BRAIN GAIN
IN THE
HEALTH SECTOR OF GHANA -
DIASPORA COLLECTIVE IN-KIND REMITTANCE AND KNOWLEDGE TRANSFERS

BY

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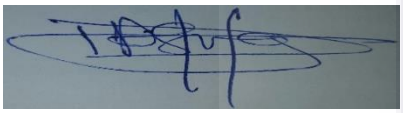
DECLARATION

I, Jemima Asigma Diakpieng, hereby declare that this dissertation is an original work I produced from a research conducted as part of my studies at the Centre for Migration, University of Ghana, Legon, in partial fulfilment for the award of MA in Migration Studies. Other researchers are duly acknowledged for referencing their works. This work has never been presented in any form to any institution.



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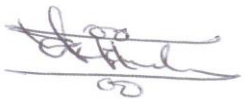

_____ 14/05/2020

Dr. Leander Kandilige **Date**

(Supervisor)

DEDICATION

This work is dedicated to God Almighty, for the strength and grace bestowed on me and my family, especially my late Dad Mr. J. N. Diakpieng - I am on the way to making you proud. Also included in this dedication are my friends, for their prayers, support and words of encouragement that which have motivated me from start to finish.

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Finally, my sincere gratitude goes to all the institutions/organisations - the Ministry of Health, Ghana Health Service, Ghana Medical and Dental Council, Nursing and Midwives Council, Ghana Medical Association, Ghana Registered Nurses and Midwives Association, the returnee health workers and health workers associations for their immense contribution to this work.

LIST OF ABBREVIATIONS

ABBREVIATION	FULL MEANING
ACBF	African Capacity Building Foundation
BEU	Biomedical Engineering Unit
EDP	Equipment Development Planning
FDA	Food and Drugs Authority
GDP	Gross Domestic Product
GHS	Ghana Health Service
GMA	Ghana Medical Association
GRNA	Ghana Registered Nurses Association
IOM	International Organization for Migration
ICF	Inner City Fund
MoH	Ministry of Health
MOU	Memorandum of Understanding
N&MC	Nursing and Midwives Council
NGO	Non-governmental Organization

OECD	Organization for Economic Cooperation and Development
PSGH	Pharmaceutical Society of Ghana
PPME	Policy Planning Monitoring and Evaluation
UN	United Nations (United Nations Organization)
UNCTAD	United Nations Conference on Trade and Development
UK	United Kingdom
USA	United States of America

ABSTRACT

Migration is gradually becoming an important feature of globalization, due to the individual's will to overcome adversity and to live a better life. Several reports have emerged on migration of health professional from developing countries to developed ones. Studies have tagged this form of migration as 'Brain Drain' and concluded that health professionals' migration poses a major challenge to the health sector of the country, in this case Ghana. Against this background, this study sought to fill in the research gap regarding the benefits of Ghana losing some of its medical professionals to developed countries. Hence, the study examined, the 'Brain Gain' in the health sector of Ghana: diaspora collective in-kind remittance transfers. Specifically drawing on the pull and push migration theory of Lee, the study explored; the motivation drivers that influence health professionals to migrate. The purposive sampling technique was used to collect data from five (5) medical stakeholders, health organization, and medical associations in Ghana, while the snowball sampling technique was use to gather information from seven (7) returnee medical practitioners in Ghana. The study revealed that, most medical professionals migrate due to poor condition of services in Ghana and their desire to better their lives. These health migrants mostly remit in-kind to the state and they do that through donation of medical equipment, medical supplies and through organization of medical outreach programs for poor and deprived communities in Ghana. Most of the respondents affirmed that remittances from this migrated health professionals' helps to reduce the burden on government budget in the health sector of Ghana. On the other hand, the findings revealed that, Government has no deliberate policy to manage migration of health professionals from Ghana.

CHAPTER 1

1.1. INTRODUCTION AND BACKGROUND

Global migration has grown tremendously and as it has, developing countries have increasingly become immigration destinations in their own right (ACBF, 2018), and due to this, international migration is now high on national, regional and global policy agendas (Asare, 2012). In 2015, the global immigrant population stood at 243.7 million, an increase of 41 percent from 2000. Although the majority of immigrants (about 58%) still lived in developed countries, immigrant populations in developing countries grew faster than those in developed countries. Traditional destinations for migration still dominate, but Asia's steep growth of 52 percent after 2000 has led to immigrant population parity with Europe, while North America follows with 55 million people (ACBF, 2018).

Most sub- Saharan African migrants often migrates to countries within the African continent, while other African migrants (comprising those from North Africa), have destination countries outside Africa has been important. Africa's emigrant population has continued to grow in absolute and relative terms with net migration increasing from 7 million to 12 million (International Migration Report, 2017). In 2015, the population of migrants of African origin across the world was 32.5 million, a 53 percent increase from 2000. In 2015, Africa hosted 20.6 million immigrants, a 39 percent increase from 2000. Africa's share of the global population increased marginally from 12 percent in 2000 to 13 percent in 2015.

According to the United Nations, highly skilled migrants from the sub-Saharan countries living in OECD countries varied between 33 and 35 per cent (United Nations, 2006). For island nations like

Haiti, Fiji, Jamaica, and Trinidad and Tobago, the proportions were above 60% and 83% in Guyana. It is estimated that more than half of their university-educated practitioners was lost to Haiti, Cape Verde, Samoa, Gambia and Somalia in 2006 (UNCTAD, 2007 in Ronald Skeldon, 2008). It bears noting that within the developing world or Global South, emigration of skilled labour has contributed and still contributes to their countries development in diverse ways. According to the World Bank (2016), Chinese emigrants contributed immensely to their technological capability building and the same for Brazil and India. The same report highlights the significant contribution of skilled emigrant Jews in the diaspora to Israel's health, industrial, and technological sectors.

The health sector of Ghana generally comprises the formal and informal sectors. The formal sector is composed of public sector health institutions established by government, and are governed by the Ghana Health Service (GHS). They include Government medical facilities (health care centres), Quasi Government Institutional Hospitals, Teaching Hospitals, Polyclinics and Health Centres. The Board of Private Hospitals and Maternity Homes is responsible for the private sector; they include Mission Based Providers and Private Physicians and Dentists. In addition, traditional medicine in the private sector has coexisted over the years with the public and private institutions, managed by the Traditional and Alternative Medicine Department. It includes Traditional Providers of Medicine, Alternative Medicine and Healers of faith.

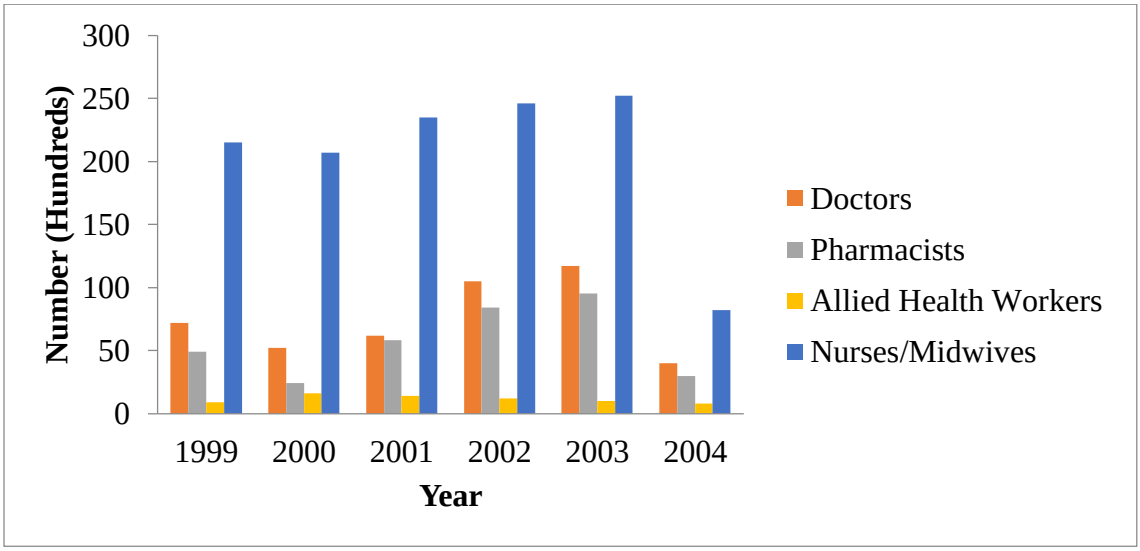
The study on the benefits of collective in-kind remittances focuses on the formal public and private sectors of Ghana's health sector. The inadequacy of staff in the health sector of Ghana, both public and private has inevitably created the need for a targeted policy framework to attract and optimize in-kind remittances of Ghanaian health labour migrants. In particular, the existing doctor-patient

ratio of 1: 10,450 as of 2017 (GHS Annual Report) is above the WHO recommended ratio of 1:1320, and this makes Ghana's case intolerable. The consequences of this disproportionately high ratio has far-reaching dire consequences for the health system in Ghana and foregrounds the urgent need to prioritize Ghana's health labour migrants as a strategy to improve service delivery and quality.

In the past, Ghana's economy, along with its educational system and political instability has been combined factors responsible for migrant outflows (Awumbila, 2008). Harsh economic conditions have continuously forced Ghanaians to adopt alternative strategies for survival and emigration presents an alluring alternative. Today, the first two factors (the economy and education) continue to drive emigration from Ghana.

Available data on international migration statistics of selected African countries show that between 1999 and 2002, Ghana had a cumulative migrant stock of 465,932, an annual average of about 186,000 over the same period (Awumbila et al 2008). In the case of health professionals, it is estimated that the OECD countries is the destination for more than half of the physicians trained in Ghana. The number of physicians trained in Ghana between 1999 and 2004 and registered in the UK doubled from 143 to 293 even though among the health professionals migration of nurses is higher with 59.1% followed by doctors at 21.4 %, pharmacists 16.2% and other related health workers at 3.3% (Mensah et al 2005 in Awumbila et al 2008). Notwithstanding the high nurse emigration from Ghana, the country's nurse-patient ratio is below the recommended WHO level, but high in relation to that of doctor-patient ratio. Certainly, the high doctor-patient ratio is inimical to the future service delivery to the extent the country has to rely on Cuban doctors to bridge the deficit.

Fig. 1: Ghana: Migration of Health Workers 1999 - 2004



Source: Ministry of Health, 2005, Awumbila et al, 2008.

1.2. Problem Statement

The health sector of Ghana has been battling with the number of health professionals in the country as against the population putting a lot of pressure on these health workers especially the doctors and nurses. According to the GHS (2017), the doctor to patient ratio is 1: 10,450 and whiles the pharmacist to patient ratio stood at 1:46,000 as of 2017 and the nurse per patient ratio stood at 1:627, but these ratio has witnessed a significant reduction over the last eight years, especially the doctor-patient ratio (1:13,074). This has been as a result of increased in the enrolment of medical professional in our various universities and training colleges.

"Throughout human history migration has been a courageous expression of the individual's will to overcome adversity and to live a better life" (UN, 2006), health professionals of Ghana are of no exception. Anecdotal evidence suggests that most of the health professionals have migrated hence the reason for high patient to health professional ratio particular for the doctors and pharmacists in Ghana. Health professionals move or migrate for economic reason, including high level of GDP per capita, economic growth, purchasing power and efficient labour market policies (ICF, 2018), or political reason. The price paid by origin countries for the emigration of their health workers are said to be the investment in their training and the void in healthcare provision from their departure (Crush et al, 2014). This movement has resulted in the loss of educated citizens referred to as 'brain drain'- defined as the large migration of people or citizens with technical skills or knowledge, from one country (origin) to the other (destination) with the aim of landing a better job and favorable working environment. On the other hand, others stay back in their host countries after they have finished with their studies instead of returning to serve their motherland.

