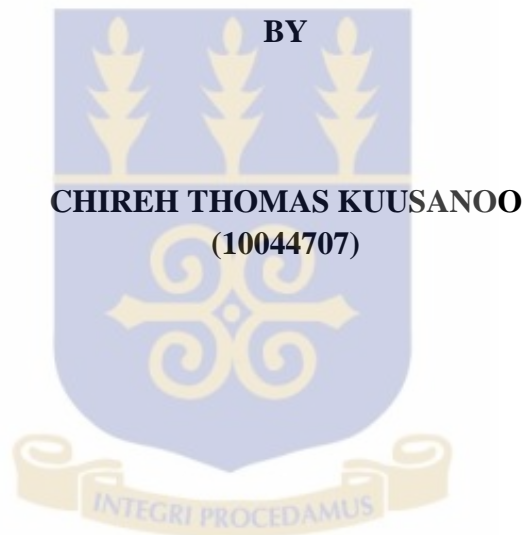


UNIVERSITY OF GHANA

**ATTRACTION AND RETENTION OF MEDICAL DOCTORS TO THE
UPPER WEST REGION: PROSPECTS, CHALLENGES AND THE WAY
FORWARD**



**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON
IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE
AWARD OF MASTER OF PHILOSOPHY IN PUBLIC ADMINISTRATION
DEGREE**

JULY 2015.

DECLARATION

I do hereby declare that this thesis is the product of my own research undertaken under supervision and has not been presented by anyone for any academic award in this or any other University. All references used in this work have been fully acknowledged.

I bear sole responsibility for any shortcomings.

.....
CHIREH THOMAS KUUSANOO
(10044707)

.....
DATE



CERTIFICATION

I hereby certify that this thesis was supervised in accordance with procedures laid down by the University.

.....
DR. EMMANUEL Y. M. SEIDU
(SUPERVISOR)

.....
DATE



DEDICATION

This thesis is dedicated to the entire Chireh's Family of Lassia-Tuolu, my siblings and most especially my wife, Juliana Annuoh and my children, Elsie Fereporoh Chireh and Esmond Saanomah Chireh for their sacrifices and support.



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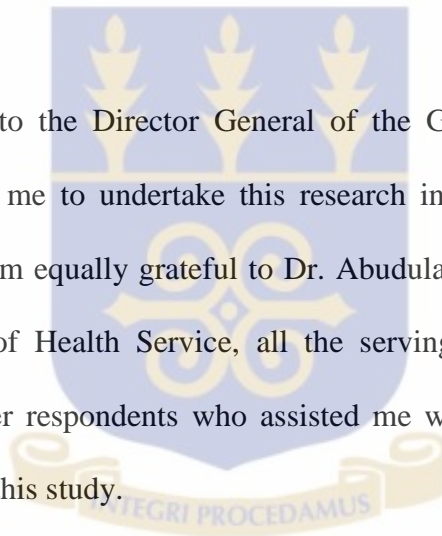


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LIST OF ABBREVIATIONS

ADHA	--	Additional Duty Hours Allowance
CHAG	--	Christian Health Association of Ghana
CHPS	--	Community-Based Health Planning and Services
DA	--	District Assembly
DAA	--	Deprived Area Allowance
DCD	--	District Coordinating Director
DHMT	--	District Health Management Team
GCPS	--	Ghana College of Physicians and Surgeons
GHS	--	Ghana Health Service
GHS-ERC	--	Ghana Health Service Ethical Review Committee
GSS	--	Ghana Statistical Service
HRH	--	Human Resource for Health
Hr-MDG	--	Health Related Millennium Development Goals
HSS	--	Health Sector pay Scale
IGF	--	Internally Generated Fund
iMMR	--	Institutional Maternal Mortality Rate
JMU	--	Jichi Medical University
MLGRD	--	Ministry of Local Government and Rural Development
MoE	--	Ministry of Education
MoH	--	Ministry of Health
NCR	--	National Capital Region
PSAP	--	Physician Shortage Area
RCC	--	Regional Coordinating Council
RDHS	--	Regional Director of Health Service

RHA	--	Regional Health Administration
RM	--	Regional Minister
SSPP	--	Single Spine Pay Policy
TH	--	Teaching Hospital
UNDP	--	United Nations Development Programme
UW	--	Upper West
UWR	--	Upper West Region
UWRHS	--	Upper West Regional Health Service
WHO	--	World Health Organisation
ZHWRS	--	Zambian Health Workers Retention Strategy

ABSTRACT

This study is aimed at understanding the prospects and challenges associated with attracting and retaining medical doctors to the Upper West Region of Ghana. The study looked at the reasons medical doctors were unwilling to accept postings to the Region, the current initiatives by the Ministry of Health and its partners and their effectiveness, and the key factors considered viable to brand the Region as the employer of choice in getting medical doctors to take up appointments there and be retained. The study used a qualitative research methodology and employed structured interview guide. A total of sixteen respondents comprising medical doctors, health managers and other health related partners participated in the study. The findings from this study suggest that medical doctors were unwilling to take up appointments to the Region generally because of limited opportunities for career and continuing professional development, poor financial inducement, weak leadership, and in particular superstition and high dependence on indigenous doctors. Critical success factors needed to brand the Region to help surmount the challenge included concessions for medical specialisation training, sponsorship, and clear, coordinated and coherent national and local policies that offer a brand promise on appointments to the Region.

