurses, many of them administrators or clinical specialists, on whom the government was dependent to implement key aspects of the National Health Service (*NHS*) Plan, received a salary increase of 5 percent (Finlayson, Dixon, Meadows & Blair, 2002). Nurses' basic pay, however, remained low in relation to that of other public sector workers. While a newly qualified nurse received 15,445 pounds (\$23,544 US) per year, a newly qualified teacher started at a minimum of 16,038 pounds and an untrained police recruit received 17,133 pounds (Finlayson, Dixon, Meadows & Blair, 2002). A gender gap was clearly reflected in the remuneration. No doubt this inequity is reflected in the number of nursing graduates who actually make a decision to practise, in that, about a third of newly graduating nurses in the UK do not register to practise (Finlayson, Dixon, Meadows & Blair, 2004). The reasons for this may be multi-factorial but Maynard (1996) believes that the most efficient response to the nursing labour shortage is to increase their salaries.

### **2.3.2 Workplace Satisfaction:**

Workplace satisfaction is multifaceted and includes issues relating to workload and work environment. Satisfaction is related to many factors including participating in interesting and challenging work, having supportive management, and having adequate resources (Finlayson, Dixon, Meadows & Blair, 2002). Nurses experienced an increase in paperwork in recent years, partly as a result of a regular audit and clinical governance activities. In the UK, efforts by the *Regulatory Impact Unit* at the *Department of Health* to limit paperwork for general practitioners have not been replicated for nurses. Nurses from the United States, Canada, and Germany complain that they spend significant time performing functions not related to their professional skills, such as cleaning rooms or moving food trays. They also perceive a

lack of administrative support or recognition of their professional roles and responsibilities.

Vacant positions and high turnover of nurses increase workloads of those who remain at their place of employment. Nurses have reported that they often supervise temporary nurses who are unfamiliar with the unit or with the specific nursing care required of patients commonly cared for on the unit. Cutbacks in staffing and trends toward community care cause nurses who are employed in hospitals to have to care for larger numbers of more acutely ill patients and it is necessary that they do this with fewer professional nurses. Nurses believe that the nursing shortage has contributed to greater burnout, increased turnover, and poorer quality of patient care (Erlen, 2004).

The number of nurses who are fatigued and stressed in the workplace is increasing. They feel powerless to make changes and are frustrated with their inability to take what they believe is the ethically appropriate action. They cannot act on their professional values and believe that these values are being compromised. Nurses are concerned for both their patients and themselves. They express frustration over a lack of control in their work and especially when addressing patient care issues. They describe a lack of regard for their opinions and input when decisions are being made (Erlen, 2004).

When interviewed, a focus group of nurses in Nevada cited concerns about management and staffing as two reasons why they had left their previous positions. These nurses expressed dissatisfaction with managers who do not listen to them or provide support. They also expressed a concern that inadequate patient-nurse ratios compromise the quality and safety of patient care (Erlen, 2004). Nurses reported that

they were pressured to assume management responsibility, which took them away from direct patient care (Finlayson, Dixon, Meadows & Blair, 2002).

These stressors are not unique to nurses in one particular country, but rather exist worldwide. Factors related to work environment can be crucial and there is some evidence that a decentralized style of management, flexible employment opportunities, and access to continuing professional development are attractive to nurses (Buchan, 2002) and thus contribute to workplace satisfaction.

### **2.3.3 Career Mobility:**

Nurses, like other professionals, like to advance in their careers. Historically, senior clinical roles for nurses have been lacking. In 1999 the government in the UK reiterated its commitment to a modern career framework for nurses, which incorporated the creation of consultant posts for midwives and health visitors. The *National Health Service (NHS)* established only 500 nurse consultant posts but doubled this figure by 2004. Even this number may be insufficient given the overall size of the nursing and midwifery workforce.

Administrators in the *NHS* plan also promised to reinstate the position of Matron, but it is unclear how many of these posts will be available. More opportunities to expand nurses' prescriptive authority, allow nurses to make and receive referrals, and apply for admitting and discharge privileges. The NHS Plan also champions the need to consider new ways of working and a programme has been initiated by the *Department of Health* to assess different ways of doing this (Finlayson, Dixon, Meadows & Blair, 2002).

### **2.3.4 Availability of Alternative Employment Possibilities:**

As nurses reflect on the shortage of applicants to their educational programmes and in their practice setting, they may have concerns that steps needed to

resolve the nursing shortage have not been taken. Although nursing schools may be producing graduate nurses, they are not meeting the current demand. Because of the many options that are available to them, individuals who formerly would have entered nursing are finding that positions in other professions, such as medicine, engineering or law, more attractive to them in that they offer more autonomy and more opportunities for advancement (Erlen, 2004). It is not surprising, therefore, that conditions favouring international recruitment of nurses are common and likely to continue, thus perpetuating the movement of nurses from less advantaged to more advantaged countries and, consequently, exacerbating the existing health system crisis in Sub Saharan Africa.

### **2.3.5 Strategies to Attract and Retain Nurses:**

The critical nature of the national nursing shortage is challenging nurses and administrators in health care organizations to think creatively about how to recruit and retain nurses. Reducing the moral distress that nurses are experiencing must become a priority. When nurses are unable to do what they believe is ethically right in the situation in which they find themselves, they experience moral distress.

These situations may occur frequently for nurses in low income countries who do not have the needed resources to provide care that they believe would promote the health and comfort of their patients. In Ghana while increases in salaries and other monetary benefits are important, nurses also need to feel that they are providing optimal care. To reduce feelings of moral distress they need to feel that they have acquired the needed skills and have access to appropriate resources to adequately assist their patients. Valuing bedside nursing and enabling nurses to be agents within a restructured and supportive work environment has the potential to enhance positive patient outcome (Erlen, 2004).

The nursing shortage described by Finlayson and colleagues (2002) is not new. It has been a recurrent problem that has been exacerbated over decades and could become a health care crisis. Serious shortages in the short run are likely to constrain planned capacity expansions as such the proposed new expenditure on the *NHS* in the UK will have a profound but as yet unknown effect on the demand for nurses (Gage, Pope & Lake, 2002).

There is the need to attract and retain nurses in order to avoid losing them. Several strategies have been suggested, including the concept of magnet hospitals. Relevant previous research with respect to attracting and retaining nurses is presented next.

Strategies to attract and retain nurses include salary increases (Ellenbecker, 2003; Maynard, 1996); autonomy in the practice setting (Ellenbecker, 2003); appraisal for promotion and recognizing and accommodating career diversity (Mitchell, 1986); and health benefits (Kuhl, 2002). When considering compensation it is necessary to budget for salaries as well as additional payment for shift differentials, preceptors, charge duty, weekend differentials, call-back when on call, per diem, overtime, longevity increases, service credit and educational leave (Kuhl, 2002). Other strategies include attention to scheduling with no cancellation from a regularly assigned shift. Longevity incentives such as no mandatory weekends after 20 years of employment, salary increases after 9, 11, 16, 20, and 25 years of employment, increased vacation time after ten years and increased monthly pension for persons with long service are advocated (Kuhl, 2002).