Most researchers have focused on the negative effect of brain drain of health professionals; one of such is Serour (2009), who is of the view that migration of health professionals mostly from the developing countries to developed countries result in brain drain. In his findings, he saw nothing positive about the migration of health professional, he said, "…Brain drain contributed to impaired reproductive and sexual health services and the high rate of maternal and newborn mortality and morbidity in these counties". Moreover, Crush (2014), also sees the migration of health works from global North to global South as brain drain to the health sector, since it leads to momentous decline in the quality of healthcare in origin countries. According to Misau, Al-Sadat and Gerei (2010), the migration or mobility of health workers in search of a better living standard, higher remuneration, advanced technology and more stable political environment in different countries is

a loss to the countries of origin and thereby termed 'Brain drain'. Most of these researchers and scholars deem movement of health workers from the health sector as being a loss to the country, relegating to the background that, in as much as they try to prevent 'brain drain', other forms of migration is being encouraged by some sending states because of the potential brain gain and remittances associated with their emigration. That is, potential circulation of skills and knowledge, which are supposedly beneficiary to national development. The notion of most researchers and scholars labeling movement/ migration of health professionals as brain drain has led to countless study in that field, leaving research gab in the gains made from these migrated health professionals.

According to Crush (2006), migrant's remittances are now the main emphasis of governments and development agencies worldwide. Cash remittances according to the World Bank, globally recorded an annual remittance flows to low- and middle-income countries to be around $529 billion in 2018, a 9.6 percent increase over the previous year of $483 billion, easily outweighing the value of development assistance. It's an undisputable fact that these medical professionals remit to their family and friends in Ghana, but how much of this cash remittances directly come to the country to help the state gain what they have lost in the professionals? As a result, this research will fill the research gab of finding out the brain gain made by these health professionals to Ghana. Specifically the study will explore in-kind remittance pattern of migrated health professionals to Ghana and the effect of these remittance to the health sector of Ghana.

1.3. Objectives

1.3.1. General Objective

The general objective of the study is to examine the in-kind remittances of Ghanaian migrant health workers and the effects of their migration on the health sector of Ghana.

1.3.2. Specific Objectives

The specific objectives of the study are to:

1. Explore the motivations for health worker migrations from Ghana.
2. Examine the in-kind remittance practices of Ghanaian migrant health workers.
3. Examine the effects of in-kind remittances on the health sector of Ghana.
4. Evaluate government policies towards managing migration trends of health migrants from Ghana.

1.4. Research Questions

This study answered the following questions:

a) Given the shortage of Health Professionals in Ghanaian health facilities, what factors motivate nurses and doctors to migrate from Ghana?
b) What remittance practices do migrant health professionals from Ghana engage in? And how often do health professionals send remittances to Ghana?
c) What practical effects or otherwise do in-kind remittances have on the health sector of Ghana?

d) What policy options exist for the Ghana government in an attempt to manage migration trends of health migrants from Ghana?

1.5. Operational Definitions

Brain Gain: Health professional who have migrated and later return to Ghana to help the country with their acquired skills, knowledge and even with technology.

Remittance: Feedback effect of returnee migrants in-kind, or what the country gain from migrated health professionals in-kind.

1.6. Rationale for the Study/Significance of the Study

Discussions on migration of health professionals from developing countries such as Ghana to the more developed countries has remained relevant for decades. Irrespective of the migration drive, migration of health professionals from developing countries to developed ones, have been understood to cause more harm than good in the health sector of every economy. This has led to many researchers undertaking study into the effect or impact of brain drain to countries like Ghana. This study, tried to close the gap that existed in the gains made by the Ghanaian health sector from the migration of health workers from Ghana (Brain Gain).

It is also widely acknowledged that migrants whether health workers or other economic migrants remit to family and friends in countries of origin. These remittances have mostly been in cash and are quantifiable and as a result used to calculate cash inflow to the country. Specifically, the study

focused on the pattern of remittance by migrated health workers from Ghana – with special interest on in-kind remittances. The findings of the study prove that, the Ghanaian health sector gained from their migrated health professionals diversely, but mostly in-kind and these have helped the health sector of Ghana transformed and seen great improvement.

The study provided an overall framework for analyzing in-kind remittances flow by migrant health professionals to the health sector of Ghana. It further provided significant data or materials on the benefit of health workers migration and proved beyond doubt the gains made by the Health Sector of Ghana despite losing it health professionals to developed countries.

The study has provided significant knowledge and insight to policy makers with regards to in-kind remittance flows and it's corresponding impact to domestic sub-sectors of the economy. The data therefore will aid policy makers come up with deliberate policies or adopt some of the recommended policies to help encourage migrated health professionals to help assist the country with the needed Technical Know-How and modernization of our hospitals.

Indeed, prospects of Ghanaian health worker migrants within the health sector of Ghana have been under researched. This study therefore closed this gap, by contributing to the empirical literature on brain gain for the Ghana health sector. Specifically, the net effect of this study empirically foreground collective remittances from Ghanaian health migrants who were hitherto seen as a drain to the country.

1.7. Organization of the Study

The study is composed of five main chapters.

Chapter one consists of the background of the study, the statement of problem, the research objectives, the research questions, the significance of the study, scope of the study, limitations of the study and the organization of the study.

Chapter two focused on the review of existing literature on the concept of migration, specifically brain gain and drain, as well as forms of remittances. It also looked at empirical studies and theories on the three concepts. Chapter three also focused on the methodology, which comprises of the research design, study population, sample size, the sampling techniques used, data collection techniques among others.

Chapter four is the findings collected after the in-depth interviews conducted and also discussed the findings by analyzing and interpreting the data. Chapter five also looked at the summary of the findings, conclusions and recommendations of the research. This part concluded with recommendations for policy makers, future researchers and generally interested parties about any aspect of the study's focus.

CHAPTER 2

2.0 LITERATURE REVIEW

2.1. Introduction

This chapter presents a review of relevant literature on the subject matter of this study. Particularly, this literature review is centered on the definitions of migration, trend of health professionals' migration, divers of migration, forms of remittances and the impact of collective in-kind remittance on the health sector. Additionally, the various theories that underpin the focus and context of the study are further discussed in this chapter.

2.2. Definition of Labour Migration

Human migration is a universal phenomenon. The Oxford Dictionary defines migration as movement of people to a new area or country to find work or better living conditions. While IOM (200), defined migration as the movement of persons from their home state to another state for the purpose of employment. Similarly, it is a process through which people move from a permanent place of residence to another more or less permanent one for a substantial period of time (Chakravarthi, 2001; Chand, 2002 and Singh et al; 2001). In short migration simple means movement of humans from one place to the other to achieve a set goal or objective for a period of time.

Redistribution of people has been the result of migration at the country of origin and at the place of destination (Singh, 1998). Population tends to migrate from low opportunity areas to higher opportunity areas (Lingan, 1998). Migration can be classified into different types - The relocation of people to a different home within a state or country for a period of time is denoted

as internal migration (rural urban migration); however, migrating across borders into a different state, country, or continent is called external/international migration. The out-migration of health workers from developing countries is part of a broader global trend of health workers migration from the South to the North globally. In the health sector, this "brain drain" has resulted in a substantial drop in the quality of health care in affected countries. Below is the global trend of migration over the years.

2.3. Global Trends of Health Professional Migration

The past decade has witnessed swift rise in migration of health workers globally, especially in most OECD countries (OECD, 2007). Notwithstanding current data indicating stabilization or a reduction in some countries, largely health worker migration to OECD countries continues to be on the rise (for updated statistics see www.oecd.org/health/workforce and OECD, 2009).

According to the WHO (2006), the world has about 60 million health workers. There are numerous factors that drive away health professionals to move from poor countries to developed countries, which include higher salaries, better job conditions, and quality management. In most developed countries, there is an increasing demand for doctors, nurses and other health workers who have been trained locally and abroad. The consequences of the mass exodus of these health workers from countries of origin, has affected most health systems and thereby causing financial loss to the states of origin. According to WHO (2010), the number of migrant health workers over the last 30 years amplified to more than 5% every year in many European countries. About 20% of doctors in Organisation for Economic Co-operation and Development (OECD) countries are from abroad (OECD, 2010). More than 50% of health care personnel are migrants in some Gulf States like Kuwait or the United Arab Emirates (WHO, 2010).

According to the WHO (2004), better working conditions in destination countries serve as a motivating factor for movement of health professionals, though income has been established as an important motivation for migration, other key motivating factors such as better working conditions, job satisfaction, career opportunities and the quality of management and governance have been widely acknowledged as important factors in the migration of health workers globally. Other political factors such as political upheavals, and the risk of violence in the workplace also serve as push factors in various countries. People are seen to migrate within a country from the neediest regions to the richer cities before they finally move to high-income countries. In the event where there are considerable differences in income, people move from public sector to the private sector to gain better income.

Since 1975, developing countries have been affected by health professionals' exodus than developed countries (Syred, 2011; Naicker *et al*., 2009). Moreover, Hazarika et al. (2011), note that in the last few years, a lot of emphasis has been placed on demand for quality health care services in countries of origin because of the creation of awareness on the unequal trends in the migration of health professionals. The preference for quality health care delivery has culminated in another preference for private health care services, due to the notion that private health care providers are better off than public health care providers.

Africa is no exception to the increase in migration of health professionals. This situation is more pervasive especially the case of the most important and crucial personnel to the health care systems and in critical demand in their home countries. Anarfi et al. (2005), make it more explicit by attributing this trend to economic hardships and some structural problems confronting these African countries, which makes it harder for them to hold on to their highly-skilled

professionals including the health workers (Anarfi et al. 2005). The United States alone is said to have had about 21,000 Nigerian doctors practicing there in 1995 to the detriment of their country which needed their services (Africa Recovery, 1999). According to Immigration Issues (2004), the number of Sierra-Leonean doctors practicing in Chicago is more than the entire doctor population in Sierra-Leone.

2.4. Drivers/Motives of Migration

Overall, the causes for the migration of health workers are acknowledged and deliberated on in different literatures regularly, using the basic but vivid intuition of the push and pull dichotomy. (Labonte et al, 2015). Hagopian et al. (2004) are of the view that a sizeable number of physicians trained in Africa migrate to further their education in different specialties after they have completed their medical training. They stay back in the country when personal development arrangements are present and available to them but no monetary gains, because health workers value progress and only return when they fill they are self fulfilled or want to return to help their motherland. On the other hand, Nyberg– Sørensen, Hear, and Engberg Pedersen (2003) concludes that, the upsurge in the migration of health professionals have come about as a consequence of the world economics being integrated, the varying necessities of the origin and host countries and the diverse needs of people. Haour-Knipe and Davies (2008), believes that the above is aided by technology and unfailing transportation systems which is lacking in some developing countries.

The debate in international migration has branded these factors “push and pull factors”. Push factors are the situations in the sending countries or the individuals’ reality provoking the exit while pull factors are the prospects in the destination countries that entice migrant workers. Scholars across diverse academic fields, including economics, political science, sociology, law,

and demography, have attempted to explain why individuals (economic migrants in particular) voluntarily leave their homelands.