Keywords: Attraction, Retention, Medical Doctors, Prospects, Challenges, Way Forward, Upper West Region

CHAPTER ONE

GENERAL INTRODUCTION

1.0 Background of the Study

It is a truism that the health status of the citizenry of any nation determines its productive capacity and by extension its economic prosperity and the general welfare of the population. But health care delivery is largely labour-intensive and therefore the utmost critical element of health systems, necessary in furthering this objective are health workers. Consequently, managers of health care systems, in considering their local priorities and resource availability, strain a big deal to find the most effective blend of employees necessary to accomplish their objectives (Buchan & Dal Poz, 2002). The determination and achievement of the right mix and distribution of health personnel, however, remain major challenges for most health care organizations and health systems (The World Health Report, 2000). In respect of the foregoing, the World Health Organisation (WHO) has cautioned that achieving the Health-related Millennium Development Goals (Hr-MDGs) would be a mirage without adequately trained and supported health workers in sufficient numbers (WHO, 2006).

Although Ghana's performance in the areas of social competencies: education, health, command over and allocation of resources, population trends, and the environment is improving, the United Nations Development Program (UNDP) has placed the country in the league of nations with medium human development (UNDP, 2014). This is because phenomenal variations continue to exist in Ghana's 24,658,823 population with 50.9 and 49.1 per cent, respectively, living in urban and rural areas (Ghana Statistical Service-GSS, 2012). For instance, a joint survey report

by the Ghana Statistical Service, Ghana Health Service and Macro International Incorporated (GSS; GHS &MI, 2009), on maternal health in Ghana has found that urban households have 83.8% per cent electricity coverage compared to 39.5% of rural households (GSS, 2012), and 85.3% of women in urban and more endowed areas have health facility delivery matched with 38.3% of rural women (GSS; GHS & MI, 2009). What this posits is that quality maternal health care in rural and deprived areas is a privilege for those who have it.

Despite the apparent imbalances in health coverage, the limited numbers of health professionals, particularly medical doctors, have tended to concentrate in these advantaged areas. For instance, in an assessment of the Health Sector Programme of Work for 2013, out of the 2, 615 doctors in public employment in Ghana as at 2013, over 50% of them were located in the Greater Accra Region and more than half of the remaining number concentrated in the Ashanti Region. The rest of the nation contented with the remaining numbers (Ministry of Health-MoH, 2014). This development presents a spectacle of disparaging differences in doctor population ratios across the country. Whilst the national average of doctor per population ratio stood at one doctor per 10,170 in 2013, that of Greater Accra was 1:3,178 whilst regions such as the Upper West (UW) could only boast of 1:53,064 (Ministry of Health, MOH, 2014). Considering that the Upper West Region (UWR) is among the regions with the least penetration of private health facilities in the country (GHS, 2010 & Upper West Regional Health Service-UWRHS, 2014), the implications of such poor doctor/population ratio could be dire. This study therefore sought to understand the issues that resulted in the unwillingness of most Ghanaian doctors to accept postings to the Upper West Region and also to assess strategies that can be adopted to curb the situation to help improve health care delivery in the Region.

1.1 Problem Statement

The prime concern of most health systems around the world, in current times, is the achievement of the Health-Related Millennium Development Goals (Hr-MDGs). But essential to the achievement of these goals is the adequacy of the right numbers and mix of human resource. As rural areas are hurt by the inadequacy of skilled healthcare providers, there is pessimism about the feasibility of accomplishing the Hr-MDGs in rural settings (Adzei & Atinga, 2012). This is because attracting and retaining the adequate mix and distribution of health workers, remain elusive and a major challenge for the global health effort.

Ghana's population is served by 2, 615 public sector doctors as at 2013, a marginal increase over the previous year's (2012) figure of 2,252, and other providers (private and quasi-governmental) (Ministry of Health, MoH, 2014). The national doctor per population ratio has witnessed some improvement from one doctor per 11,515 people in 2012 to one doctor per 10,170 people in 2013 (MoH, 2014). Despite the seeming improvement in the availability of doctors in the country, the Greater Accra and Ashanti Regions take more than half that number, thus skewing the distribution to the detriment of other regions. Indeed Greater Accra Region holds more than 50% of all government-employed doctors in Ghana thus presenting it with a doctor to population ratio of 1:3,178 whilst a Region such as the Upper West with a population of 702,110 (16.3 per cent urban and 83.7 per cent rural), has a doctor population ratio of 1: 53, 064 (Ministry of Health, 2014).

The above poor statistic has had adverse implications for the health care delivery and socio-economic development of the Upper West Region. For instance the Region has less than 60 per cent skilled delivery, nearly 15 per 1000 infant mortality and an almost 200 per 100,000 institutional maternal mortality rate (iMMR)

(Ministry of Health, 2014). In the face of the above worrying statistics, most medical doctors posted to the Region have often failed to take up their postings (Upper West Region Health Service, 2014), and therefore creating severe shortages with their attendant ramifications for quality health care delivery. This development therefore presented an urgent need for research in this area to understand the issues that informed the lack of interest or unwillingness and the inability to attract and retain medical doctors to the UWR.

Furthermore, though Snow et al. (2011) looked at the subject of attraction and retention and focused on some of the key factors leading to reduced recruitment and retention of health professionals to remote areas of Ghana, their study did not adequately provide for contextual factors critical to branding these segments of the country as places of choice for employment (Sokro, 2012). This is because it did not involve the political administrative partners in those areas that control the local dynamics. Meanwhile researchers (e.g. Bocoum, Koné, Kouanda, Yaméogo & Bado, 2014) have emphasized the importance of contextual factors in health service research. This research seeks to do an in-depth study of the specific initiatives taken by the Ministry of Health and other health-related partner organisations aimed at branding the Upper West Region as a place of choice for employment.

Again, most of the studies in this area of research have tended to be quantitative (e.g. Hatcher, Onah, Kornik, Peacocke, & Reid. 2014; Bonenberger et al., 2014; Adzei & Atinga, 2012), and therefore tended to establish associations between factors but are inadequate in offering the underlying reasons that underpin such relationships (Adzei & Atinga, 2012, p.481). This study is in response to the call for more qualitative research studies that will unearth the myriad of perspectives that

various individuals and institutions hold about the attraction and retention of medical doctors to the Upper West Region.