Magnet hospitals are hospitals that have adopted certain strategies in order to retain nurses. This includes shared governance. Nurses do their own time schedules and are given a forum in which they can make their concerns known. They actively

participate in decisions that involve them. In one article it was reported that a family spirit existed on units where shared governance was the norm (Kramer & Schmalenberg, 1988).

Nurse administrators need to consider ways in which they can recognize outstanding employees including hosting luncheons, and retreats. One magnet hospital openly described itself as a “hugging organization”. They further described a unique organization that was casual, yet committed to high quality care. Everybody cares about everybody. They may have a slogan that, if you wanted nurses to take care of you, you had to take care of them (Kramer & Schmalenberg, 1988). A cluttered desk seemed to be a characteristic of many of the Chief Nursing Executives (CNE) in the hospitals. The door was always open and during the three days in which this hospital was visited and observed, there was a steady and constant stream of staff nurses, head nurses and directors coming and exchanging information. There was no formal change of shift. On their way out of the building the nurse managers casually stopped by and relayed to the CNE and clinical directors whatever information they deemed to be necessary. More often they relayed information about a patient whom the CNE or director had been up to see, or was particularly interested in. The end result of this investment in the people of the organization is clarified by one of the nurses who noted that one can devote one’s psychic energy to one’s patient because someone else is taking care of you. This leads to improved productivity (Kramer & Schmalenberg, 1988).

Magnet hospitals are known for their innovations. In a computer search of related and relevant research, 13 of the 16 manuscripts relating to Chief Nursing Executives (CNE) were from one who was heading a magnet hospital. Innovations or programs that had been put into effect were evaluated. Researchers and others



associated with several magnet hospitals published or are publishing books written by teams of staff nurses. Some of the activities of the magnet hospitals were firsts; others were built on the accomplishments of others (Kramer and Schmalenberg, 1988).

## **2.4 The Ghanaian Context**

Little documentation has been found that relates to the retention of nurses in Ghana. Ghanaian nurses have been migrating to the Western world for some time. Increasing numbers of nurses have been leaving the country since 2000. The majority were recruited to nursing positions in the United Kingdom (Akosa, 2000). It is difficult to ascertain the number of nurses who have left the shores of Ghana for more promising employment but it is believed to be directly related to international recruitment strategies.

The nurse per population ratio is 1:2598. In Ghana the physician-patient ratio is variable and ranges from 1:12 000 to 1:66 000. The ratio for Europe is 1:300.

The Chief Nursing Officer reported that graduate under employment is the cause of “brain drain” (“The Magnitude”, 2000). She stated that in making decisions about promotions, nurses with less than 10 to 12 years of service are disregarded. Other concerns raised by nurses are a lack of accommodation near their place of employment and a lack of availability of personal transport.

The effects of Ghanaian nurses being recruited to higher income countries include a loss of mentors who provide their knowledge, experience, competency and training skills to professional nursing. Other losses to the country are the highly valued skills of those practising nursing. The nurses that remain are overworked. At the Korle-Bu Teaching Hospital, in the third quarter of 1999 alone, 108 nurses missed work as a result of illness, causing a loss of 963 working days. Further causes of



nursing shortages in October 1999 were leave without pay (4); resignation (5); and study leave (2) ("The Magnitude", 2000).

In Ghana, strategies have been put in place to retain nurses. Some include (1) bonding i.e., an agreement on the part of the nurse to serve the nation in a particular place of employment for an agreed-upon length of time before it is possible to be released for any other employment or opportunity; (2) payment of full tuition fees with targeted scholarships for nurses pursuing further education; (3) incentive systems such as extra duty allowance, (4) access to cars and land with flexible payment conditions (5) inefficiencies in human resource management systems are being tackled; (6) more rewarding career pathways such as the introduction of clinical specialties (e.g., theatre course) with an incremental increase in salary attached to successful completion; and (7) relevant and varied postgraduate opportunities (Sagoe, 2000). There is a suggestion that there is the need to have bilateral agreements with countries that have recruited Ghanaian health professionals. In these cases, specific agreements with health authorities or hospital trusts and other employment agencies in the recipient countries could be sought to reimburse Ghana for what has been invested in the training of migrating health professions. While this concept is being explored, Ghana would need to offer something to the agency or country in which it enters this sort of agreement. If some sort of agreements were possible, perhaps with pressure from United Nations (UN) agencies, a flow of funding back to Ghana would increase enrolment capacity in nursing programmes. Again, capacity for increased enrolment needs not only funding but also requires that sufficient numbers of nurses and other health profession educators remain in Ghana so that the programmes can be presented. Encouraging the return of Ghanaians from abroad is also beneficial. Some may have benefited by developing advanced skills, while abroad, that would be useful

for educational and practice settings within Ghana. A mechanism for streamlining promotion processes for nurses and the effects of delayed recruitment and appointments, which are common issues in Ghana, will also have to be addressed.

Those responsible for human resource development in Ghana are facing a number of challenges. It is an undesirable fact that the exodus of nurses and other health professionals presents a huge challenge. More than half (i.e., 60.9% of 489) of the graduates from the medical school between 1985 and 1994 migrated to other countries. The exodus of highly qualified health professionals decrease quality of care that can be provided, affect practice standards and decrease professionalism. This, in turn, leads to spiralling problems in educating and recruiting new nurses and other health professionals. Other problems are those of acceptable service delivery, service management, service development and equitable distribution of skills across the country (Amoa, 2002).

The question is less to find out why people are leaving, but more to identify strategies to retain nurses (Amoa, 2002). Factors that “push” nurses away or affect their decision not to choose to stay and work within the Ghanaian health care system have been identified. These include low remuneration, inadequate working conditions, few opportunities for postgraduate training and inadequate infrastructure (“The Magnitude”, 2000). Factors that “pull” nurses away or make migration an attractive option have also been identified. These include prospects of a more material life in a higher income country, choices in educational opportunities, and increased quality of life with respect to access to health care, education, and social services. The establishment of a postgraduate training programme, building of adequate accommodation for nurses that is in close proximity to health facilities, provision of vehicles (transportation) and provision of scholarships for training are recommended

along with an increase in the training and production of medical assistants and development of human resource management systems (Amoa, 2002).