Even though the level of development economically facilitates migration (e.g. reduced barriers to entry), the environment is not automatically the reason why people move. Scholars of migration continue to focus on economic development whilst other works also talk about array of motivations for migration. Borjas (1989), also claimed that economic factors such as the wage differential between origin and destination countries, for example, may be the driving factor behind someone's initial decision to migrate.

During the WHO – OECD dialogue in 2008 in Geneva, they provided acumens into bases and magnitudes of the migration of doctors and nurses. Specifically, those countries that people emigrate to more and those that host highly skilled migrants have more health worker migrants (OECD, 2007; OECD, 2008).

Escalating incomes, new medical technology, improved specialization of health services, and ageing population are the reasons for the demand in healthcare workers in OECD countries (OECD, 2010). Yet other factors push the few trained professionals to neglect their duty to their motherland in favor of better and serene working conditions abroad.

Also, push factors are important in making the decision to migrate because those who are happy with their work and living conditions are not likely to emigrate (Clark et al. 2006). Pull factors on the other hand impact the decision to migrate, that is, labour markets in the receiving countries define the call foreign workers. Labonte et al (2015), also claimed that, push factors

including low remuneration, poor living and working conditions, lack of career development opportunities, high burden of HIV and MDR-TB, high cost of living, and job and economic insecurity drive outward migration.

According to Labonte et al (2015), pull factors attract migrants to high income countries and these are made up of availability of spots, higher wages, better living and working environments, career improvement opportunities, and guaranteed safety and family security.

Awases et al. (2004), conducted a survey in six African countries on health professionals and came out with varied reasons why they migrate. These include, by decreasing frequency of responses from four countries: Better pay for workers, harmless locations, living environments, availability of medical amenities, lack of advancement, no future for young health workers, heavy workloads without incentives, inability to save money, rigorous work pace, failing health service, failing economy, poor administration and advancement in training (WHO, 2006:99, based on data of Awases et al, 2004). Not being sure of the return of these migrants is what brings up the discussion on why health professional would want to migrate in the first place.

Regardless of the shortages of doctors and nurses in several emerging economies, the stimulus behind their leaving is to gain good employment (including salaries, working conditions, career advancement, etc.). The difference in wages among countries is important but not the only factor. Issues such as availability of enhanced and harmless future for children are also considered. Health worker migration is often seen to be an indication of the hitches in the health sector and usually the whole society of the origin country rather than it being a cause (OECD, 2010).

Best and Idyorough (2003) and Naicker et al. (2009), were of the view that people migrate mainly in the pursuit of food and security. These people ensure that they are able to provide for their basic needs, especially food and also safe from any form of harm. Some health workers believe that they are not safe in their country of origin and as a result move to ensure their safety.

2.5. Remittances (In-Kind)/Feedback Effect of Migration

Remittance is when money or merchandise is sent between people over some distance, but the term is generally assumed to mean a transfer by migrants to their countries of origin (Savage & Harvey, 2007). Remittances can be classified into four types including Family Remittances, Community Remittances, Migrant Worker Remittances and Social Worker Remittances (Maimbo & Ratha, 2005).

Remittances, either sent internally or internationally, monetary or in-kind, are only part of a wider network of engagement and solidarity among migrants and their origin (Savage & Harvey, 2007). Realistically, remittances in-kind are referred to as Feedback effects of migration and some of these feedbacks are usually in the form of 'brain gain' remitted by returning migrants.

Findlay and Lowell (2002) outlines three feedback effects of the migration of skilled individuals: (i) return migrants bring back their skills and work experience from abroad, thus boosting productivity; (ii) Expatriates who remain abroad contribute money via worker remittances; and (iii) expatriates transfer of knowledge development.

Similarly, Johnson and Regrets (1998), who preferred to speak on brain circulation or professional transience, are of the view that, return migration accelerates productivity. Where

you have more returned migrants after they have stayed abroad for a while would be an ideal situation in a brain drain world. After pursuing higher education abroad and returning home can increase sending country's output, more so when they return with knowledge and skills from a developed country. It is believed that return migration is high enough. Fifty per cent of skilled migrants return on the average which warrants doing away with the term brain drain (Findlay & Lowell, 2001).

Most workers migrate for better opportunities. Nevertheless, they maintain their ties and networks at their origin countries after moving abroad. These networks when nurtured create a transfer of knowledge and new technologies that enhance the county of origin's growth. It does not matter the status (permanent or temporary) of the migrant, the connections with the origin can increase productivity (Lowell & Findlay, 2001).

According to Sjenitzer and Tiemoko (2003), return migrants in Ghana come with a transfer of skills and an improvement of jobs for the migrants. Evidence from the 1995 migration survey (Twum-Baah, et al. 1995) specifies that some return migrants return after they have gained a higher-level of education which is valuable to the formation of human capital for the country. Diko and Tipple (1992) also focus their work on migration and long distance housing development by Ghanaians in London. Expatriates networks sometimes encourage return and also lead to collective projects with researchers back home (Kaplan, 1997; Brown, 2000).

2.6. Theoretical Framework

International migration has different dimensions and multifaceted occurrences which makes it difficult for a single theory to provide an explanation that is all-encompassing. To understand the

causes of this phenomenon, there is the need to incorporate variations of viewpoints. Theories propounded by expects to clarify the key drivers for the decision of health professionals emigration are outlined below:

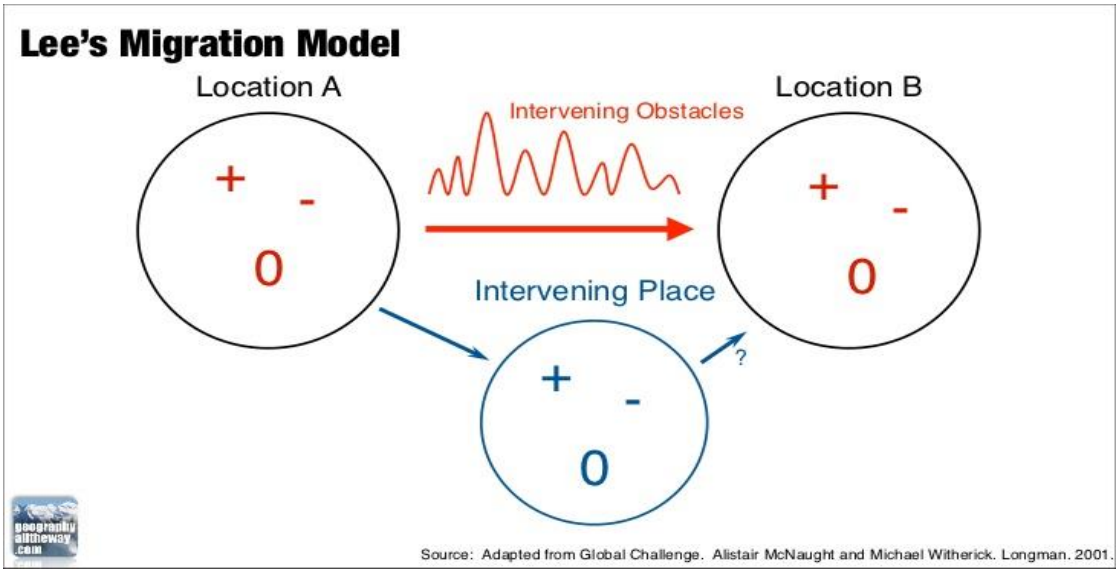
2.7. Lee's Model of Migration

Everett Spurgeon Lee, Professor of Sociology at the University of Georgia is known for his pioneering theory of migration, which is known as the Push and Pull Theory, 1966 or also as Lee' Theory.

Lee theorized the causes linked to the choice to migrate and the process of migrating into four categories: (1) Factors associated with the area of origin; (2) Factors associated with the area of destination; (3) Intervening obstacles; and (4) Personal factors.

He first formulated migration in a push-pull framework on the level of the individual (micro), looking at it from both the angles of supply and demand side of migration. Arguing that positives and negatives at both the origin and destination push and pull migrants towards (none) migration which can be affected by intervening obstacles e.g. migration laws and affected by personal factors.

Fig. 2: Lee's Migration Model



From the diagram above, there are push/pull factors and intervening obstacles to consider before planning migration patterns. It supported the notion that intervening obstacles can prevent migration to some areas, while push and pull can stimulate migration from one place to another.

The model is used alongside Ravenstein's "Laws" of Migration, the Migration Transition Model, and other models in order to show migratory patterns. The push factors induce. people to leave old residences or is anything/ circumstances that forces people to move out of a certain area. According to Lee, the three main types of push factors are economic, cultural and environmental push factors. Within these three groups there are a variety of push factors but some notable ones are few opportunities, discrimination, loss of wealth, war, etc. As shown in the model above, the push factors are what drive people out of Location A.

Furthermore, the pull factors encourage people to migrate to a new place or is the reason that entice an individual or group to migrate to a certain area. Similar to push factors it is divided into economic, cultural, and environmental factors, but unlike push factors which deals with the reason for leaving, pull factors deal with the reasons for moving to certain place.

There are many pull factors but a couple include job opportunities, better living conditions, attractive climate, security, etc. Pull factors are an integral part of Lee's migration model as they show why certain groups desire to go to certain locations.

From the diagram above, Lee further talks about intervening obstacles - environmental or cultural feature of the land that hinders migration or things that prevent migration to a certain area mainly to do with features of the land. The two main types of intervening obstacles are cultural and physical/environmental intervening obstacles.

Amongst the cultural intervening obstacles are cultural taboos on travel or traversing hostile territory, while some environmental intervening obstacles can include physical features such as mountains or deserts. Intervening obstacles are a key aspect of the model because they help us identify the intervening place between Location A and Location B.

According to Lee (1966), in both location A and B, there are both positive and negative factors, due to that, there has to be more positive reasons to migrate than there are negative for a person to choose to leave. Also, the intervening obstacles also have to be easy enough to overcome for one to opt to migrate. Finally, the personal factors are of the utmost importance because, instead

of the actual factors connected with the place of origin and/or destination, the individual's view of these factors is found to play a huge role on real act of migration.

Health professionals in Ghana have all the needed conditions to succeed although they face both positive and negative circumstance, there are factors such as the push factor that incite or motivates health professionals to want to move abroad. In the same vain, some of this health professionals are attracted by better conditions in developed countries to move. In spite of all these, medical professionals are faced with some intervening obstacles such as marriage or family commitment, issues with visa processing, government policies etc.

Although the push-pull theory has been acknowledged as a path-breaking model that explains migration at various periods and is still stands strong, it has also faced criticism. It has been criticized for being difficult to determine the plus and minus factors at both the origin and destination that are more significant quantitatively, to different groups and classes of people.

Also, the intervening obstacles makes it difficult for demographers to ascertain the factors that influence the most and the least. Therefore, this theory is not useful that much to policy and decision makers in developing nations like Ghana because it offers little guidance.

2.8. Neoclassical Economics

Perhaps the oldest and well-known theory of international migration and the simplest model of migration highlights that migration is as a result of the difference in wages at markets or countries that developed from various degrees of labour market rigidity. It was developed

originally by Hicks (1932), Lewis, 1954; Ranis and Fei, 1961; and Harris and Todaro, 1970, in Kurekova, 2011. This theory can be examined on two levels; Macro and Micro level.