Lastly, previous studies in the field in Ghana did not consider the aspect of employer branding (Ambler & Barrow, 1996) that seeks to distinguish specific attributes that add on or take away the zeal of health workers in choosing particular locations for work. This study seeks to employ the concept of employer branding to explain how well or otherwise the Region has positioned itself as an employer of choice.

1.2 Objectives of the Study

The main objective of the study was to assess the prospects and challenges of attracting and retaining medical doctors to the Upper West Region. The specific objectives include the following:

1. Examine the reasons for the unwillingness of medical doctors to accept postings to and remain in the Upper West Region
2. Identify specific initiatives taken by the Ministry of Health and other health-related partners to attract and retain medical doctors to the Region.
3. Assess the effectiveness of the interventions of stakeholders to attract and retain medical doctors to the Region.
4. Identify critical success factors in the attraction and retention of medical doctors to the Region

1.3 Research Questions

1. What are the reasons for the unwillingness of medical doctors to accept postings to and remain in the Upper West Region?
2. What are the specific initiatives taken by the Ministry of Health and other health-related partners to attract and retain medical doctors to the Region?

3. How effective are the interventions of stakeholders to attract and retain medical doctors to the Region?
4. What are the critical success factors for the attraction and retention of medical doctors to the Region?

1.4 Significance of the Study

First, this study offers better insights into how to brand the Region to attract doctors and the strategies to adopt to retain them. It also provides a deeper understanding of the issues that hamper the welfare of medical doctors not to accept postings to the Upper West Region. This study therefore enhances our knowledge of the factors that underpin medical doctors' motivation in working in deprived areas.

Secondly, by targeting both serving and former medical doctors of the Region, the study will help to establish at the personal level specific motivating factors from the experiential knowledge of these doctors and thus contribute to framing policy measures that recognise individual motivational factors to take advantage of in branding the Region as a place of choice. It will also point out de-motivational factors that affect the brand image of the Region so as to avoid them.

Thirdly, the poor doctor/population ratio in the Upper West Region is not a new phenomenon. But attracting and retaining staff in deprived areas the world over is a public health policy matter that requires the appropriate authority, skill, resources and power to take the decisions and implement them. However, as Dye (1987:1) puts it, a policy is "whatever governments choose to do or not to do". Since this challenge has persisted for some time, the study will help unearth the different policy perspectives from the key stakeholders to offer a better understanding of the extent of awareness that exist of the challenge and how harmonious their conscious and unconscious policy actions have helped in addressing it.

In a similar vein, the study will also bring to bear the region specific initiatives, by the Regional Health Administration (RHA), the Regional Coordinating Council (RCC) and the District Assemblies, aimed at branding the Region to attract and retain medical. In so doing, critical factors for success or failure will be identified and thus pave way for such policies to be improved upon, modified or changed entirely to better inform policy decisions on attracting and retaining medical doctors to the Region.

Lastly, by employing the concept of employer branding in the study, it will help assess how the Region has positioned itself in the job market of doctors in the country with what it offers. This will enhance our understanding of the steps the Region can put in place to attract and retain doctors there.

1.5 Chapter Disposition

This study has been organised into six chapters. Chapter One looks at the research background, research problem, study objectives, research questions, and the significance of the study. Chapter Two considers the theoretical framework that underpinned the research. Chapter Three presents a review of literature relevant to the attraction and retention of medical officers. The Fourth Chapter focuses on the methodology of the study highlighting the research paradigm, research approach, scope and limitation, study population, sample size, sampling technique, data collection instruments and method of administration, sources of data, data management and analysis, and ethical consideration. Chapter Five focuses on data analysis and discussions, done along the lines of the four objectives guiding this study. Chapter Six gives a summary of the research, its implications and recommendations to research, practice and policy. Future research directions are discussed here as well.

CHAPTER TWO

THEORETICAL FRAMEWORK

2.0 Introduction

Human Resource has long been recognised as the catalyst for putting other factors of production to effective use because it provides the know-how or the skill, ideas and the manpower (Torrington, Hall, Taylor, & Atkinson, 2011). This recognition has therefore led to the evolution of many theories in an attempt to offer better directions on how to acquire, nurture, and utilise this resource whilst maintaining its viability at all times. This study is underpinned by Adams' Equity Theory (1963, 1965) and supported by Ambler and Barrow's (1996) concept of 'employer branding'.

2.1 The Equity Theory

The first proponent of equity theory was John Stacy Adams in 1963 in his work on "Wage inequities, productivity, and work quality". He later gave the theory clarity and extension in 1965 in his paper on "Inequity in social exchange". The theory centred on exchange relationships where individuals gave something which he called inputs and in return expected something called outcome (Adams, 1965). Beyond the inputs and outcomes, Adams talked of a third factor or variable, the reference person or group (i.e. the referent other or comparison other) necessary in the exchange relationship. This person or group could be a co-worker or group of co-workers. Adams (1965) mentioned some of the inputs as education, intelligence, experience, training skills, seniority, and age. For outcomes, pay, intrinsic rewards, satisfying supervision, seniority benefits, fringe benefits, poor working conditions, monotony, fate, uncertainty are also mentioned.

Perceived equity occurs when an individual perceives his inputs balance with his outcomes whilst seeing the inputs of others are balanced with others' outcomes.

Also, an individual could still feel equity exists, when in his opinion, the other is not having his inputs and outcomes in balance just as his inputs and outcomes do not balance (Pritchard, 1969). The objectives of equity theory are captured in four propositions: first, the relationship between individuals is evaluated on the basis of the ratio of their outcomes from and inputs to the relationship as compared to the outcome/input ratio of a comparison other; second, inequity exists when the comparative ratios are perceived by the individual to be unequal; third, the greater the perceived inequity felt by the person, the more distress and tension is felt, and; fourth, the greater tension an individual feels due to perceived inequity, the harder they will work to decrease their tension and increase perceived levels of equity by adjusting their inputs and outcomes or even attempt to change the inputs or outcomes of the comparison other (Huseman, Hatfield & Miles, 1987).