## **2.5 Summary**

In order to explore retention of nurses within the Ghanaian health care system, it is helpful to conceptualise the issue within the context of global migration. It is also necessary to understand how nurses weigh factors influencing their decision to emigrate or remain in their country. A global phenomenon that is related to market forces is migration. International migration of skilled professionals, including health professionals, especially nurses is not new (Makinwa-Adeboysaye, 1995; Mejia, 1978). There are forces in place that “push” professional nurses away from Ghana and forces that “pull” them to potentially more attractive employment settings in higher income countries (Buchan, 2002; Kline, 2003; Xu, 2003). There are forces both internal and external to a given country that affect why nurses and other health professionals or other citizens choose to migrate (Buchan, 2002; Kline, 2003; Xu, 2003). Some of the issues internal to a given country include low or inadequate remunerations, ability to gain autonomy, opportunities to develop professionally and participate in decision-making. Low income countries are disadvantaged in that they are losing skilled and educated nurses who could perform crucial services within Ghana and contribute to the health and economy of their country. In times of nursing shortages, the attraction of qualified persons into nursing and the retention of nurses, both in the professional organizations and the work place, are challenging. Workload satisfaction is multifaceted and includes issues relating to workload and work environment. There is not much documentation on retention of nurses in Ghana and there is little knowledge of what motivates some nurses to stay and

actively practice in their native country. However some strategies have been put in place to retain nurses. Some include payment of full tuition fees with targeted scholarships for nurses pursuing further education and incentive systems such as extra duty allowance. This research seeks to find out less about why people are leaving but more to identify strategies to retain nurses.

## **2.7 Research Questions**

The following research questions will be addressed.

1. Why do nurses and administrators at Korle-Bu Teaching Hospital in Ghana think so many nurses migrate to higher income countries rather than practice in Ghana?
2. What do nurses and administrators at Korle-Bu Teaching Hospital in Ghana perceive as useful strategies to enhance retention of nurses in Ghana?
3. What do nurses and administrators at Korle-Bu Teaching Hospital in Ghana perceive as potential strategies to enhance retention of nurses at Korle- Bu Teaching Hospital in particular.

## **CHAPTER THREE**

### **Method**

#### **3.1 Research design**

A qualitative approach, which is exploratory and descriptive in nature, was used. This approach has also been described as interpretative/descriptive research (Polit and Hungler, 1999). In qualitative research the aim is to document and interpret a phenomenon from the participants' viewpoint. A qualitative design is used when there is an interest, not in quantifying the phenomenon under study, but in developing an in-depth understanding of the feelings expressed by those close to the phenomenon.

Using this methodological approach the phenomenon was described as it was understood by the participants. Insights gained from their rich description led the researcher to a greater understanding of how participants perceive their situation rather than relying only on a description of the situation through personal observation (Polit and Hungler, 1999).

#### **3.2 Research Setting**

The location for the research study was the Korle-Bu Teaching Hospital. It is one of three teaching hospitals in Ghana and provides educational, research, curative and preventive services to the population at large. It is located in the South Ablekuma District of the Accra Metropolis, in the southern part of Ghana. To the north of it is the Kwame Nkrumah Flats; to the south is Korle Gonno Township; to the east is the Korle Lagoon and to the west is the Mamprobi Township. Founded in 1923 by the then colonial government of the Gold Coast, which was headed by Sir Gordon Guggisberg, the hospital caters for approximately 1682 in-patients and about 2500 outpatients daily (Korle-Bu Teaching Hospital, 2000 to 2005). There are 17

departments at Korle Bu Teaching Hospital which includes 1,265 beds, 162 cots, 235 treasure cots and 20 incubators (Korle-Bu Teaching Hospital, 2000). Three of the departments are specialized centres. These are the Cardio-thoracic unit (CTU), Reconstructive and Burns unit and Radiotherapy and Nuclear Medicine centre. As at the first quarter of the year 2004, there were 1,032 nurses (Korle-Bu Teaching Hospital, 2005 Annual Report). It is about 0.5 kilometres from the Korle Lagoon. From year 2000 to 2005 an average of 77 nurses assumed post at the hospital and there was an average turnover of 81 nurses who left their post (Korle-Bu Teaching Hospital, 2000 to 2005).

### **3.3 Method of Sampling**

The number of participants to be interviewed could not be determined before data collection started, as the sample size was considered adequate when data saturation was reached. Data saturation is said to occur when no new information is forthcoming and there is a repetition of themes that have already been developed (Morse & Field, 1995). In addition to recruiting professional nurses, one nursing administrator and two enrolled nurses were recruited. Convenience sampling was employed to recruit professional nurses. The original criterion for selection included all professional nurses who have been employed at Korle Bu Teaching Hospital for a minimum of 10 years. However, enrolled nurses were purposely recruited as the study progressed so that emerging themes could be further clarified. Convenience sampling entails the use of the most conveniently available volunteers. Purposive sampling is used to ensure that the researcher selects participants who can respond to specific questions arising from the data. In this case, purposive sampling was also employed to ensure that there was at least one nurse administrator in the sample. One

of the enrolled nurses agreed to participate but then refused to answer any question except her demographic data.

### **3.4 Data Collection**

Before data collection commenced, ethical approval to conduct the study was granted by the Noguchi Memorial Institute for Medical Research, University of Ghana. Following ethical approval, an introductory letter obtained from the School of Nursing, University of Ghana was sent to the Director of Nursing Service, Korle-Bu Teaching Hospital to explain the nature and purpose of the study (Appendix A). The nature and purpose of the study was also explained to Charge Nurses from several of the nursing units and permission was asked to recruit participants from the professional nursing staff on their units. Potential participants were given a letter of invitation to participate in the study (Appendix B). Informed consent was obtained from everyone who agreed to participate in the research study and this was done before data collection from that particular participant commenced (Appendix C1&C2).

A semi-structured interview schedule was used to collect data (Appendix D). This was done without compromising the participants' freedom of expression. It allows the participants to tell their stories using a naturalistic narrative (Morse & Field, 1996). The interview schedule was reviewed and revised by thesis supervisors and graduate nursing students prior to commencing data collection to ensure that questions reflected the intent of the study. An information sheet was also given to the participants (Appendix E). The time line can be found in Appendix F and the budget in Appendix G.

The interviews were conducted in English and tape-recorded. Each interview lasted approximately 45 minutes. The Ward Sisters provided an office for the



interviews. The process started by creating a warm atmosphere and good rapport with the participants to ensure that they were relaxed for the interview. Participants were given an opportunity to express themselves fully when answering questions without the researcher imposing her ideas on them during the interview. They were invited to ask any questions that they had about the study. The need to respect one's beliefs, habits and lifestyles was considered. The nature of intrusion on participant's psyches was carefully thought through. This could be done by considering the rephrasing of questions (Polit & Hungler, 1997).