For this theory, international and internal migration are as a result of geographic variations in the supply and demand for labour. Countries with surplus labour compared to capital have a low market wage, while countries with scarce labour compared to capital are seen to have high market wage as shown clearly by the familiar interface of labour supply and demand curves. The differential in wages is the bases for workers to move from a low wage country to a high wage country. This movement results in a decrease in the supply of labour with the rise in wages in the capital poor country and the capital rich country also experience an increase in labour culminating into a fall in wages leading to equilibrium in an international wage differential that reflects only the costs of international movement, financially and mentally (Kurekova, 2011).

Also, the theory believes that highly-skilled workers migrate from capital-rich to capital-poor countries earn higher revenues for their skills. Labour markets are the key devices that influence international migration. Other markets play next to no role in this. Thus, governments can regulate migration through labour market policies (e.g. through wage increases in sending countries).

This variety of neoclassical economics theory enhances the opinions at the macro level by suggesting that international labour migration is triggered by differences in wage and employment rates and that migrants expect their wages to be higher in the destination country.

This theory claims that prospective migrants assess the costs and benefits of moving to other locations. In theory, they migrate to places they think incomes will of outmost benefit over a specific period. The result of this cost-benefit calculus as a decision to migrate based on returns to the individual's investment in his or her human capital (Sjaastad, 1992)

In short, the decision to migrate is made by the individual with the bases being the difference in labour markets. Costs of migration include also social and emotional costs. Governments can influence immigration primarily through policies that affect expected earnings in origin and destination countries.

The neoclassical theory of migration has been subject to a conceptual critique. While rigorous, it has been viewed as mechanically reducing migration determinants, ignoring market imperfections, homogenizing migrants and migrant societies and being ahistorical and static. It generally ignores the effects of home and host states and leaves out the importance of politics and policies, which are only considered as distortion factors or additional migration costs. The theory has been criticized for presenting an overly optimistic view of migration, which is not always a voluntary process to maximize gains (Kurekova, 2011).

CHAPTER 3

3.0 RESEARCH METHODOLOGY

3.1. Introduction

This chapter presents the research method employed in the study as it gives the study's general overview guided by the aims and objectives. This chapter therefore explains the processes involved in collecting, analyzing and interpreting data in relation to how Ghana gain from health professionals who migrate to work after they have been trained and how these professional remit to the state in kind. The main topics discussed in this chapter include the research design adopted, the form of data required and sources used, data collection tools that were employed in the research, sampling procedures and the process involved in the analysis of the data. In addition there is some information on the challenges faced.

3.2. Research Design

The methodological approach selected for any research is aimed at providing the right data that will respond to the research questions and achieve the research objectives (Owuso, 2014). This is an exploratory research to study the brain gain made from health professionals that migrate and how these professionals helps the country in the form of remittances (in-kind). This methodology provided the best opportunity to gather information about the less known merger between the subjects.

This research adopted the qualitative design using the case study approach. In accordance with Hammond (2015), this design is primarily concerned with the exploration of richness, depth and complexity of phenomena as they occur in their natural and normal setting.

The case study method aided in the exploration of the issue of brain gain and remittance in-kind from respondents' personal experience in order to gather in depth information on the phenomenon. As posited by Yin;

"A case study is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident." Yin (2009:18)

This approach enabled the gathering of comprehensive information on the topic of the research. This was achieved by looking at the cases presented by the respondents from the institutions, associations and returnees.

The use of the case study method also gave the researcher the ability to carry out an in-depth analysis of each situation presented in relation to the organizational context. It allowed the researcher to answer the 'how' or 'why' questions in relation to a real life context (Kumekpor, 2002; Yin, 2009; Fraenkel et al: 2012). This ensured the preservation of the principles of peculiarity and uniqueness of the case of each of the organizations' so the data can be treated as such.

Furthermore, the method also gave the researcher a better understanding of the issues under discussion, which leads to the provision of new meanings and insights to the research. This resulted in the flow of more detailed information concerning the issues under discussion.

3.3. Sources of Data Collection

The study is a purely qualitative one relying fully on qualitative tools to generate the needed results. This was necessitated by the need to physically go to the people in order to explore their perspectives and experiences (Hammond, 2015). Basically, the research aimed at assessment of in-kind remittances of Ghanaian health worker migrants to the Ghanaian health sector. Primary and secondary data sources were used to understand issues better and make the research more empirical.

3.4. Primary Data

Primary data (also known as raw data because it has not been subjected to processing or any other manipulation) is a term for data collected from a source (directly from research participants). Primary data is "data that is gathered and assembled specifically for the research project at hand" (Zikmund, 2003). It is also defined as "information obtained firsthand by the researcher on the variables of interest for the specific purpose of the study" (Sekaran, 2003).

Primary data were gathered for the research from respondents from the participating health institutions, associations and health returnees. This was aimed at gaining answers to the "What", "Why" and "How" questions pertaining to in-kind remittances of Ghanaian health worker migrants. This was aimed at; exploring the motivations for health worker migrations from Ghana; examine the in-kind remittance practices of Ghanaian migrant health workers; examine the effects of in-kind remittances on the health sector of Ghana; and to evaluate government policies towards managing migration trends of health migrants from Ghana.

The main data collection tool used was semi-structured interviews. This involved the use of an interview guide to facilitate interactions with participants. Here, the researcher asked a number of questions considered to be of relevance to the topic of study. They include; social demographic questions, awareness of migration trend in the health sector, factors that leads to migration in the health sector, remittance pattern and purpose, impact of remittances, and government policies to curb migration of health professionals. Though a longer time was spent on data collection as a result of using this tool, it offered an opportunity for follow up questions by the researcher based on the response of the participants. It also provided the opportunity to probe for further explanations in situations of ambiguity.

These interviews were recorded in audio formats through the use of a tape recorder. Note taking was also employed by the interviewer to promote the efficiency of the data collection for better transcribing.

3.5. Secondary Data

According to Kamarudin et al (2010:52), secondary data "is usually historical, already assembled, and do not require access to respondents or subjects." It refers to data that was collected by someone other than the user for other purposes than what the researcher intends to use it for. These can be in the form of census reports, minutes of meetings, strategy papers and even reports from other researches. This can be collected from both internal and external sources based on the information required. In relation to this research, secondary data were collected from various articles, books published and unpublished reports on health and the drain and gain in that sector for analysis. This provided a general background on brain gain in the GHS and gave insight on government policy on the subject. Secondary data was obtained from the Ministry of Health,

Ghana Health Service and the various health association on in-kind remittance flow from Ghanaian health workers in the diaspora and diaspora associations. Also, information was obtained from existing literature, documents, books, the Internet and other sources.

3.6. Selection of Cases and Identifying Participants

According to Fraenkel et al (2012), it is essential for the researcher to choose the case(s) that will most likely illuminate the research questions. This implies that the cases that are selected must assist the researcher to respond to the research questions. It is necessary to select cases with exciting topics that address entirely the subject being studied. Yin (2009) in explaining the necessity for an exploratory case study pointed out that the selection process must be approached with the same degree of rationale and direction as would be applied to planning an exploration to the New World. He added that each case must have a definite case analysis.

The cases that were studied in this research includes; GHS, Ministry of Health, Medical and Dental Council (MDC), Ghana Medical Association (GMA), Ghana Registered Nurses and Midwives Association (GRNMA), Nursing and Midwifery Council (N&MC), Pharmaceutical Society of Ghana (PSGH) and Returnee Health Professionals. They were examined for their knowledge on health sector migrations and the gains made from practicing abroad.

The study population for this research was selected from The Health Sector of Ghana. The research population is an aggregate of all the objects, subjects or members that inform to a set of conditions (Polit & Hungler, 1999). It comprises all the possible cases (persons, objects, events) that are either affected or likely to benefit from the study. Fraenkel, Wallen and Hyun (2012), also added that a population is typically the persons who have certain characteristics that the

study seeks to examine and analyze. To them, "the population, in other words, is the group of interest to the researcher, the group to whom the researcher would like to generalize the results of the study" (Fraenkel et al, 2012: 92). In all a total of 12 participants distributed across different organisations, who were deemed as information rich case, were sampled. The sample distribution is shown in Table 1.

Table 1: Sample Distribution

Respondents	**Sample Size (n)**
Ghana Health Service	1
Ministry of Health	1
Ghana Medical and Dental Council	1
Ghana Medical Association	1
Nursing and Midwifery Council	1
Returnee Health Professionals.	7
Total	12

Sampling is the method of choosing units (e.g. people, organizations) from a group that interest you to be able to make or give objective results that can be generalized and can be traced to the original population (Trochim, 2006). Kothari (2004), also defines a sample size as the number of items to be selected from the population to constitute the sample.

3.7. Sampling Procedure

Kumekpor (2002) briefly defines sampling technique as "the sampling scheme by which the sample for a particular study is selected." The study, as a qualitative research adopted the non-probability sampling. The sampling techniques employed under this methodology were the purposive and snow balling sampling technique. The former was used in the determination of workers of the selected Organization or Associations to be interviewed, while the later adopted for the Returnee health professionals.

The purposive sampling technique was adopted because it allowed the researcher to choose the respondents in the right place to provide the needed content for the research. This sampling method was preferred because of the different sampling units needed to fulfill certain standards of concern.

Furthermore, purposive sampling was used in selecting respondents from the population to be interviewed because participants needed to satisfy certain criteria of interest (Management positions). The use of the purposive sampling also known as judgmental sampling allowed for the selection of individual or member of the team who were in the best position to provide the required data (Kumekpor 2002; Hammond, 2015) for analysis. Management members of Health institutions and associations were selected purposefully because they have worked directly with most of these health professionals and have data about these migrants and were therefore the most informed in relation to issues pertaining to brain gain and remittances. The researcher did not simply choose whoever was available but rather worked with a respondent in the position to answer the research questions based on prior information which is needed during data collection.

The researcher interviewed senior staff members of the above-mentioned associations and organization in the health sector, especially persons with data (facts and figures) with relation to the research objectives. Also, returnee doctors, pharmacists and nurses were interviewed on their experiences working abroad and also find out from them how health professionals remits back home and in what form (Kind or Cash).

Snowball is a method used to find research respondents. When a respondent introduces another respondent to the researcher, who will also introduce another and so on (Vogt, 1999). However, this sampling technique can be widely used to conduct qualitative research whose population is difficult to find Due to the challenges faced by the researcher in finding health professional returnees for the study, this strategy was seen as an answer to overcoming the issues that come with sampling a population that is hidden such as the medical professional returnees. Snowball sampling consists of two steps:

- Identify potential subjects in the population. Often, only one or two subjects can be found initially.
- Ask those subjects to recruit other people (and then ask *those* people to recruit).

Participants were made know they do not have to provide any names. The steps were repeated until the needed sample size was exhausted. Several scholars have identified shortfall of the snowball sampling technique, but according to Sharma (2017), since snowball sampling does not select units for inclusion, it is impossible to determine the possible sampling error and make generalizations (i.e. statistical inferences) from the sample to the population.

3.8. Data Collection Technique and Instruments

The study adopted the qualitative technique. This technique or method relied on existing secondary data such as documents and literature from libraries, databases and institutions, while the primary data collected were from respondent from institutions or association within the health sector as well as migrant returnees to Ghana. The research used unstructured interview guides as the primary data collection instrument. The unstructured interviews afforded opportunities to get insider view and in-depth information.

Due to the nature of the study, the researcher used three different interview guides to solicit for information. The first guide was for respondents within the Ministry of Health and the Ghana Health Service – these two institutions provided information or data on the migrant health professionals, trend of migration within the sector, remittance pattern as well as the impact of these remittances on the economy of Ghana.