The theory further postulates that a person paid more than he deserves usually performs at a substantially higher level, in quality and/or quantity. Inequity also exists when people are overpaid and not just in instances where there is underpayment. It adds that in everyday human interactions, outcome maximisation is the prime objective of the interacting parties (Adams, 1965). Consequently the institution of systems that ensure equity are necessary in instilling equity norms among members of a group because groups tend to reward members who behave equitably toward others and punish those who behave contrary to their expectation of equitable behaviour (Adams, 1965; Walster et al., 1973).

Equity theory, just as many other theories, has suffered some criticisms. Cosier & Dalton (1983) take issues with the theory because, according to them, it does not adequately deal with the effects of multiple inequities and also the varied forms that

inputs take thus rendering the comparison of inputs as the foundation for establishing equity an arduous task.

Again, equity theory predicts that where there is underpayment or overpayment there would be a corresponding decrease or increase in work effort but the precise level of change in effort is a product of the subjective valuation of the individual and therefore the magnitudes of these increases or decreases cannot be measured as equity theory would predict (Hofmans, 2012) .

In spite of these criticisms Equity theory has gained the support of several other studies for its efficiency, effectiveness, and the applicableness of its components (Lawler & O'Gara, 1967), its accuracy in predicting behaviour and making practical sense (Greenburg, 1990), and its ability to fit with other theories, particularly the expectancy theory (Stecher & Rosse, 2007).

The adoption of Equity Theory for this study is informed by the fact that it helps situate the attraction and retention of medical doctors to deprived areas in the context of an exchange relationship where both employees and employers expect mutually beneficial exchange of inputs and outcomes. This therefore raises the consciousness of both parties of what they owe each other and what they possibly should expect should they fail to fulfil their part of the bargain. Again the adoption of the theory will help bring to the fore the role that the influences of the conditions of service of urban doctors latently have on the decision of doctors in taking up rural appointments. In doing so the complex nature of attracting medical doctors would be best understood as a relationship that goes beyond employer and employees and therefore inform policy makers and managers of the need to critically assess the conditions of endowed area doctors to form a basis for the adoption of equitable measures to attract and retain medical doctors to rural areas.

2.2 Theoretical Framework for Attracting and Retaining Doctors to Deprived Areas

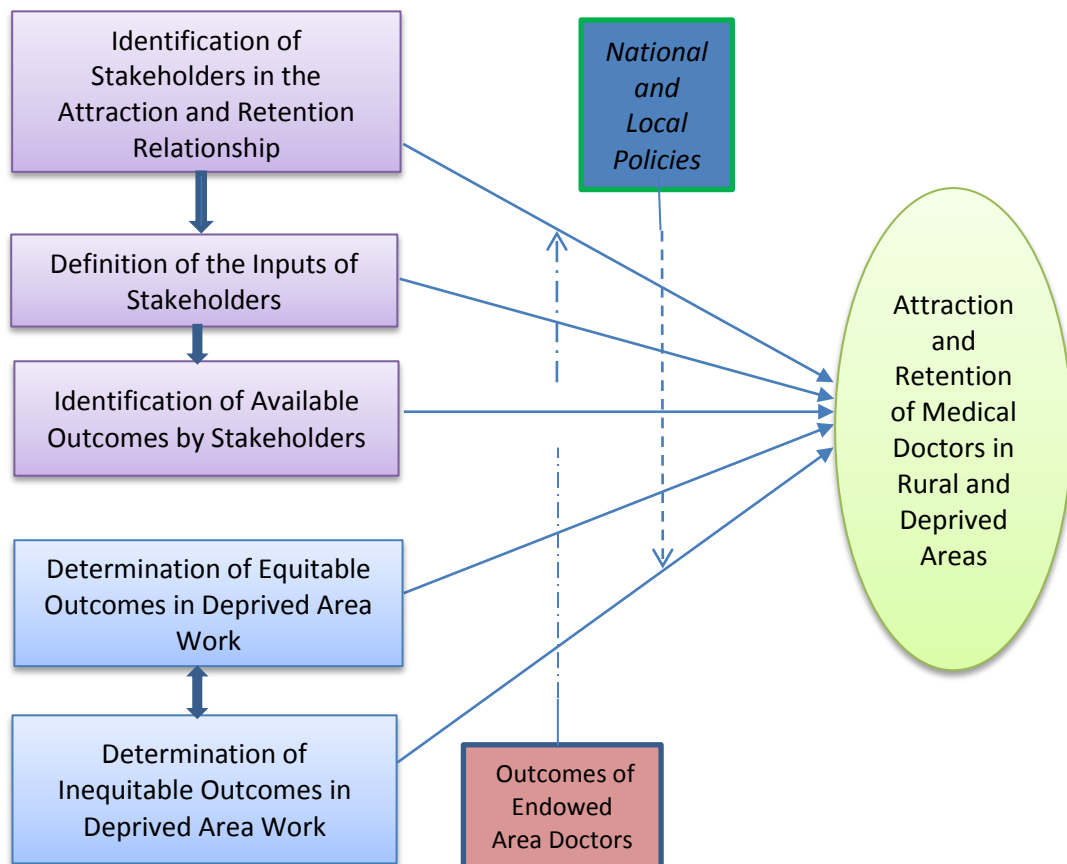


Figure 1: Theoretical Framework for Attracting and Retaining Medical Doctors to Under-served Areas. Source: Author's Construct from Equity Theory

2.3 Operationalization of the Components of the Theoretical Framework

The framework posits that the effective attraction and retention of medical doctors to deprived areas involves an exchange relationship that is affected by a number of equity variables. However, the strength and degree of their influence on the effectiveness of attraction and retention may be moderated by both national and local policies on attraction and retention as well as the outcomes available to urban employees. Success in attracting and retaining medical doctors to the Upper West Region, would therefore hinge on: first, the proper identification of the stakeholders in the attraction and retention exchange relationship; second, the definition of the inputs of the stakeholders in the attraction and retention relationship; third, the

identification of available outcomes by stakeholders; fourth, the determination of equitable outcomes in deprived area work; and fifth, the determination of inequitable outcomes in deprived area work. Whilst looking out for all these, a conscious attempt must be made in ascertaining which national/local policies and endowed area outcomes exist that have the potential of diminishing the potency of these measures.