Personal diaries have long been used as a source of data in qualitative research (Polit & Hungler, 1991, 1999). A diary was kept so that the researcher could record any event that might have affected the interview and also plan for any necessary information that could be gathered in subsequent interviews. At the end of each session, participants were thanked for their co-operation. The recorded interviews were transcribed verbatim.

### **3.5 Data Analysis**

The analytic strategy for this type of design is content analysis. For all interviews there was verbatim transcription, checking, correcting and coding (Morse and Field, 1996). The researcher used coding to begin the data analysis; uncover underlying meanings in the text and identify metaphorical references; and to bring both central and peripheral statements to the researcher's attention. Data analyses were concurrent with data collection.

Morse and Field (1996) suggest that line-by-line (and sometimes word-by-word) analysis of an interview transcript facilitates comprehension of the data. All transcripts were read and re-read in order to identify central concepts and key statements made by participants. The meaning drawn from the concepts was identified



and organized into different categories. The relationship among categories used to describe factors that facilitated or created barriers to retention of nurses was formulated. Threads or themes that are apparent throughout the data were recorded. Finally the categories were integrated into a description of the phenomenon under study.

### **3.6 Rigor in Qualitative Research (Trustworthiness)**

Rigor is a necessary component of the practice of good science and needs to be considered for both qualitative and quantitative research projects (Streubert and Carpenter, 1999). The rigor or trustworthiness of the data collection and analysis process was evaluated using several criteria. The criteria for trustworthiness are credibility, transferability, dependability and confirmability (Sandelowski, 1994). Credibility refers to the believability of the data. That is how one can establish confidence in the truth of the findings and the context in which the inquiry is carried out (Polit and Hungler, 1999). Credibility in this study was addressed through peer debriefing and member checks. To ensure that peer debriefing took place, a session was held with peers including thesis supervisors and fellow nurses to obtain a feedback about the quality of the data. Attention was paid to non-verbal cues exhibited by participants whilst the interview was in process. Member checking, a strategy whereby informants were asked to comment on the data and on the researcher's interactions was employed. The purpose was to ensure that the data accurately reflected what participants wanted to say at the end of each interview. Member checking was carried out by encouraging participants to comment on the data and on the researcher's interpretations.

Dependability refers to the stability of the data over time and over different conditions, that is, how one can have confidence that the findings will be replicated if

the study were repeated with the same or similar persons in the same or similar situations. Confirmability refers to the objectivity or neutrality of the data, that is, how one can be sure that the findings are determined by the participants and the situation and not unintentionally biased by the interests of the researcher. Dependability and confirmability were addressed through the use of an inquiry audit whereby members of the supervisory committee scrutinized the data and relevant supporting documents. In this way an audit trail was developed so that supervisors and others could understand how the researcher arrived at decisions about the data. The audit trail included interview transcripts, notes from member-check sessions, personal notes on researcher's intentions and drafts of the report.

Transferability refers to the extent to which the findings from the data can be transferred to other settings. This was achieved by providing a thick description of the phenomenon in the setting in which the phenomenon occurred so that consumers could evaluate or determine the applicability or 'fit' of the data to other contexts.

### **3.7 Ethical considerations**

The researcher submitted the research proposal to the Noguchi Memorial Institute for medical research for approval. Participants were provided with information sheets (Appendix E) and a consent form (Appendix C1) was signed prior to the commencement of data collection. A verbal explanation and a written consent form were used to provide potential participants with the option to participate in the study without prejudice. Participants were informed that they could withdraw from the study at any time without penalty and no one else would even know whether or not they participated. Participants could refuse to answer any question that made them uncomfortable or they could decline to answer all the questions. They were assured that anything they said that could potentially identify them would be held in strict

confidence. They were assured that what they said would not be reported to their authorities. An opportunity was provided for participants to ask questions at the end of the interview.

In the written transcript, and during the interview, real names were not used. To address confidentiality, a code number was used on the transcripts with the participant's identity being known only to the researcher. The participants were assured that they would never be connected with their responses and their identities would not be revealed to anyone. Consent forms were placed in a locked cabinet separate from the data. The data were also kept in a separate locked cabinet. Transcripts would be kept in a locked place for a minimum of five years after completion of the study. Participants were informed that if data were used for another study, appropriate ethical approval would be needed.

### **3.8 Limitations**

Many potential participants who could provide important insights into why nurses remain at their work site were overworked. Many potential participants were not willing to take time off to be interviewed. The willingness of the nurses to divulge information was also a limitation because the topic is sensitive for many and some could not feel comfortable sharing their insights about why nurses remain or leave their positions. It is also possible that some may actually have been planning to emigrate and did not wish to share this information.

## CHAPTER FOUR

### Findings

To explore perceptions of nurses employed at Korle-Bu Teaching Hospital with respect to why they stay and what they believe would enhance retention of nursing staff in that particular setting, eight professional nurses, two enrolled nurses and a nurse administrator were interviewed individually. The interviews were conducted at a time and in a place that was convenient for both the participant and the researcher. Participants responded to open-ended questions related to structures put in place to retain nurses and what could be done to persuade nurses to stay at their place of employment. Participants also described their previous and present working experiences.

#### 4.1 Characteristics of Participants

Participants were between 36 and 55 years. All but two were *State Registered Nurses*. One had a baccalaureate degree in nursing. The remainder entered diploma programs with various qualifications. For example, 2 were A' level holders, 1 had advanced diploma in peri-operative nursing, 6 were O'level holders and 2 were Middle School Leaving Certificate holders. All were Christians. All were married but 3 have lost their partners. The occupations of their husbands included physicians, teachers, architects, and self-employment. Ethnic backgrounds included Fante, Ewe, Ashanti and Ga. All participants had children who were alive and well.

#### 4.2 Findings

The following concepts emerged as major categories. The categories were identified by participants as factors that influence nurses to remain in Ghana. These were,

- . Personal convictions

- Monetary Benefits
- Improved working conditions

Each of these factors will be described separately.