The second groups interviewed were relevant stakeholders within the health sector, including but not limited to the GMA, GMDC and PSGH among other associations. They also responded to questions similar to that of the Health institutions above. Finally, some health professional returnees were interviewed. The researcher sought to ascertain their social demographics, reasons for their migration and return, frequency of remittance, form and pattern of remittance to their homeland, and how their knowledge gain has helped or will help Ghana as a whole.

3.9. Ethical Consideration

Fraenkel et al (2010:61) simply says “ethics refers to questions of right and wrong.” To them, researchers must ask themselves whether they are justified to conduct a particular study or carry

out certain procedures. Kamarudin et al (2010) also believe that "it is especially important in qualitative studies to seek the cooperation of all subjects in the research endeavor." In accordance with Polit and Hungler (1999) and Fraenkel et al (2012) the first ethical principle to consider is the principle of autonomy, which implies the right to self-determination and the right to full disclosure. This principle of self-determination means that participants have the right to decide voluntarily if they want to participate in the study or to terminate their participation. Therefore, researchers have to obtain informed consent before conducting the research.

The researcher also endorsed respondents' rights of self-determination and full disclosure. Though the nature of qualitative research does not allow for anonymity (because they hold key positions and usually the only people that have relevant data or information of the study), the researcher ensured that appropriate confidentiality procedures were implemented. Personal details of the participants were neither mentioned in the research report nor divulged to any person or institution. Also, the researcher ensured that as pointed out by Hammond (2015), participants were not allowed to do things that affected their self-respect.

3.10. Limitation of Study

The major challenge encountered during the research had to do with the availability of participants. This is mainly due to the heavy schedule of the organizations around this period. This resulted in a lot of delays in relation to data collection due to the need for face-to-face interaction to conduct the semi-structured interviews. Some meetings had to be rescheduled because participants had other commitments. This was however addressed with the selection of alternate member of the institution or association to ensure that an appropriate number of cases can be collected for analysis.

Also, the researcher had to ensure that misinterpretation and observer bias were eliminated from the research. This was addressed by the use of a well-structured interview guide with questions grouped into themes. This thematic approach helped to eliminate bias by ensuring that data analysis is done in relation to the established themes.

CHAPTER 4

4.0 ANALYSIS OF FINDINGS AND DISCUSSION

4.1. Introduction

This chapter presents the analysis of findings and discussions based on the data collected from the field on "Brain Gain" in the Health Sector of Ghana: Diaspora Collective in-kind Remittance Transfer. The Researcher adopted the qualitative methodology and the case study method to help answer salient questions of the study. Data were collected from the Ministry of Health (MoH), Ghana Health Service (GHS), Ghana Medical Association (GMA), Medical and Dental Council (MADC), Nurses and Midwifery Council (NAMC) and Returnee medical practitioners. The socio-economic and demographic characteristics of participants are discussed as well as motives for health workers migrating from Ghana, brain gain of migrated medical professionals, specifically diaspora collective in-kind remittances during the in-depth interviews. Also, the study analyzed government policies towards managing migration trends of health professionals from Ghana.

4.2. Socio-Economic and Demographic Characteristics of Respondents

The socio-economic and demographic characteristics are important in research as it brings to light the sort of respondents who took part in the interview. The respondents were made up of Deputy Human Resource Director, Director for Policy Planning Monitoring and Evaluation (PPME), Deputy Registrar, National Treasurer, Deputy General Secretary and seven professional medical Returnees who provided some basic and personal information about themselves, which was useful in analyzing the migration trend in Ghana Health Sector.

4.3. Sex, Age and Marital Status of Respondents

Twelve (12) people were interviewed, 8 were male, while the remaining were female within the health sector of Ghana. Out of the five (5) respondents from the various associations and organizations/institutions, one (1) was female from the Nursing and Midwifery Council (N&MC) of Ghana while the rest were male - one each from the MoH, GHS, GMA and the GMADC. There were five (5) male returnees and two (2) female returnees. The age range for the five (5) medical stakeholders (associations) was the late forties to mid-fifties, with the majority of the returnee respondents falling within the range of late thirties to late fifties as well. One of the female returnee respondents was a young lady in her early thirties with just about five (5) years' experience working as a nurse abroad. The other six (6) returnee participants were more matured with many years of experience working abroad, with vast skills and expertise.

Moreover, the difference in positions between the five (5) respondents from the associations and medical organizations was infinitesimal with just a level difference between them. Also, all respondents were married.

4.4. Given the shortage of Health Professionals in Ghanaian health facilities, what factors motivate nurses and doctors to migrate from Ghana?

Ghana faces significant health care challenges. The rates of maternal and infant mortality are high. There is a heavy burden of disease resulting from malaria, tuberculosis and HIV/AIDS. African region has 24% of the burden of disease but has only 3% of the world's health care workers (Mtonga & Anyangwe, 2007).

The many problems of a long history of losing personnel to migration, inadequate policies to stem the flow, and of poor documentation and data handling, have contributed to Ghana's difficulties with planning human resources for health. The migration problem also affects other health professionals including nurses, laboratory technicians and even hospital assistants who are internationally recognized cadres.

Interview data provides insight into diverse factors that drives the migration of health professionals from Ghana. However the key identified factor was largely economic. Ghana, like most sub-Saharan countries, has had its share of political, economic and social problems. Salaries have remained very low, especially for health professionals in the public sector of Ghana, the main employer. According to the representative of the GHS;

> *"...some 30% of the population is defined as being below the poverty line with another 15% with incomes that are too low to make private-sector care a profitable venture in most areas..." (An official from GHS, 2019).*

Thus, the scope of private medical practice is also limited. Closely linked to insignificant pay and lack of training opportunities, other reasons have focused on the reality that Ghana's payment system does not reward extra work and provides only a flat pay and allowance system throughout the country that does not recognize workload variation and unfavorable work locations. Although these problems have persisted over time and have been cited in the situational analysis in Ghana's Medium-Term Health Strategy Document (2014-2017), little has been done by succeeding governments to curb or eradicate the situation.

Often, there were expressed frustration with senior practitioners and supervisors. Though we do not have detailed information about these frustrations, they may be related to factors such as the 'generation gap,' cultural patterns that require respect for elders, a rigid system of seniority, the low rates of turnover from local postgraduate programmes, making it seems a lot easier to obtain training and qualifications abroad than in Ghana.

Other reasons given by the participant of the representative of the GMADC and Nursing and Midwifery Council contributing to migration include delayed promotions and adverse inefficient bureaucratic procedures respectively, which affect the country's civil service, even including employees of the Ministry of Health. According to the participant from the GHS;

> *"Poor pensions and social security benefits with the visible distress that some senior practitioners have faced after retirement may also have contributed to the exodus"* ***(An official from GHS, 2019).***

Almost all the returnees seem to have a unanimous view of why they and other migrants preferred to leave Ghana and practice their profession outside. Reasons given for migration include;

'Seek greener pastures' – Almost all respondents were of the view that it was necessary for them to seek better remuneration and better service conditions. According to one returnee urologist;

> *"My take-home salary was not worth dying for and working conditions in Ghana as in 1996 was not worker-friendly and due to that, I had to be smart and move when the opportunity came knocking"* ***(A returnee urologist, 2019).***

> Another returnee said; *"Why should I toil for politicians and other greedy people to enjoy". They believe that the loopholes in the health sector were far too discouraging and this is the first factor that encourages them to move abroad to work"* ***(A returnee, 2019).***

Others are also motivated by the fact that they could improve upon their knowledge in the health field. Therefore, search for better postgraduate training opportunities results in medical professionals migrating.

> One returnee nurse gave a reason as infinitesimal as*; "To afford basic life amenities." Among these amenities she said; "to acquire basic things in life such as a car, domestic appliances, and descent housing"* ***(A returnee nurse, 2019).***

Further reasons given include; lack of incentives for hard work in Ghana is one of the latent reasons identified by the returnees as motivating them to leave the shores of Ghana. Most of them also claimed that the workload in Ghana is heavy, yet there is no compensation for long working hours and sacrifices. According to one returnee, she left the shores of Ghana because;

> *"Heavy workloads, a lack of compensation for long working hours and an absence of policies on work-life balance make working abroad attractive"* ***(A returnee, 2019).***

That same returnee had this to say as a motivation factor for her movement with her family;

> *"The absence of flexible working hours in Ghana creates difficulties and barriers for working mothers like myself, who have child care responsibilities"* ***(A returnee, 2019).***

Other reasons given by the returnees include; the frustration of junior doctors due to their senior colleagues; and ill-defined and poorly structured local postgraduate programmes in the country. Finally, one returnee nurse stated that;

> *"Better technology available in developed countries, enabling nurses and midwives to provide better quality care and gain work satisfaction makes it more lucrative to want to travel abroad"* ***(Another returnee nurse, 2019).***

4.5. Research Question Two (2): What remittance practices do migrant health professionals from Ghana engage in? And how often do health professionals send remittances to Ghana

4.6. 4.4.1 Remittance Pattern and Purpose

In Ghana, three methods have often been used to estimate remittance flows; the use of the balance of payments estimates, micro or household surveys of recipients of remittances, and through banks or financial institutions in countries of origin where the focus is on the resource transfer institutions. In-kind remittance although they have monetary value, globally, governments have

failed to quantify equipment, logistics, medical supplies and knowledge transfer as a form of remittance. But in the health sector of Ghana, cash remittance is very rare, as most individuals and organizations remit to hospitals and health care centers in-kind rather than in cash. When the question was posed to respondents on the remittance pattern of migrated health professionals, they all affirmed most remittances are in-kind.

Unanimously, respondents were of the view that migrant health workers do remit to family and friends but there is no data in their outfit to suggest how much is remitted to those family and friends.

> *"… cash remittance from such persons first goes to their family, but not to the ministry or medical associations. I constantly receive cash from my boy (Dentist), and I don't account to my ministry in any way…"* **(A respondent from the MoH claimed, 2019)**

Moreover, respondents affirmed that migrated health professionals mostly remit in-kind to the country. It is believed that remittances come in in-kind due to the challenges faced in the health sector of Ghana. The health sector lacks sophisticated equipment and technology, as such; migrants use the opportunity of serving in advance countries to solicit support in the form of equipment and technology for the health sector of Ghana.

Almost all respondents were of the view that the health sector receives some form of remittances from migrant health workers. The respondent from GMA asserted;

> *"Cash remittance from migrant doctors are very rare to the association or institutions, but the Ministry and some of the professional association like ours receive a lot of donations in-kind from groups headed or led by some of our trained medical professionals abroad"* ***(An official from GMA, 2019).***

It was emphatic that in-kind remittances to Ghana are received through groups and not individuals. A respondent from MoH claimed that:

> *"Most of these our migrants do not remit direct, they join hands with some NGO's to help provide medical facilities and organize outreach programmes and many more complex health-related services to some citizens of Ghana for free"* ***(An official from MoH, 2019).***

Another from the GMADC admitted that;

> *"Some of them come as a group. We have those who come in to provide outreach programmes and there are lots of them and every year they come…"* ***(An official from GMADC, 2019).***

It was further discovered that some of these professional medical migrants do not remit directly through the ministry or medical associations. Due to their association with some private medical facilities in Ghana, they directly encourage the NGOs to directly remit to specific hospitals in Ghana. As such, neither the MoH nor any other association is contacted.