A thorough examination and application of these measures would mean that partners would be known, roles and responsibilities would be well defined and assigned, systems and structures would be well designed, and accountability can thus be sought. In doing so efforts and resources would be well harnessed and the attraction and retention of medical doctors would be better coordinated, thus creating the needed positive employer brand (Ambler & Barrow, 2012) of the underserved area and rendering it as a destination of choice for employment.

Whilst the framework would help to interrogate the issues relevant to the subject, the concept of employer branding would aid the assessment of the extent to which the Region has distinguished and positioned itself as an employer of choice through the actions of stakeholders.

2.3.1 Identification of Partners in the Attraction and Retention Exchange Relationship

Properly identifying the partners in the attraction and retention of medical doctors to deprived areas is a first major step at succeeding in any policy measures aimed at a fair distribution of medical doctors. Identification of the exchange partners means that any person who can affect or be affected, positively or negatively, by the decision of medical doctors to accept postings to and remain in deprived areas must be identified. In this respect it has been suggested that both national and local

authorities, institutional managers of health systems and host communities have roles to play in the attraction and retention of medical doctors to rural areas (Araujo & Maeda, 2013). In the context of this study therefore, national authorities would be the Ministries of Health (MoH) and its implementing agency (i.e. the Ghana Health Service, GHS), Ministry of Education (MoE) and the Ministry of Local Government and Rural Development (MLGRD). Local policy implementers would be the Regional Health Administration (RHA), institutional managers [i.e. District Health Management Teams (DHMTs) and Hospital Managers] and serving doctors. The Regional Coordinating Council (RCC), District Assemblies (DAs) and traditional community structures would constitute the host community. For the purpose of this study, however, only officials of Ministry of Health and its agency, the Ghana Health Service would represent national authorities. The Regional Health Administration will suffice for the local implementing authorities, whilst the RCC and Municipal and District Assemblies would represent the host community.

2.3.2 Definition of Inputs of Stakeholders in the Attraction and Retention Relationship

The inputs of stakeholders are the roles that they play in the attraction and retention of medical doctors to deprived areas. Inputs in an exchange relationship like the attraction and retention of medical doctors to deprived areas may be looked at from two perspectives; contributory inputs or deprivation inputs. Contributory inputs could further be seen in two strands; Personal and Functional. Personal contributory inputs are those individual qualities such as intelligence, experience, skills and abilities that the person brings into the relationship. Functional contributory inputs are those things that the stakeholder does in his official capacity in dealing with the attraction and retention of medical doctors to deprived areas such as policy decisions, institutional design and implementation measures. Deprivation inputs

could also be looked at from two perspectives; loss inputs and risk inputs. Loss inputs could be seen as those things that a party loses clearly in seeking to find solutions to the attraction and retention debacle such as sacrificing health infrastructure for salary adjustments by health authorities or an assembly sacrificing the sponsorship of teachers to sponsoring only doctors for training. On the part of the doctors such loss input could include loss of income from locum or prestige. Risk inputs on the other hand are the potential things to be lost or suffered in taking steps to resolve the attraction and retention difficulty such as the potential denial of geographic access to some other people in using clinics expansion funds to offer incentives to doctors in district hospitals. For the doctor that could be risk to life from insecurity (Witter et al., 2011) or risk of denying children of good quality education in taking up postings to a deprived area. Therefore recognising the roles or inputs of all partners could help establish how complementary, contradictory or counterproductive they are. For the purpose of this work however, the focus will be on the functional contributory inputs of other stakeholders whilst for the doctor both loss and risk inputs will apply.

2.3.3 Identification of Available Outcomes by Stakeholders in the Attraction and Retention Relationship

Equity theory suggests that in every exchange relationship the parties, on the strength of their perceived or real contribution, expect some rewards in return to cover the cost of inputs into the relationship. But the rewards should be mutually satisfying to the giver and the receiver to guarantee the survival of the relationship. They could be negative and therefore cause anger and dissatisfaction, positive and thus lead to satisfaction, or perceived to be in excess of the inputs and thus elicit some guilt (Adams, 1965). Literature in this field has variously classified these benefits but they can largely be grouped into two, financial in the form of salary and

salary supplements, and non-financial as in career development and supportive management (Adzei & Atinga, 2012; Henderson & Tulloch, 2008). Variables such as autonomy, security of job, deference and respect, and a reasonable balance between work and life are also seen as some of the returns doctors receive for their inputs into the health system (Edwards et al., 2002). Properly identifying and defining the sort of rewards that are available from stakeholders from the onset of any attempt to attract and retain medical doctors to deprived areas would be appropriate. This will ensure that rewards match expectations and also serve as the driving force to push people into accepting posting to deprived areas and thus facilitate their retention. As noted by McCoy et al. (2008), whether one is in the private or the public sector, rural or urban, pay and income disparities affect retention and distribution of health workers. In this work therefore current policy initiatives by the Ministry of Health and other health-related partners are considered the available outcomes.