#### 4.2.1 Personal Convictions:

Personal conviction was identified as a major reason for nurses wishing to remain and practice in Ghana. Patriotism emerged as a theme for why nurses will stay in Ghana and not leave for greener pastures. The motivation for these nurses was their commitment to make a difference by contributing to their own community and country. Coupled with this was the concern that if they left and returned in their later years, they would not have helped and support from those who stayed. Some had already experienced spending at least some time outside Ghana. For example, one nurse said:

*“ For people who know me I think that I keep saying that my community is where my people are and I have this strong conviction that if there’s anything that we have to do it’s to try and in our own small way at least make sure the right things are done whatever it takes and I believe very much that [is] staying in Ghana for me, I’m not retrogressing. At the end of the day, it is what you do as an individual to improve upon your own- self and of course be able to help those less fortunate than you are. So far I am still in this country because I think I have something to contribute to the health sector and in fact a stronger commitment to see that the nursing profession is transformed maybe better off than I think. I am not prepared to go and labour in somebody’s country, I’m not prepared to go and pay taxes to another country which is already developed, I don’t think at the end of the day I will be that patriotic and to have any moral right to come back to demand that I need any form of care because I am a Ghanaian I will die a Ghanaian I will not sell my birthright*

*Sure we all want the good things of life. I have had the opportunity to have gone on a rotary club's exchange programme in New York city and it was worth the effort and I think people even thought I wasn't going to come back and for the things that I saw for myself it was like I could not if I didn't have a strong conviction. I could have stayed behind because I had a visa for 3 years but I was to be there for 6 weeks but I came back. You see the whole essence is that we should be aiming higher and not become the custodians of the status quo that we have as at now because for a lot of us it is like this is how it is so must it be. I am saying that we are badly underpaid but you know I believe in this thing that we better bear the ills we have today than to leave to unknown places or foreign lands." (Ama)*

Another participant said:

*Some of us still believe that we can continue to do the work that others have started for a long time. Others have been in it for a very long time and have to continue even though the income is not very good but we still want to be in this mission to help build our nation. After all, all of us cannot leave. When we have left it is this same country that we will come back to one day and when we come back and you are sick and there's nobody to help, I believe that will not be the best for us. (Georgina)*

Another participant said, "I love to work for my motherland." (Francisca)

An important factor for why many wanted to stay was that they did not want to distance themselves from family ties. One participant said:

*I think that I have family commitment. I hold very strong family ties and I think I put them above all the world's money that I will get because for me I am bound to my family, my husband and to my fellow country men to be there for them." (Ama)*

Another noted that she would leave the country for a short period but would not want to distance herself from her family for long enough to work outside the country. She said:

*The most important thing is that maybe I enjoyed my status as a married woman looking after my family and the other thing is I have never envisaged myself going to work in any European country. I feel comfortable somehow I can't picture myself working as a nurse in any other country apart from Ghana. If anything I would want to go for a short course and come back and work in Ghana but not to go and live there and work."*(Adjoa)

#### **4.2.2 Monetary Benefits:**

The participants noted that monetary benefits had influenced their decision to stay in the country. They mentioned the "Additional Duty Hours" allowance (ADHA), the allocation of cars that could be purchased with a flexible payment schedule as well as the allocation of plots of land so that they could build their own houses as benefits that they could receive within their own country. The ADHA, especially, was an incentive that the nurses reported influenced them to stay. One participant said, *"I think the ADHA, yes is doing something."* (Koko)

Another said:

*Well I've been out of the system if I say out of the system because I have not really been at the forefront of what has been happening but I could say to some extent that yes for some of them it is helping them. Yes it is helping.*  
(Ama)

Yet another said:

*The ADHA has helped in the sense that just like I told you in my situation that I didn't want to leave for anything. There are some nurses, a thousand or so*



*that I talk about who for one reason or the other may not want to leave and I think the ADHA has helped them because without the ADHA I mean if you take a PNO who is taking a little over 2 million cedis with several dependants and also embarking on for a building project it would have been really difficult but even though the ADHA does not measure up to what we would have expected to be today. It has helped in so many instances. (Adjoa)*

Yet another said:

*I believe that, it has actually helped some of us because if you consider the basic salary that we receive, without the ADHA I think that most nurses would have gone a long time ago. Well I believe that the ADHA is helping. It is what gave us a little relief. (Georgina)*

She was hopeful now that the allowance will increase.

She said:

*Now that they have assured us that something better will be done about it, it is good." (Georgina)*

Another participant noted that while the ADHA was important, there was a need to increase the amount that nurses received. She said, "*The ADHA is ok.*" (Mansa) She further stated that she had heard that the paramedics were getting more than the nurses and wished it would be rectified.

Yet another said, "*Well it is ok but it's not much.*" (Monica)

She wished that something could be done about it. Yet another said, "*In someway it is helping but it is not much.*" (Francisca)

According to yet another participant, the ADHA is the only incentive that has influenced the nurses to stay. She said: "*Only the ADHA.*" (Angela) According to participants, the introduction of institutions helping nurses buy cars using flexible



payment schedules makes it possible for nurses to purchase their own vehicles. It is incentives such as this that was reported to sustain nurses and retain them. One participant is on record as saying, *"I think the ADHA yes is doing something, the cars Yah."* (Koko) Another participant said:

*The car allocation is a good thing. Well it's a good thing that the ministry has decided to give vehicles to staff.* (Adjoa)

Another participant is on record as saying:

*I think it's a good idea, very, very good because you have car loan so that those of us staying far away and can afford to pay, can use it. So that nurses can also be retained.* (Akos)

Finally mention was made about plots of land being allocated to nurses so that they are able to build their own houses. According to participants the sale of land and its payment deducted at the source (i.e., on the nurses cheques) sustain nurses and retain them. One participant said:

*I don't think it is solely money but where to lay your head after retirement. I think that is the main problem. I have seen Korle-Bu authorities giving land and payment on instalments; that's fair.* (Koko)

Another participant said:

*Well I think it was a good move because the chief executive was of the opinion that, I mean he ...had on several occasions eh.... lamented on how nurses who have gone on retirement continue to live at the nurses flat because some of them go on retirement without their own accommodation and with their meagre salaries and other social commitment they have not acquired their own houses so he decided that well let's try and acquire some plots of land for the nurses.* (Adjoa)

One of the participants noted that in addition to being able to purchase land over a period of time, it would be helpful to have some capital through loans so that construction on a house could be started. She said:

*I'm already living in my own house. I think the land issue is good but you have to get a capital to start with. If you are given a land and you don't have money you can't build. So there should be loans. (Akos)*

Yet another participant said:

*I am interested, that is what I've applied for Oyibi land. Eh... it's good because we are paying it in instalments. Nobody is having this big money just to go and give it to somebody. So if somebody is going to be a middleman for another person it is good. Most of us will not be able to buy such an expensive land. (Afua)*

Another participant said:

*I am one of those nurses who have actually asked for the land because I believe it is the beginning of greater things to come and I always congratulated those who started this land project. If we had it from the beginning I believe a lot of us would have started something but it's never too late we have just started. I believe that at my age I could do something on the land before I go on retirement. So this is a very good idea. (Georgina)*

Yet another said:

*The land issue is very good, it will help the nurses put on their own houses. It's a very good thing and I, myself will like to have one but I am waiting to get one next year. (Francisca)*

#### 4.2.3 Improved working conditions:

Participants were of the view that improved working conditions were a factor that caused them to stay. Prompt promotion was identified by some as the most important factor in retaining nurses. One participant said:

*Yeah that is also good. Eh... because when you are also promoted it boosts your morale that alone can also make you stay on. (Akos)*

Career Development was identified as a way of retaining nurses. Asked whether she had given a pep talk to or encouraged a junior nurse before, Georgina said,

*Yes I've been in a position. We try to see if they can do some courses so that they will stay. (Georgina)*

It is possible that persuading nurses to develop professionally by taking advantage of continuing education programs (e.g., a course) may help to retain them at their place of employment and in their country.