The researcher further probed to ascertain the form and kind of remittances received by the hospitals, the MoH respondent said:

> *"… Donations were largely made up of cash, surgical supplies, assorted drugs, vehicles, motorbikes and bicycles, computers, books, and other educational materials, clothing and food items"* ***(A staff at MoH, 2019).***

These were items that have been received over the years from individual migrants and associations abroad. Most of the respondents were of the view that cash, surgical supplies usually come in handy to mostly the government hospitals. This donation according to the representative of the Nursing and Midwifery Council and the GMA, is done to help alleviate poverty in society. It is believed that most Ghanaians in the rural areas do not have quality healthcare, as such most in-kind remittances by migrants are geared towards deprived societies in Ghana. One important form of remittance that cannot be quantifiable is the knowledge these migrants bring on board when they return.

> *"… The knowledge they say is power… they come back with new ideas and dimensions of doing things, this knowledge makes them superior amongst their equals, and due to their advanced knowledge, most of them become indispensable…"* Those were the words of the GMA representative **(A staff of GMA, 2019).**

Finally, the participant from GMADC added that:

> *"… they bring in equipment, they bring in expertise and when they come in and go, they leave the equipment. In fact, I am talking about the support that runs into hundreds of thousands of dollars… There is another group, that is the Ghana Physicians and Surgeons Foundation that has virtually taken the Tarkwa hospital and every year they come with medicines and equipment and they also provide service"* ***(An official from GMADC, 2019).***

From the above it is clear that migrated medical workers remit in-kind than in cash. Their goal is to support and promote better healthcare in their motherland. One returnee is of the view that;

> *"The healthcare system is not the best, that is why most of the leaders are transported abroad to receive medical attention. We try our best to donate facilities and transfer knowledge to ensure that our brothers and sisters will receive the best form of attention in the hospital"* ***(A returnee from Canada).***

Although there is no data on which specific medical professionals that remit most often, when the question was posed, some were of the opinion that general medical doctors do get more opportunities to collaborate with many NGOs to remit home.

On the question of the procedure to follow when one wants to remit all sorts of medical supplies and equipment, all respondents gave different views and procedures in remitting. There was a general consensus that with regards to moveable equipment and supplies the MoH and GHS have

a documented procedure for migrants and donors to follow in remitting to the country, which all other respondents affirmed was cumbersome. According to the participant of the GMA;

> *"The MoH and GHS procedures sometimes are a bit cumbersome but we also have our own procedures we follow"* ***(An official from GMA, 2019).***

> He was of the view that usually, the MoH collaborates with the association to bring in the items (remittances or donations). *"I know for instance the American group, have signed MoUs and are working on MoUs with the various agencies"* ***(A staff from MoH).***

He further asserted that although the groups have MoU with the GHS, the bureaucratic process is too much and as such some migrants will prefer to ship their items into the country without going through the procedure of the MoH. Even if they want to come and do an outreach program, they have to make sure that they get a temporary license or a valid license to practice in Ghana because it is a regulated profession. Even if you are a doctor who attended medical school here and you are no longer within the jurisdiction, when you come back you need to get the license here to practice. So, going through that licensing process is a bit difficult for them sometimes. Those are some of the challenges, if you want to import something even if it is for charity purposes, you have to have clearance, and you have to get permission from the ministry of health and all those things.

Furthermore, the representative from the GMADC shares a different opinion in the way they get their expert remittance into the country. They prefer to receive remittance in the form of knowledge rather than equipment and as such their procedure in getting this knowledge to the country is different. He further elaborated on the process;

"For us, we are interested in the professional, so to come in for example if you are coming in to teach, then you have to come in through a Medical School. This is the basic level. Then the medical school says we are engaging you, in this case, there are certain wavers that we can give. If you are coming through the postgraduate level to teach, you come through the college, so once the college submits that this person is a professor in this discipline, consultant in this discipline, which we don't have and we want to come and help or teach so that Doctors will have a different approach. It is good to bring different lecturers even on the same subject, from a different context to enrich your own local experience. Those that are coming for service delivery may come in different ways. First, if you are coming, we want to dissuade people from just coming in and going out... So, if you are coming to provide service, then the region in which you are providing the service, the Regional Director must know. So, you must send a cover letter indicating which area/district/region you are going to work so there is a partnership. Then you come through our licensing processes and we will provide you with the license. If you are coming with an NGO, it has to be a specific, designated facility, then you do all the verification process. Once we are happy, then we can register you" ***(A representative of GMADC).***

The representative of the MoH acknowledged that there is a procedure to follow if an individual or a group wants to remit any medical supply or equipment into the country. He said;

"... Yes, of course, there are long laid down procedures that everyone follows when trying to ship in medical supplies or equipment into the country. Although it is a gift, they have to follow the procedure to the later..." ***(An official from MoH, 2019).***

He confirmed that the procedure or guidelines are in two parts:

- Guidelines on Donations of Drugs, Medical Supplies, and Healthcare Equipment
- Guidelines on Medical Outreach Services

With regards to the first guideline or procedure, he spelled out that, all donations should be based on an expressed need and be relevant to the disease pattern in Ghana. Also, these should be based on existing and approved selective list on drugs, Medical Supplies and Equipment.

Furthermore, all donated items should appear on the national standards lists (which he did not have on him during the interview), but he made it clears that an exception can be made for items needed in sudden outbreaks of uncommon or newly emerging diseases. The specifications of donated items should be similar to those of items commonly used in Ghana.

> *"…That ends the selection list, from there we move to quality assurance, as I said earlier, the donation has to be of a certain standard, which are elaborated the ministry's handbook"* ***(An MoH representative, 2019).***

> He further elaborated the two procedures need to be followed by this health professionals in their bid to successful remit Healthcare Equipment to Ghana.

> *"… With regards to Healthcare Equipment, we have two different procedures to follow, that is the procedure for used equipment and that for new equipment varies and as such must be followed to the later"* he claimed **(An MoH representative, 2019).**

For used equipment, the person or organization shall submit detailed information to the Biomedical Engineering Unit of the Ministry of Health before the items are shipped, then wait for feedback and authorization before the items are shipped. Failure to comply with this requirement shall lead to the outright rejection of the donated items.

The information to be provided includes; names, item model, manufacturer details, serial numbers and years of manufacturing, availability of user and technical manuals, year of commission and decommission, name and address of the previous user, and state and current location of the items.

For new equipment, they must fit into the Ministry of Health Equipment Development Planning Program (EDP). Donors intending to support healthcare activities in the public sector through the donation of new equipment must, therefore, consult the Biomedical Engineering Unit of the Ministry of Health for a list, specifications and application guidelines.

4.7. 4.5 Research Question Three (3): What practical effects or otherwise do in-kind remittances have on the health sector of Ghana?

Brain drain has been the general effect of migration of health professionals from Ghana. Most research has been on the negative effect of migration of medical professionals from Ghana to developed countries after years of training them with the limited resources of the country. But in recent times, Ghana can boast brain gain from the movement of health professionals to developed countries. These health professionals have helped grow the country's economy with the level of remittances they bring back into the country. It has been established that migrant health professionals remit cash mostly to their friend and family, while the country has gained so much from donation in-kind by its professional medical migrants over the years. Below are the effects

of the in-kind remittances made by individual Ghanaian medical professionals and other groups with the help of these migrated health professionals. The dominant benefit acquired by health personnel was in the area of skill acquisition. Many acquired skills. In the words of the GMADC participant;

> *"Some of these migrants return with extraordinary skills which helps improve healthcare delivery in the county. Skills in in-vitro fertilization, neonatal abnormalities, dialysis, gastrointestinal surgery, hematology, pediatrics, obstetrics, gynecology, anesthesia, ear, nose, throat, postpartum, geriatrics, cardiothoracic, oncology, dietary, instrumentation, and other skills in management and teaching are remitted back to the country…"* ***(An official from GMADC, 2019).***

He further lamented that;

> *"These skills are important to the development of the health sector of Ghana because it limits the tendency of our politicians and rich men and women from traveling abroad to seek specialist services. Gradually the return of some of these our migrants has helped repose confidence in some notable hospitals in Ghana. The rich and famous now trust their lives to some doctors and hospitals here. Initially, they all move abroad for surgery and further medical consultation"* ***(An official from GMADC, 2019).***

Moreover, the expertise and knowledge that are brought into Ghana in the form of outreach programmes, go a long way to better lives of mostly the poor and needed in society. Most migrated

professionals associate themselves with NGOs who engage in outreach programs. According to the representative of the GMADC;

> *"Most of the outreach programs help address mental health issues in societies. From my experience, I have seen lot of community outreach programs and we know how beneficiary it's to the Ghanaian society and the nation as a whole. We, therefore, encourage more of that outreach programmes because it helps those that have special medical problems to seek medical attention for free"* **(Representative of the GMADC, 2019).**

He further expatiated on how outreach programs help address mental health issues in most of our rural communities.

> *"Community outreach isn't just about physical health; they help train community residents on how to identify neighbors or relatives with mental health issues and connect them with care. They also provide on-the-spot counseling to adults and children experiencing or at risk of psychological crisis, often enabling these individuals to connect with outpatient care and avoid being admitted to a psychiatric hospital unit. At the end of the day, they help avert a certain situation that will lead to a financial burden on the government"* **(Representative of the GMADC, 2019).**

It is an indisputable fact that most of the interventions take place outside of formal visits to a doctor's office, hospital or clinic, typically at a lower cost than an in-office consultation with a physician or other clinician. Most of these outreach programs across the country which involve

formal medical services remain an essential part of our healthcare system, and it has helped in giving support to healthy lifestyles and, a healthy body and mind.

Also, according to the representative of the GHS:

> *"Strategic partnerships create long-term, sustainable improvement in healthcare in Ghana by offering educational programs to young up and coming medical professionals and also provide disease management training for local volunteers who serve as Community Health Workers"* ***(Representative of GHS, 2019).***

With regard to the medical equipment, logistics, and medical supplies, almost all respondents were of the view that it impacts tremendously in the lives of the citizenry. It saves the country a few millions of dollars – through the donation of these items, the government is able to invest the limited resources into other parts of the economy.

According to the representative of the GMA;

> *"Although these remittances come in with a positive intention, sometimes the supplies get into the country a little too late when they are almost about to expire. In some cases, some of the drugs might have expired and if proper checks are not made, they are distributed to the already vulnerable in the society which leads to other medical challenges"* **(Representative of the GMA).**

He further commended the medical returnees for some of the sophisticated medical equipment they bring to the country. According to him, some of this equipment is modern and helps provide better medical care for the country.

4.8. 4.6 Research Question Four (4): What are Government Policies Towards Managing Migration Trends of Health Migrants from Ghana?

When the researcher enquired from both sets of respondents (Stakeholders and Returnees) whether there is a policy by the government to attract more Ghanaian health worker migrants back to the country or to remit, most of the respondents 'sat on the fence'. Others tried to find excuses and divert the course of the discussion. Both the representative of the GHS and the MoH were of the view that the government liaises with individuals and groups who are interested in remitting equipment to the country. They believe that through government facilitation of the process, they reduce the burden on the people and that to them is a good government policy.