2.3.4 Determination of Equitable Outcomes in Deprived Area of Work

Though rewards are expected in exchange relationships, they are valued more when they are considered to be equitable (Adams, 1965). Rewards are equitable when they are seen by their recipients to be commensurate with the effort made in getting them and at the same time exuding the satisfaction that they have not been disadvantaged in anyway as compared to others. In respect of attraction and retention of doctors to the Upper West Region (UWR) therefore, equitable rewards are those perceived not to disadvantage doctors in the UWR in comparison to those in the endowed settings. Salary supplements, hardship allowances, enhanced conditions of work and living, and a fair system that guarantees professional development in a continuing manner are some of the outcomes considered equitable and tend to motivate and retain

health workers in deprived areas (Henderson & Tulloch 2008; Wibulpolprasert & Pengpaiboon, 2003). These are therefore the critical success factors necessary for attracting and retaining doctors to the UWR.

2.3.5 Determination of Inequitable Outcomes in Deprived Area of Work

When imbalances exist in rewards and the effort made at achieving them, then such outcomes are considered inequitable. But inequitable outcomes can be both advantageous and disadvantageous. They are advantageous when they are in excess of expectation and therefore cause guilt that could result in hard work in reciprocity. But when they cause anger and dissatisfaction, they are disadvantageous and could result in reduced output and possibly departure from the organisation (Adams, 1965). Low and poor salaries (Manafa et al. 2009; Stilwell et al., 2004), equal years of promotion between urban and rural workers (Manongi et al., 2006) are considered some of the inequitable rewards that do not motivate and retain health workers in remote areas. It is therefore imperative that in deciding on what will help motivate and retain doctors, factors perceived and felt to be inequitable are clearly identified and appropriately dealt with in policy and implementation mechanisms. For this study inequitable outcomes are those factors that respondents considered as the cause of the unwillingness of doctors in taking up postings to the Region.

2.3.6 The Mediating Role Endowed Area Doctors' Outcomes on Attraction and Retention

A key distinguishing feature of Equity Theory is the acknowledgement of the role that a third party plays in an exchange relationship between two parties. But for that, the subject of inequity would have been non-existent or less felt because there would be no basis to compare and determine whether an offer is equitable or inequitable. In the attraction and retention of medical doctors to deprived areas, rural medical doctors will only get to know whether they are getting their due or not getting their

due when the conditions of their colleagues in urban and endowed settings are known to them, whereupon a basis would be established for comparison.

Following from the above therefore, in considering policy options to attract and retain medical doctors to deprived areas, a thorough examination of the outcomes of medical doctors in endowed areas, would be imperatively obligatory for policy makers. This is because these outcomes affect the identification of the stakeholders, definition of inputs, and the determination of what is equitable and what is not. For stakeholder identification, knowing the sorts of outcomes available to endowed area doctors will help determine who can offer similar or better outcomes to those doctors who accept postings to deprived areas. For instance if the urban doctors' outcome is proximity to educational institutions and therefore are able to combine work with career development, then it will point to who to approach to provide such opportunities as distance learning or on-site training to rural doctors. For input definition, knowing endowed area doctors' outcomes will for instance help to determine how much hours they put into both official and private work and how much they get paid for that. This then will form the basis to appropriately assess the work of rural doctors and thus determine whether the outcomes available to deprived area doctors are equitable or inequitable. Where outcomes of rural doctors are seen to be the same or better than their urban counterparts, then outcomes would have been considered equitable and therefore they can be leveraged on and used to attract others. Where, however, the disparities are to the disadvantage of rural doctors, then inequitable outcomes would have come their way and therefore not motivating them to move to and remain in such areas. A basis then would have been found to take steps to equalise such outcomes or even made better and attractive. In this study therefore key success factors are considered equitable outcomes of deprived areas

whilst the reasons for the unwillingness of doctors in taking up appointments to the Upper West Region would be the inequitable factors. Failure therefore in properly identifying the outcomes of endowed area doctors could render whatever policies put in place to attract doctors to the Region worthless, especially if they fall short of the urban outcomes.

2.3.7 Employer Branding

The aim of seeking to know who the stakeholders are and what they ought to do to attract employees to and retain them in particular areas or institutions is to make such areas attractive enough as compared to others. The quest to make better some areas or institutions for work has culminated in the emergence of the concept of Employer Branding. Employer branding is an evolving concept in the field of human resource management. It was first used in the discipline in 1996 by Ambler and Barrow to recognise the employer as the brand whilst at the same time treating the employees as customers. Ambler and Barrow (1996, p.187) defined the concept of employer branding as the “the package of functional, economic and psychological benefits provided by employment, and identified with the employing company”. For these authors therefore employees not only benefit economically from an employer’s brand, but psychologically as well. This view was elaborated further in 2004 by Sullivan to include a long-term strategy targeted at managing a particular organization’s employees, prospective employees and other stakeholders’ perceptions and awareness. Employer branding is therefore about managing the perception and reality of seeking and taking up employment with a particular organization.

Unlike product and corporate branding that have external audiences as the primary target, Backhaus and Tikoo (2004) argued that employer branding has as its target

both internal and external audiences. However, in campaigning to roll out both corporate and product brands, the employer branding process could also go alongside. Barney (1991) thus averred that the rationale for employer branding is that there is value in human capital and that productivity can be improved with strategic investment in this capital to make it valuable, scarce, and impossible to imitate and therefore distinguish such an organization from its competitors.

There is no consensus as yet as to how employer branding should be done but Backhaus and Tikoo (2004) suggest for instance that it could be done in a three stage process. First, the particular values that the organization intends offering to both applicants and employees should be developed into a concept. The proposed values must carry the central message of the employer brand which emanate from an exhaustive review of the qualities that present a firm or organization as the preferred place of work. Second, the organization must market the proposed values externally to the targeted hopefuls to attract them. Third, incorporate the 'brand promise' to applicants into the culture of the organization. For Berthon et al. (2005), however, employer branding could be done in five steps. First, make a conscious effort to understand your organization. Second, fashion a convincing brand promise that is in sync with the promise to customers. Third, develop a criterion to measure the brand promise accomplishment. Fourth, strengthen the brand promise by aligning organizational culture (i.e. people's practices) to support it. Fifth, implement the promise.