In summary, personal convictions, monetary benefits and improved working conditions are the issues that have caused nurses to stay on. Personal convictions are convictions that were important to the individual that caused them to continue at their place of employment and that they were willing to stay further if those conditions remained the same or were improved. Participants elaborated more specifically about why they remained at Korle Bu Teaching Hospital. With respect to personal convictions, patriotism, family ties and a feeling of security in one's native country caused nurses to resist migrating elsewhere. Monetary benefits within Ghana were also powerful motivators to remain at Korle Bu. These benefits include cars being allocated to them for purchase and the payments spread over a flexible period of time, the introduction of the ADHA and plots of land mortgaged to nurses. For improved

working conditions, prompt promotion and career progression were considered important factors.

## **CHAPTER FIVE**

### **Discussion**

Analysis of the data from the individual interviews will be discussed in this section. This discussion will be based on the thematic findings and existing literature research related to the research question. The themes will be discussed hence. These themes are personal convictions, monetary benefits and improved working conditions.

The first theme that emerged was that of making a decision to remain in Ghana and in one's place of employment because of deeply held personal convictions. These convictions were important to the identity of individual participants and buttressed their reasons for remaining in their country. It is possible that these convictions could be exploited to understand how nurses are being and can be retained within their country.

Important personal convictions that caused nurses to stay at Korle Bu Teaching Hospital and in Ghana included feelings of patriotism and a commitment to family ties. According to these participants they never envisaged themselves working abroad because they felt an intrinsic accountability to their country and believed that they could make a meaningful contribution to their fellow citizens. They also wanted to be there for their nuclear and extended families. Assuming their families had migrated earlier, in many cases they likely would have joined them. Family ties in that circumstance can be a factor to "pull" the nurse away from her native country (Makinwa-Adeboysoya, 1995).

Improvements in monetary benefits were also reported as important reasons for remaining at Korle Bu and in Ghana. Some of these benefits had been

recently implemented. Therefore nurses were optimistic that more would follow. The *Additional Duty Hours Allowance* was of particular interest to most participants. According to participants these monies gave a little relief to supplement what they were receiving as salaries. Many thought the allowance should be increased but also believed that it was a “good start”. In many cases these monetary benefits were very welcomed as many nurses did not want to migrate and the benefits and promise of more benefits gave them the opportunity to stay in Ghana and still get ahead. This finding supports those of Buchan (2002b). As a pull factor for “brain drain”, Buchan (2002b) reported that higher remuneration was a factor that will cause nurses to migrate. Again Buchan (2002) refers to being adequately rewarded as a way of attracting and retaining nurses in times of nursing shortage. Improved remuneration in a bid to attract and retain nurses has been reported by other investigators (Finlayson, Dixon, Meadows & Blair, 2002).

Various pay structures for a nurse, a newly qualified teacher and an untrained police recruit would indicate that a gender issue exists in the payment of nurses in the UK in that the nurse’s salary was less than either the teacher or the untrained police. This gender barrier that results in low remunerations for some nurses is a factor that will “push” them to migrate (Amoa, 2002). Maynard (1996) asserts that the most efficient response to the nursing labour shortage is to increase their salaries. Using the example of Magnet hospitals as a means to attract and retain nurses, Ellenbeker (2003) and Maynard (1996) both recommend pay increases. According to Sagoe (2000) incentive systems such as extra pay are being instituted in order to retain nurses.

Participants noted that the allocation of cars with flexible payable conditions was very important to them and could very much influence nurses to make a decision

to remain at Korle Bu and not to consider moving to another institution or to migrate as a solution to their economic problems. Previous research is supported by findings in this study in that being adequately rewarded in the form of a fair salary that is competitive with other groups such as teachers and untrained police as well as receiving other incentives such as hospital bills and supported car loans will contribute to the retention of professional nurses at Korle Bu Teaching Hospital (Maynard, 1996; Finlayson, Dixon, Meadows & Blair, 2002; Buchan, 2002b; Buchan, 2002; Makinwa-Adeboysoye, 1995; Ellenbecker, 2003).

Participants also reported that plots of land were being allocated to nurses in the form of guaranteeing their mortgage and deducting the monthly payments from the nurses' salaries. This provides nurses who otherwise might not be able to obtain a loan with an opportunity to build their own houses. Land ownership is a powerful factor in persuading nurses and other professionals to remain in their place of employment. It was noted in previous research that being offered incentives will do much to retain nurses in their place of employment (Maynard, 1996; Finlayson, Dixon, Meadows & Blair, 2002; Buchan, 2002b; Buchan, 2002; Makinwa-Adeboysoye, 1995; Ellenbecker, 2003; Sagoe, 2000).

Finally, nurses reported that improved working conditions were a reason for remaining at their place of employment. When the participant nurses discussed their improved working conditions, they noted that prompt promotion and career development were important benefits. According to them prompt promotion will cause nurses to stay at their present place of employment. This finding is supported by other investigators in that appraisal for promotion is necessary to attract and retain nurses (Mitchell, 1986). Streamlining the promotion process for health professionals has to be addressed in order to retain nurses (Sagoe, 2000). The promotion process

must be transparent so that nurses believe that they will receive their promotions if they earn them.

Participants noted that providing opportunities for career development is important to consider when developing strategies to retain nurses. The development of these opportunities in recipient countries has been a “push” factor used by recruiters to attract nurses to work settings outside of Ghana and other low income countries (Brown & Connell, 2004). A lack of opportunity for further education is a “pull” force that can lead to nurses migrating to a higher income country (Buchan, 2002b; Damodaran, 2004, Finlayson, Dixon, Meadows & Blair, 2002). Buchan (2002) also says that to attract and retain nurses, health system managers need to include opportunities for them to develop professionally as these benefits are attractive to nurses. Sagoe (2000) notes that more rewarding career pathways are being developed for nurses in Ghana that are intended to curb their interest in migrating abroad.