The participant further stressed that inferred that, government previously allow philanthropies to ship in their equipment and medical supplies and they are cleared at the port at no cost. In his words, he said;

> *"In the past, they used to just be accepting that it will be done but people were abusing it. So, people will bring their goods, claim that they are doing outreach and then they go and sell"* ***(An official from GHS).***

This cunning process and deeds of some of the migrants and donors have led the government to be more involved in the process from scratch. According to the MoH participant, the government

has put in place the policy and a procedure which involves the migrant identifying the medical center they would want to remit or aid with their equipment or logistics then other due processes follow suit. He said:

> *"There has to be a local hospital beneficiary identified, then you need to write to the agency to get verified and sometimes if it is in partnership with a public organization, the ministry will provide logistics to help move some of the materials. If you are coming to donate to a hospital in a particular place, the government will help you in moving the things, and clearing them so that a presentation will be done publicly"* ***(A Staff from MoH, 2019).***

The representatives of GMA and two (2) medical returnees, in responding to the same question, strongly disagreed with the above claim by the GHS and the MoH. According to one of the returnees:

> *"During 2007, I pleaded with the ministry to help bring in some X-ray machines and some other supplies but for over 2 years I had no responses… our people do not help us… no deliberate policies to encourage us to help build our motherland (the health sector)"* ***(A returnee from Canada).***

The representative of GMA also had this to add;

> *"I don't think there are deliberate policies. Every now and then you hear various government agency heads saying they would call on doctors of ours to come back in and practice, but there is no deliberate policy. Deliberate policy starts with tracking where the*

people are, if you ask the Minister of Health today to tell you where all Ghanaian doctors are based, I doubt he will be able to tell. So knowing where the people are, what they do, what level of specialization they have, credentials of their qualification, establishing regular routes of these collaborations that are institutional-based, that will be better at the level of policy. But I don't see that deliberate policy" **(The representative of GMA, 2019).**

On the issue of policies, the researcher enquired from stakeholders whether there are policies in place to control or prevent the migration of health professionals in the health sector, there was a unanimously negative response from respondents, but the respondent of the MoH and that of the GMADC were of the view that migration has subsided in the health sector. MoH representative exclaimed;

"With the introduction of the new salary structure, I think since 2007, remuneration of health professionals has improved and conditions of service are better, so most doctors do not run away…" ***(A staff from MoH, 2019).***

The representative of the GMA had a contrary view to what the representative of the MoH said above. He believes that other factors other than monetary have encouraged more health professionals to stay in Ghana and work than to travel. In his words:

"…None that I know of because now the brain drain appears to have come down a bit. But unfortunately, it is restarting. When it was at its peak, policies were made deliberately to attract people to stay. You cannot prevent someone from going, but you can make situations attractive for people to stay. And one of the most important interventions was the institution

> *of local postgraduate training. We didn't have that before and it started about eleven years ago where you can train specialists in Ghana and that one was a masterstroke that made a lot of people want to stay back here to specialize and work because that job satisfaction from working as a specialist is what people were looking for"* ***(An official from GMA, 2019).***

He further elaborated on why he thinks that the trend of migration has gradually begun again in Ghana. He further stated that;

> *"…You are trained with all this money for six, seven years medical school, you have finished house job and you are sitting down waiting for posting for seven months, what should you be eating during that period when you have a skill that is needed elsewhere, then you move. This postgraduate programme that made people want to stay, now gaining access to it has become a challenge just after 10 years. Some people work in the districts, you'll bring a policy that if you work in a rural area for three years you will be allowed to come for specialization. The person will work for four years, five years and cannot get access to it. Those are the things that frustrate people and then people begin to move again. The financial motivation for people to begin to work in the rural center is poor"* ***(An official from GMA, 2019).***

Finally, with regards to deliberate policies by the government to make migration unattractive, the representative of the N&MC shared this view;

"… I think the policy in place now is to encourage them to go (sarcastically). More nurse graduates each year, but there seem not to be enough funds to absorb them in the health sector. They get frustrated and those who have relatives abroad leave, some even migrate illegally with some of these smugglers. The system is pushing the people away and it's very bad, so the government needs to rethink and help retain our nurses and doctors here because they are needed" **(A representative of the N&MC, 2019).**

4.9. Challenges of Migrant Health Personnel

Healthcare professionals experienced challenges upon their return to Ghana. Some of these challenges were more institutional, such as the level of support received from governmental agencies in Ghana, governmental agencies abroad, and the health sector in Ghana. Other challenges were the constraints associated with movement from their country of residence (their host country) to Ghana and the long wait to secure appointments for interviews, receive a response, and secure an appointment letter for work. A nurse respondent said:

"By the time one is done going through an interview and getting an appointment letter, your colleagues who went to the private sector would have moved ahead and already settled in" ***(A nurse from the UK, 2019).***

Other challenges occur at the facility level, and they include interpersonal challenges, as mentioned by some respondents. One said;

> *"When you return, of course, your colleagues would also have moved on to higher positions but they still feel intimidated by you and would want to frustrate you. Some administrations would even have you start from where you left off, which to me is a discouragement to return"* ***(A returnee from USA, 2019).***

Another said;

> *"Sometimes at work, you may get an understanding manager; you may also come across the other one, who will let you feel that when things were difficult you left. Now that you have come, they make things difficult for you and make you feel alone"* ***(A returnee from UK, 2019).***

5.0 DISCUSSIONS

The study found that factors such as limited opportunities for personal development, a limited ability to acquire one's own house on one's current salary, a limited opportunity to acquire one's own vehicle and some basic necessities, minimal job satisfaction, low income, and poor working conditions were responsible for pushing health professionals out of Ghana to seek better conditions of service. These findings support Best and Idyorough's work (2003), which suggests that individuals migrate in search of food and security. The findings are consistent with reasons given by Naicker et al. (2009) as being responsible for the migration of health professionals. For many health workers, owning a building and having a vehicle and a reasonable amount of money in a bank account are pertinent to continually staying on a job. This opinion is motivated by the perceived status of the profession of medical practice or health personnel. This plausible explanation may seem more practical for three reasons. The first is that the most touted migration in Ghana is that of health workers. The second reason is that a majority of health personnel leave within the first few years of practice without giving themselves ample time to grow and develop to a position where they can earn more rewards for their work. Third, other professions, though important to the development of the nation and requiring high qualification (just like nurses and doctors), do not see most of their professionals leave the country as often. The third reason is stated against the backdrop of the fact that a significant proportion of the workforce in Ghana (including health personnel) are low- or middle-income earners, suggesting that the incentive to migrate is more social.

An important pull factor other than remuneration was the opportunity for personal development, which was limited in Ghana, as asserted by the health professionals and stakeholders. Humans by nature would want to be progressive in life, in terms of higher education, status, and the development of skills. That is why Hagopian et al. (2004) suggested that large numbers of African-trained physicians leave home upon completion of their medical-school training to further their education in various specialties in their profession. Even when there is not much money accrued to them and personal-enhancement structures exist and are accessible to them, health workers would feel progressive and stay back in the country. Some workers work hard just to make enough money to achieve these goals. This highlights the assertion by Landon et al. (2004) that improving access to training is an important element of improving retention. It suffices that policymakers can create an enabling environment that would make health professionals feel worthy by working in their home countries.

Poor working conditions were a push factor identified by the study. Poor working conditions encompass the safety and healthfulness of the workplace, including the physical work environment and the procedures followed in performing work. This is clearly a demotivating factor for hard work and lowers productivity—which contradicts workers' goal to live to their highest potential. The issue of poor working conditions was a factor that pushed health professionals away from Ghana, Labonte et al's work (2015), affirmed it that, push factors including low remuneration, poor living and working conditions among others drive health professionals away from their country of origin. Doctors and nurses perform best when the hospitals they work in are equipped with modern diagnostic equipment and good furnishings and lighting systems. Such attractive work conditions in the advanced countries pull health personnel from developing nations like Ghana. In consonance with OECD (2010), due to the absence of new medical technology in

Ghanaian medical facilities, health professionals find it very difficult for them to function fully and at their best.

In contrast, the most compelling pull factor for migration was income. Given the above unattractive conditions in the home country, it was easy to see the relative opportunities that other countries presented. Indeed, opportunities are seen only in the light of present circumstances. Income was the most attractive consideration for travel because most of the aforementioned reasons are hinged on remuneration. Responses showed that the economic motivation to travel abroad took its inspiration from the poor financial background of some health professionals.

The increase in migration of health professionals has come about as a consequence of increasing integration of world economies, the changing needs of host and origin countries, and people's different needs (Nyberg– Sørensen, Hear, and Engberg Pedersen 2003), facilitated by high technology and reliable transportation systems (Haour-Knipe and Davies 2008).

Numerous benefits have been acquired from migrated health professionals who either practice their profession abroad or have returned to their motherland to serve. The prevailing benefit acquired in the form of remittances made by health personnel abroad was mostly in the area of skill acquisition. Many acquired skills in in-vitro fertilization, neonatal abnormalities, dialysis, gastrointestinal surgery, hematology, pediatrics, obstetrics, gynecology, anesthesia, ear, nose, throat, postpartum, geriatrics, cardiothoracic, oncology, dietary, instrumentation, and other skills in management and teaching. These skills are important to the development of the health sector in Ghana. Their remittance supports the proposition by Straub-haar (2000), that, countries of origin stand a chance of benefiting from the transfer of knowledge. It confirms the findings of Lowell

and Findley (2001), that migrated health professionals and returnees bring back their skills and work experience from abroad, thus boosting productivity and transfer of knowledge by these professional medical migrants for development. Johnson and Regrets (1998) also affirm the same position of health migrants accelerating productivity through brain circulation.

Among other benefits to society in more economic terms was the creation of employment through the setting up of clinics and diagnostic centers for health workers in the home country. This reduced unemployment marginally, providing a source of income, not only to the employed but also to the families of those employed, making them better off (Petras & Kousis 1988), as well as contributing to the government treasury by way of taxation. This is a financial benefit to the country, as the employee and employer both get taxed on their income.

CHAPTER 5

5.0 SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Introduction

The mobility of health workers in search of a better living standard, higher remuneration, advanced technology and more stable political environment in different countries is a loss to the country of origin. This movement has resulted in the loss of educated citizens and professional healthcare workers, which is referred to as 'brain drain'. Adopting the qualitative research design and using the case study methodology, the study answered the following objectives: Explore the motivations for health worker migrations from Ghana; Examine the in-kind remittance practices of Ghanaian migrant health workers; Examine the effects of in-kind remittances on the health sector of Ghana; and Evaluate government policies towards managing migration trends of health migrants from Ghana.

5.1. Summary of Findings

The study assessed the in-kind remittances of Ghanaian migrant health workers and their effects of migrating on the health sector of Ghana. Specifically, it explored the motivations for health worker migrations from Ghana; examined the in-kind remittance practices of Ghanaian migrant health workers; examine the effects of in-kind remittances on the health sector of Ghana; and evaluated government policies towards managing migration trends of health migrants from Ghana. Below are the key findings of the study.

5.2. Research Question One (1): Given the shortage of Health Professionals in Ghanaian health facilities, what factors motivate health professionals to migrate from Ghana?

- Poor remunerations were key factor for migrating.
- Others identified Poor pensions and social security benefits with the visible distress that some senior health practitioners have faced after retirement contributed to their exodus
- The desire to seek greener pastures was also deemed as reasons for migrating
- The ability of some health professionals to afford basic life amenities was another driving motive.
- Heavy workloads, a lack of compensation for long working hours and an absence of policies on work, make working abroad attractive
- The absence of flexible working hours in Ghana creates difficulties and barriers for working mothers who have child care responsibilities

5.3. Research Question Two (2): What remittance practices do migrant health professionals from Ghana engage in? And how often do health professionals send remittances to Ghana?