For the Upper West Region to be seen as the employer of choice therefore, there ought to be a policy that outlines what the Region has to offer based on clear understanding of the dynamics of the Region, , it must be aggressively marketed internally and externally, develop a system for monitoring the impact of such a

policy on attraction and retention of doctors, ensure that the policy is be made part and parcel of the work ethic of the health system of the Region, and there should exist an aggressive implementation structure and strategy.

CHAPTER THREE

LITERATURE REVIEW

3.0 Introduction

In Chapter three, relevant literature on the attraction and retention of medical doctors to deprived and underserved areas are reviewed. The reason is to establish what has been done already on the subject. The literature review focused on the Structure of Ghana's Health System, Ghana's Human Resource for Health (HRH) deployment system, the roles of partners in the attraction and retention relationship, existing policies on attraction and retention of health professionals to deprived areas in Ghana, equitable outcomes in deprived area work, inequitable outcomes in deprived area work, and the influences of the conditions of doctors in endowed areas on policy measures

3.1 The Structure of Ghana's Health System

Ghana's national health system is structured into two levels: policy and implementation levels. At the policy level is the Ministry of Health (MoH) which deals with the general health policy of the country covering preventive, curative, rehabilitative, support service and regulation (MoH, 2007b). To facilitate the performance of these functions, the Ministry has under it various implementation organs such as the Ghana Health Service, the Teaching Hospitals (THs), the Christian Health Association of Ghana (CHAG), Quasi-Governmental Health Institutions (e.g. Trust Hospital, Military and Police Hospitals), and Regulatory Bodies (e.g. Food and Drugs Authority, Medical and Dental Council) (MoH, 2015). However, GHS, an autonomous executive agency charged with the responsibility of implementing approved national policies of the Ministry, delivers the core health services offered directly by the state. It is governed by Ghana Health Service

Council and headed by a Director-General (DG). It is decentralised into a five tier system: national (i.e. GHS Headquarters), regional (i.e. Regional Health Administration), District (i.e. District Health Management Team), Sub-District, and Community levels. Clinics, health centres, and Community-Based Health Planning and Services (CHPS) operate under the Sub-Districts (GHS, 2015a). To ensure that employees have a greater degree of managerial flexibility to carry out their responsibilities, the GHS has been granted some autonomy from the Civil Service. Teaching Hospitals, Private and Mission Hospitals do not form part of the GHS (GHS, 2015b). Owing to the multi-sectorial nature of health care, there are various stakeholders and collaborators, local and international, (e.g. community leaders, District Assemblies, Ministries and Agencies, Non-Governmental Organisations, and the World Health Organisation) at each level of the health system, that contribute towards health care delivery (MoH, 2007b).

3.2 Human Resource for Health Deployment System in Ghana's Public Health System

Human Resource for Health (HRH) deployment is a chain of activities that span their training through recruitment, orientation, postings and professional development. The training of health professionals in Ghana is the joint responsibility of the Ministry of Health and the Ministry of Education (MoH, 2007a). HRH comes from a myriad of sources: government training institutions, private and mission institutions, and foreign sources. For medical doctors in Ghana, however, the major sources have been government training institutions and foreign sources (mainly Cuba, Egypt, and Ghanaians on short visits (MoH, 2007a). Some missionary doctors can also be found in some CHAG hospitals across the country. The government's training institutions have mainly been from the four medical schools of the

University of Ghana, University of Science and Technology, the University for Development Studies, and the University of Cape Coast (MoH, 2014).

Significant to mention is the fact that the last time the MoH developed a staffing norm for the sector was in 1992 to serve as the basis for annual recruitment and the benchmark for determining the adequacy or otherwise of the requests made on it by agencies and institutions. Though an attempt was made in 2003 to review the norm for all categories, the move was abandoned because it was felt that the inadequacy of the numbers would render any such exercise fruitless (MoH, 2007a). It is however doubted if such abandonment was prudent because if you do not know what you require and how to distribute them, making progress would be ad hoc and reactionary.

3.3 Policy Attempts on Attraction and Retention of Health Professionals to Underserved Areas in Ghana

Attempts at incentives to attract, motivate and retain health professionals can be seen in two forms: financial and non-financial (Henderson & Tulloch, 2008). Financial incentives include salary supplements, allowances and benefits whilst career development, supervision and management, improved working and living conditions constitute the non-financial incentives (Henderson & Tulloch, 2008). Though it has been suggested that the former is the more potent of the two, views are divergent on that (Akintoye, 2000).

3.3.1 Financial Incentives Policies

Among the financial incentives, the Additional Duty Hours Allowance (ADHA) was introduced in 1999 to recognise the additional workload on the limited staff, particularly doctors. Whilst it stemmed the tide of health worker emigration (MoH, 2007a), and ensured the return of some private sector doctors to the public sector, it failed to attract and retain critical health staff to underserved areas because it was ill

targeted and also subjected to so much local decision making that created impressions of bias and unfair treatment (Buchan & Dovlo, 2004; Mensah, Mackintosh & Henry, 2005). Indeed ADHA has been described as the singular incentive that solved problems and created problems as well (Agyapong, et al., 2012).

Learning from the lapses of the ADHA scheme, the government through the MoH in 2004 introduced the Deprived Area Allowance (DAA). The policy sought to pay between 20% and 30% of salary top-ups to critical rural health workers, in some initial 45 deprived districts across the country, with funding from the Highly Indebted Poor Countries (HIPC) Initiative funds (Johnson et al., 2011; MoH, 2007a). Though indications were that it was going to be captured in the annual service budget of the Ministry to ensure its sustainability (MoH, 2007a), that never happened and again the DAA did not survive.