## **CHAPTER SIX**

### **Summary and Conclusion**

Retention of nurses is a delicate issue. In some hospitals in Ghana wards that accommodate 40 patients and ideally have 6 or 7 nurses on day shifts must now make do with one nurse and one nurse aid. The focus of this research was to find out what had made nurses to stay in Ghana and what these nurses believe will enhance retention of nurses. Push and pull forces are responsible for the migration of nurses from lower income countries to higher income countries. To retain nurses, there is the need to increase pay, give out incentives and there should be autonomy in the practice setting. It is also necessary for there to be appraisal for promotion, recognizing and accommodating career diversity and health benefits. A qualitative approach, which is exploratory in nature, was used. Eleven participants, including a nurse administrator were interviewed. Personal convictions, monetary benefits and improved working conditions were found to be what had retained nurses in Ghana. This is confirmed by Maynard (1996) and others. The reason that issues in the literature were not mentioned by participants would be because they are not relevant in Ghana. Ghana probably has to settle its basic needs like a good salary before the other issues could be tackled.

#### **6.1 Implications for nursing practice, policy, education and research**

The main findings from this research study pose a challenge for nursing leaders to improve nursing care through retention of experienced professional nurses. First, it is important to present findings to nurse negotiators who are bargaining for salaries and benefits. These negotiators need to be well represented by practising

nurses to ensure that during salary negotiations the expertise of professional nurses is promoted. The negotiators also need to be encouraged to discuss gender differences that may have an impact on the salary of these professional nurses. They need to emphasize the importance of retaining nurses to their professional organization as well as to those responsible for paying salaries and benefits. Benefits that need to be considered include shift differentials, preceptor pay, charge pay, weekend differentials, call-back pay while on call, per diem pay, overtime, longevity increases and service credit. Again, the types of benefits that nurses want vary internationally and it will be important to ensure that benefits deemed to be a priority by Ghanaian nurses are the ones that are bargained for by their negotiators (leaders of Ghana Registered Nurses Association).

In addition, nurse-managers need to be aware of the importance of promoting nurses promptly and assuring that promotion is fair and based on established criteria. This process needs to be transparent and all involved must be accountable so that nurses can see the fairness of decisions around promotion. Promotion should be well structured and criteria well spelt out.

Nurse-managers must be encouraged to make sure that professional nurses under their supervision are encouraged and supported to enter professional development courses in areas in which they are interested. This is important in increasing their confidence and skills; and promoting job satisfaction. This, in turn, should do much for retaining nurses in their place of employment. Other innovations may also influence nurses who are deciding whether or not to migrate to other countries. These include more autonomy when working with clients so that the nurses can feel a sense of satisfaction with what they have accomplished. There are many opportunities for career diversity within nursing and nurses who are encouraged to

develop specialized skills in their area of interest will experience high levels of job satisfaction which will influence their decision to continue working in the same location. Nurse managers should act as mentors to encourage junior nurses.

Policy makers can be encouraged to explore strategies whereby incentives and benefits are possible. For example, subsidizing health benefits for nurses and their families was suggested as an important benefit. It is also important to encourage managers to explore the possibility of allowing nurses to sign up for shifts that will work well for them and to provide opportunities for nurses to voice their concerns about working conditions. Policymakers should institute housing schemes for nurses so that they will have a home after retirement. The recommended focus of future research is in-depth explorations of nursing practice in Ghana and the number of nurses needed to meet client needs. This will involve further exploration of factors that cause nurses from various areas of Ghana and those in various clinical specialties to migrate.

Given what is known, the patriotism and family ties of Ghanaian nurses can be highlighted in efforts to retain nurses. For example, the national and professional traditions and cultures of nurses can be emphasized in the media and advertising campaigns for health care workers. Additionally, student nurses can be socialized to their profession in their country through exposure to strong mentors who have positive influences on nurses within the country. Nurses can be surveyed to identify benefits that are most important to them and these benefits can be the focus of negotiations. There will also be the need for government to fully support the idea of involving further exploration of factors that cause nurses from various areas of Ghana and those in various clinical specialties to migrate. There will also be the need for

government to fully support the idea of giving free medical treatment to staff, and perhaps this should include their nuclear family.

To develop an effective strategy to retain nurses it is important to consider their personal convictions, preferred monetary benefits and working conditions. These considerations are highly valued by nurses who may be making a decision to migrate. This the literature identified as pay increase, incentives and career development. Reasons that issues were not identified may be because Ghana is a low income country and therefore needs to reduce the basic factors that are “pushing” to migrate. Other factors like the ability to gain autonomy may not be necessary in our part of the world. The professional Master prepared nurses are in a position to accept leadership in informing policy makers of what is needed to retain Ghanaian nurses in Ghana.

## **6.2 Limitations**

Many of the issues that were raised by other researchers with respect to retention of nurses were not discussed by participants in this study. These included opportunities to gain autonomy, participate in decision-making, become part of a decentralized style of management and experience flexible employment possibilities.

## **6.3 Recommendation**

The following recommendations have been made:

1. Personal convictions should be exploited in order to retain nurses.
2. Ghana Registered Nurses Association should ensure that nurses are well paid so as to retain them.
3. Government should improve upon the working conditions of nurses.

4. Government should take the extra step of ensuring that the other push factors in migration of nurses to higher income countries as discussed in the literature review are dealt with so that nurses are retained in the country.

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**Appendix A****Introductory Letter**

ANITA AFUA DAVIES  
SCHOOL OF NURSING  
COLLEGE OF HEALTH SCIENCE  
UNIVERSITY OF GHANA  
LEGON.

THE DIRECTOR OF NURSING SERVICES  
KORLE-BU TEACHING HOSPITAL  
KORLE-BU.

Dear Sir/ Madam,

**LETTER OF CLEARANCE**

I would be very grateful if I will be allowed to conduct an interview and to collect my data.

I am a Master of Philosophy degree student who is writing my thesis on Retention of nurses in Ghana, Perspective of nurses Employed at the Korle-bu Teaching Hospital.

I would appreciate an early reply to my request and would be pleased to meet with you if you have any further questions. I can be contacted at: school of nursing, college of health science, University of Ghana, Legon.

Yours faithfully,

.....

(Anita Afua Davies) Miss

**Appendix B****Letter of invitation**

Dear \_\_\_\_\_

You are invited to take part in this research called Retention of Nurses in Ghana.

Perspectives of Nurses employed at Korle-Bu Teaching Hospital.

This will be held at the in service training school Korle-Bu teaching Hospital.

I will tape every answer you give .You can choose not to answer certain questions if certain questions make you feel uncomfortable. You can stop the interview anytime you want to if you decide that you do not wish to take further part in the research study.

Thank You.

Yours faithfully

.....

(Anita Afua Davies) Miss

# NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH INSTITUTIONAL REVIEW BOARD

(UNIVERSITY OF GHANA)

Phone: +(233) 21 500374 /501178  
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P.O. Box LG581  
Legon  
Ghana

My Ref. No: DF.22

5<sup>th</sup> May, 2005.