- Although individuals make remittances or donations, health sector Remittance or donation is usually done in groups,
- Cash remittance from migrant health workers is very rare, in-kind remittances are the most preferred.
- Medical outreach programmes are usually the most practiced by migrated health professionals, this helps them touch and serve the poor and need with special medical problems that they could not otherwise pay for.

- Donations were largely made up of cash, surgical supplies, assorted drugs, vehicles, motorbikes and bicycles, computers, books, and other educational materials, clothing and food items
- Knowledge transfers and skill expertize of most migrants seem to be appreciated and comes in handy.
- Procedures involved in remitting in-kind to Ghana are too long and cumbersome.

5.4. Research Question Three (3): What practical effects or otherwise do in-kind remittances have on the health sector of Ghana?

- Improvement in healthcare delivery through the transfer of knowledge and skills
- Reduction of government allocation of funds to the health sector as a result of donation of medical equipment by migrated health professionals and some NGOs.
- Help provide free medical consultation and services for the poor and need in society through the outreach programmes
- Some of the medical supplies have short life shelf. When expired drugs are consumed, it leads to worsening health situation and further increases burden on the government.

5.5. Research Question Four (4): What policy options exist for the Ghana government in an attempt to manage migration trends of health migrants from Ghana?

- Government have no deliberate policy on migration of skilled professionals.
- There seem to be an open door policy for trained migrants to move freely from Ghana, after they have been trained with taxpayer's money.

5.6. Conclusion

The migration of health professionals from Ghana over the years has been a topical issue in the media. A country that lacks professional health workers - invest in the future and careers of its citizenry, only to lose them to developed countries. This has led to the loss of investment and the negative repercussion of health care delivery in the country. The loss of these health professionals has been seen only in the negative lens of Ghana, as we term it 'Brain Drain'.

Based on the research findings, it was clear that most health professionals decide to embark on the journey to seek a better life and get good jobs. There are numerous factors that push these medical professionals to move from the shores of Ghana to practice their profession abroad. These push factors include; unattractive working conditions, low remuneration, high cost of living, and limited opportunities to develop. On the other hand, there were factors with the advance countries that attracted these health professionals to move there. They include; attractive remuneration, access to training facilities to develop, the existence of personal enhancement structure to ensure personal development.

Although the movement of these health professionals has a negative effect on the Ghanaian economy as well as the health sector, it is undeniable that over the years, Ghanaians have gained tremendously from these migrant professionals to the developed countries. These benefits have been in the form of remittances from these health migrants. Friends and families have predominantly received remittance in the form of cash. On a larger scale, these migrants remit to the country in-kind and cash (rare).

Skill transfer is the most received form of in-kind remittance; these health professionals gain vast knowledge and skill during their time of service. After some time, they return to impact this knowledge to the up and coming medical practitioners and serve the country with those skills. Transfer of technology is one basic form of remittance made by these migrants to help the Ghanaian health sector. Also, through their liaisons with NGO's they engage in outreach programs that provide free medical consultancy to the poor and needy, which otherwise they wouldn't have been able to afford. Finally, these migrant health professionals remit medical equipment, logistics, medical supplies and a host of items to Ghana for free. These items help improve healthcare in the country and serves the country millions of dollars to be invested in other sectors of the economy.

Also, based on the findings, the health migrants have played a major role in helping to develop the Ghana health sector, their transfer of skill has helped reduced the number of persons who will prefer to travel abroad for medical assistance and surgery. The skill and knowledge transfer, has got more people who otherwise have doubts about receiving medical treatment in Ghana to rethink. Also, these migrants with extraordinary knowledge come in and partner with the medical school to teach for a period of time. This helps them transfer their knowledge to new up and coming health professionals. Moreover, due to the skill transfer, the mortality rate in the country has reduced.

Although migration has been seen as removing the *creame de la creame* from the Ghanaian health sector, it's astonishing that there are no deliberate policies made by successive governments to manage the migration trend in Ghana. The country seems not to care about losing its health professionals to the advanced country, based on the fact that the state seem to benefit when some of these health professionals travel and seek for knowledge, as such, there are no policies in place

to deter health professionals from migrating. On the other hand, the government has a long procedure in place, ready to receive remittances from these health migrants.

5.7. Recommendations

Based on the findings of the study, the following recommendations were made:

- The government of Ghana should have a better database on its medical migrants, this will help to liaise with them from time to time and to assist with further programmes to enhance health care delivery.
- The government of Ghana through its agency the Ghana Health Service should formulate policies and guidelines that will aid migrant health professionals to return to the country with ease and work together with their peers for the enhancement of the sector.
- Medical graduates should be made to sign a bond that will keep them in Ghana over a period of years after graduation from school
- The remuneration and working conditions of health professionals should be improved to discourage young and up and coming medical workers from migrating.
- The government should put in place deliberate policies to manage future migration of health professionals

5.8. Area for Further Studies

Migration has been a typical area globally with a lot of emphasis being placed on the health sector. Based on the study, the following research gabs were identified and will need further attention by future researchers.

- The impact of medical outreach programmes by migrated health professionals and their impact of 'brain gain' in the health sector of Ghana.
- The effect of deliberate migration policy in the health sector, as a tool for 'brain gain'.

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APPENDIX A

INSTITUTIONS

Interview Guide for Key Informants (MOH and GHS)

My name is Jemima Asigma Diakpieng, an M.A .Student of the Centre for Migration Studies, Un iversity of Ghana. I am conducting a research on Brain Gain in the Health Sector of Ghana; Diasp ora Collective in-kind Remittance Transfer. I would be very grateful if you could make time, out of your busy schedule to grant me an interview lasting an hour. You are assured that this intervie w will be treated as confidential and used for academic purposes only.

Thank you for co-operation

IDENTIFICATION

- Name ……. ……
- Place of interview ……
- Date ……
- Start of Interview ……..
- End of interview ……..
- Duration of interview …….

SECTION A: Socio-Demographic of Interviewee

- Sex ……..
- Age……..
- Name of institution ……..
- How long have you been with this Institution ……..

- Position ……..

AWARENESS OF MIGRATION TRENDS

1. How many health professionals migrate every year?

   Probe for: The number of doctor, dentists, nurses, pharmacist that migrate yearly and the countries they migrate to

REMITTANCE PATTERNS AND PURPOSE

2. Do you receive remittance (s) from the Ghanaian health worker migrant?

   Probe for: Who remits (physician, dentists, nurses, pharmacist) and from which countries

3. In what forms do the remittance come in?

   Probe for: The frequency and magnitude

4. What is the remittance used for?

5. What is/are the procedure (s) to follow when one wants to remit?

IMPACT OF REMITTANCE

6. How does these remittances contribute to health care delivery in Ghana?

   Probe for: How health care delivery will be without these remittance

MIGRATION POLICIES

7. Is there a policy in place by government to attract Ghanaian health worker migrants back to the country or to remit?

Probe for: How feasible the policy is and what can be done to make it more feasible

8. What are the structures put in place for returnees to integrate into the health sector?

   Probe for: How welcoming they are to divergent views/best practices on management of the health sector

9. Is there a policy in place to control or prevent the migration of health professionals?

   Probe for: Challenges in the policy and what can be done about them.

APPENDIX B

ASSOCIATIONS

Interview Guide for other stakeholders (Medical Associations: GMA, GMADC, N&MC and GRNMA)

My name is Jemima Asigma Diakpieng, an M.A .Student of the Centre for Migration Studies, University of Ghana. I am conducting a research on Brain Gain in the Health Sector of Ghana; Diaspora Collective in-kind Remittance Transfer. I would be very grateful if you could make time, out of your busy schedule to grant me an interview lasting an hour. You are assured that this interview will be treated as confidential and used for academic purposes only.

Thank you for co-operation

IDENTIFICATION

- Name and Position of Interviewee ……
- Place of interview ……
- Date ……
- Start of Interview ……..
- End of interview ……..
- Duration of interview …….

SECTION A: Socio-Demographic of Interviewee

- Sex ……..
- Age……..
- Name of Association ……..

- Position ……..

AWARENESS OF MIGRATION TRENDS

1. How many health professionals migrate every year?

   Probe for: The number of doctor, dentists, nurses, pharmacist that migrate yearly and the countries they migrate to

REMITTANCE PATTERNS AND PURPOSE

2. Do you have any relationship with Ghanaian health worker migrants association?

   Probe for: How long they have had this relationship and how they help each other or kinds of collaborations they have

3. Who remits (Physicians, dentists, nurses, pharmacist) and from which countries?
4. In what forms do the remittance come in?

   Probe for: The frequency and magnitude

5. What is the remittance used for?

IMPACT OF REMITTANCE

6. How does these collaborations enhance your work as health providers?

   Probe for: The benefits to health sector in general and they as medical practitioners

7. What is /are the procedure(s) to follow when one wants to remit?
8. What are some of the challenges faced in trying to secure these collaborations?

MIGRATION POLICIES

9. Do government have any policy in place that facilitates or encourage the Diasporas to collaborate?

    Probe for: Processes, structures, procedures

10. What suggestions can you give government to make these collaborations more forth coming and less challenging

11. How receptive is the association (members) to divergent views from colleague returnees

12. Is there a policy in place to control or prevent the migration of health professionals?

    Probe for: Challenges in the policy and what can be done about them

APPENDIX C

RETURNEES

Interview Guide for Returnees

My name is Jemima Asigma Diakpieng, an M.A .Student of the Centre for Migration Studies, Un iversity of Ghana. I am conducting a research on Brain Gain in the Health Sector of Ghana; Diasp ora Collective in-kind Remittance Transfer. I would be very grateful if you could make time, out of your busy schedule to grant me an interview lasting an hour. You are assured that this intervie w will be treated as confidential and used for academic purposes only.

Thank you for co-operation

IDENTIFICATION

- Name of Interviewee ……
- Are you into private practice or public sector ……
- Place of interview ……
- Date ……
- Start of Interview ……..
- End of interview ……..
- Duration of interview …….

SECTION A: Socio-Demographic of Interviewee

- Sex ……..
- Age……..

AWARENESS OF MIGRATION TRENDS

13. Which country did you migrate to?

    Probe for: When, why, how and their age at the time of migrating

14. At what age did you return?

MIGRATION EXPERIENCES

15. How did migrating benefit you?

    Probe for: The challenging faced as a migrant

16. When you were out of the country did you have any contact/relationship with the health sector back home or the medical association of Ghana?

    Probe for: How the contact happened, the kinds of contacts, how often it was and the nature of relationship

17. Did anybody from a specific association and Ministry/GHS contact you?

    Probe for: How the first contact came about and did it lead to any positive or material outcome

18. When and why did you decide to return?

    Probe for: How long it took to return and the procedure (s) he/she had to go through to be able to practice back home

19. Did you face any challenges?

    Probe for: The challenges and what can be done to make it less challenging for returnees

20. Did you have an association of Ghanaian health workers at your destination?

Probe for: What the aim or objective of the association was and if he was a member and how is the functional capabilities of the association

REMITTANCE PATTERNS AND PURPOSE

21. Did the associations have any collaborations with the GHS or the medical association in Ghana?

    Probe for: *The kinds of collaborations, how they were initiated, the challenges they encountered in the process etc*

MIGRATION POLICIES

22. Was there any discussions with policy makers concerning how you (members of the association) could return home and help the Ghana health sector

23. What in your view what could be done more to encourage more people to return?

    Probe for: *How feasible the recommendations are*