Your Ref. No:

## ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824

IRB 0001276

NMIMR-IRB CPN 022/04-05

IORG 0000908

On 4<sup>th</sup> May, 2005 the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting, reviewed and approved your protocol titled:

TITLE OF PROTOCOL : Retention of Nurses: Perspective of Nurses employed  
at Korle-Bu Teaching Hospital

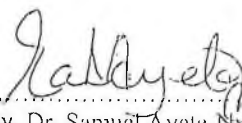
INVESTIGATOR : Anita Afita Davies

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 3<sup>rd</sup> May, 2006. You are to submit annual reports for continuing review.

Signature of Chairman:   
Rev. Dr. Samuel Ayete-Nyampong  
(NMIMR – IRB, Chairman)

cc: Professor David Ofori-Adjei  
(MB CHB, FRCP, FWACP)  
Director, Noguchi Memorial Institute  
for Medical Research, University of Ghana, Legon.



**Appendix C 1****Consent form**

Title of project: Retention of Nurses in Ghana. Perspective of nurses employed at Korle-bu teaching hospital

Name of Principal investigator: Anita Davies Affiliation: School of Nursing (College of health sciences, legon Contact Information: Phone 764104 or e-mail: [anitadee2000@yahoo.com](mailto:anitadee2000@yahoo.com)

Part 2: Consent of subject

YES NO

Do you understand that you are in a research study?

Have you read and received a copy of the attached information sheet?

Do you understand the benefit involved in taking part in this research study?

Has the issue of confidentiality been explained to you?

Do you understand who will have access to the data?

Do we have your permission to use your data for Anita Davies "Masters Thesis" conference presentation and publication?

Do you understand that the information gathered for this study could be used in research project in the future (further ethical approval will first be obtained).

Do you consent to the information gathered in this study to be used in research projects in the future?

Would you like a copy of the final report?

Part 3: Signature

This study was explained to me by \_\_\_\_\_

Signature of Participant \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name \_\_\_\_\_ Signature of Witness (if available) \_\_\_\_\_

Date: \_\_\_\_\_ Printed Name \_\_\_\_\_

I believe that the person signing this form understands what is involved in the study and voluntarily wants to be part of the study. Signature of researcher: Printed Name:

\* A copy of this consent form must be given to the subject.

**Appendix C2****Confirmation that informed consent was understood**

1. Please tell me what you are being asked to do?
2. Can you refuse to be in the study?
3. Could anything bad happen to you if you refuse to be in the study?
4. What bad thing could happen to you if you refuse to be in the study?
5. Could anything good happen to you if you decide to be in the study?
6. What good thing could happen?
7. Are you allowed to ask the researcher questions?
8. Are you allowed to quit the study once you have started?
9. What does the person doing the study mean by ‘ keeping a secrete’
10. Can the person doing the study tell anyone what you say while you say while  
you are in the study? (Why or why not?)
11. Can anyone read what you say while you are in the study? (Why or why not?)
12. How will the researcher make sure that no one knows who you are when you  
are in the study?

---

Signature/thumbprint of  
Research participant

---

Date

---

Witness

---

Printed Name

---

Printed Name

## **Appendix D**

### **Interview Guide**

#### **Demographic Characteristics**

- 1.Age**
- 2.Marital Status**
- 3.Educational background**
- 4.Religion**
- 5.Husband's occupation**
- 6.Income**
- 7.Ethnicity**
- 8.Number of children alive and their condition.**

- 1. How long have you worked as a Nurse?**
- 2. Where have you worked in the past three years?**
  - 2. What is retention of Nurses?**
- 4. How can nurses be retained?**
- 5. What structures have been put in place to make nurses stay?**
- 7. What can be done about it?**

**Appendix E**  
**Information Sheet**

Dear .....

I am Anita Afua Davies a student of school of nursing College of Health Science, University of Ghana, Legon.

I am currently undertaking a research study and I want to find out about what will make nurses stay in Ghana. You can help me since you have stayed in Ghana for the past ten years and are working as a nurse.

The study can be done wherever you like .I have some questions that I want to ask. I will tape record your answers. We can stop the tape if you don't want some things recorded.

You don't have to answer a question if it makes you feel uncomfortable. Instead I will ask another question. You can stop answering questions at any time. . All you have to do is to tell me. There will be no consequences from withdrawing from the study; no one except the researcher will know you have decided not to continue.

Your name will not go with your answers. I will put quotations from the interviews in a report but no one will identify the responses as yours.

I will listen to the tapes; No one else is allowed to hear the tapes except a committee member and you. If you want to hear the tapes someday, you can. You can ask for me and listen to them. They will be kept in a safe place.

I may talk to you again to be sure I understand what you are saying. Then I will write a report. If you have any questions please ask me. You can call me if you want to. My number is 764104. You can call my supervisors on this number 513250. Thank you very much

If you sign this form, it means that you have decided to take part in this study. It also means that you have read and understand everything that is on this form.

---

Signature of participant

---

Printed Name

Date

---

Signature of Researcher

---

Printed Name

Date

**Appendix F****Time line**

Phase	2005										2006				Revised weeks	Status
	A	M	J	J	A	S	O	N	D	J	F	M	A			
Proposal defence														1 day	Completed	
Ethics														1 month	Completed	
Advertising														1 month	Completed	
Data collecting														Two weeks	Completed	
Data analysis														One week	Completed	
Continue interviewing														One week	Completed	
Transcribing														Two weeks	Completed	
Data Analyzing														Two weeks	Completed	
Report writing														Nine months	Completed	
Submission														One day	Completed	

**Appendix G****Budget**

<b>Items /Equipment</b>	<b>Quantity</b>	<b>Price Per Unit</b>	<b>Total Price (₵)</b>
Stationary A4 papers	6boxes	170,000.00	1,020,000.00
Felt pen	36 colours	17,000.00	17,000.00
Pens	1box	70,000.00	70,000.00
Pencils	1 box	700.00	700.00
Eraser,	1 box	700.00	1,700.00
Ruler	2	1,200.00	2,400.00
Note Book (Small Size)	3	1,700.00	5,100.00
Purchase of Computer	1	1,700,000.00	1,700,000.00
Transportation to Hospitals and participants home	10 interviews	120,000	1,200,000.00
Batteries			60,000.00
Recording interview Audio Cassettes	6 packets	40,000.00	240,000.00
Dissemination of results Toner and mail attachments	1 container, for 30 minuets	1,000,000.00	1,000,000.00,
Miscellaneous: For refreshments for participants			500,000.00
Typing			4,000000.00
Tape Recorder	1	700,000.00	700,000.00
<b>Total</b>			<b>10,516,000.00</b>