A most recent step is the Single Spine Pay Policy (SSPP) introduced in 2006. This followed the realisation that there were wide pay disparities in the public service, rising cost of the public sector wage bill, large number of pay negotiations, and the disconnect between pay and productivity (Government White Paper on SSPP, 2009). Its implementation started in 2010 but not without agitations and strikes by workers over issues of fairness and determination of who qualifies for market premium and how much of it (Seniwoliba, 2014). These challenges notwithstanding, it is argued that the policy has superior benefits over previous pay policies in that it has brought some equity and eliminated discrepancies in public sector pay administration (Seniwoliba, 2014), and “well received nationally” (Dartey-Baah & Amoako, 2011, p.6). However, the challenge with most public sector pay reforms in Ghana, including SSPP, has always been that they do not recognise the peculiarities of

particular jobs with respect to such issues such as general security, workload variations and unfavourable work location but instead provide flat remuneration across the country (Dovlo & Nyongator, 1999).

3.3.2 Non-financial incentive policies

To ensure health workers are retained in the country and evenly distributed, the Ministry of Health (MoH) through the Ghana Health Service (GHS), is implementing a policy that ensures that deprived areas personnel did two years instead of three years after first appointment to qualify for further studies whilst promotion has been reduced from five to four years (GHS, 2007).

Also, MOH in collaboration with the Medical and Dental Council requires of all medical doctors seeking any specialist training at the Ghana College of Physicians and Surgeons (GCPS) to serve at least one year in a district hospital post-housemanship (College of Physicians and Surgeons, 2015). Again, the housemanship program which hitherto was one year has been extended to two years requiring house officers to do their first year internship in a teaching hospital and the second year in an accredited regional or district hospital with the aim of not only equipping them with the necessary skills required at the various levels of health care but also to help redistribute staff (MoH, 2007a).

The Ministry, cognizant of the importance of the quality of management in this course, has set up a Directorate of Human Resource Management to handle the policy issues on human resource whilst GHS has established a division for the purpose at the head office with decentralised operations at the regional and district levels (Appiah-Denkyirah et al., 2013; MoH, 2007a). But as noted by Appiah-Denkyirah et al. (2013), most of the functions of these officers at the lower levels are highly constrained and limited to just issues of leave and training approval, and

taking minor disciplinary actions. Essential decisions on appointment, promotion, and salary increases are still centralised.

3.4 Partners and their Roles in the Attraction and Retention Exchange Relationship

It has long been found that attracting and retaining health professionals in remote and deprived areas is a shared responsibility (Araujo & Maeda, 2013; Rao et al., 2013; Kyaddondo & Whyte, 2003). Araujo and Maeda for instance contended in their work on recruitment and retention that in spite of the burden placed on them by excessive workload, rural workers suffer “lack of recognition and appreciation from their managers, local and national authorities and the general community” (p.19). This emphasises the fact that rural workers consider their immediate institutional managers, policy makers and the host community to have roles in ensuring their wellbeing and work. Therefore in the exchange relationship that exists in the attraction and retention of doctors to a specific area like the Upper West Region, policy makers(i.e. Ministry of Health, Ministry of Education and the Ministry of Local Government and Rural Development), policy implementers (i.e. Ghana Health Service, Regional Health Administration, and health facility managers), local communities (represented by the Regional Coordinating Council as the apex body of the communities and their District Assemblies), and the medical doctors, are considered the principal partners. Backhaus and Tikoo (2004) describe these stakeholders in their work on employer branding as ‘internal and external audiences’. The roles of these partners are reviewed as follows.

3.4.1 Policy Makers in the Attraction and Retention of Medical Doctors

Policy makers do not only have the duty and responsibility to formulate clear policies on human resources for health, but must ensure that such policies deal: first,

with the pull factors that lure health workers out of the country; second, the push factors that cause frustration and disaffection for rural work and thus compel them to seek work elsewhere; and third, the anchor factors that will motivate and spare health workers on to stay in public service (Lucas, 2005; Bach, 2004), especially rural work. Keller (1993) concurred with the importance of top management support in attracting and retaining staff especially where employer branding is concerned. Policies in this respect, according to the WHO (2010) may target such issues as education, regulation, financial incentives, bundled packages, and factor consideration. These issues are reviewed below, accordingly

3.4.1.1 Educational Policies that Affect Attraction and Retention of Medical Doctors to Deprived Areas

Educationally, it is believed that policies that deliberately locate educational institutions in rural settings (Logombe, 2009), with curricula that are rural focused (Kaye et al., 2010; Worley et al, 2008) have the potential of ensuring that their products are retained in rural service because it offers early exposure to rural practice (Matsumoto et al., 2010). Logombe in his study in the Democratic Republic of Congo found for instance that 97.7% of the products from rurally located medical schools had their employment in the provinces (i.e. regions) in which they were trained with 81.4% of this cadre in rural areas. Similar evidence has respectively been found by Lee, Barnard & Owen (2011) and Worley et al. (2008) in Australia and Canada. Somers and Strasser (2002) are however cautious that a bad rural experience by trainees could prove more detrimental to their future decisions for rural service.

It has also been argued that those wishing to use educational policies to leverage attraction and retention could employ a special track admission system

(Thammatacharee et al., 2013). This involves special quotas given to provinces (i.e. regions) suffering from physician shortages by medical schools for candidates from those regions to compete for limited spaces in the medical school and in return serve his region on completion. Graduates from this programme were found to have a 10% higher likelihood of working in rural areas than their counterparts who went through the national admission system (Thammatacharee et al., 2013). Indeed Rabinowitz et al. (2001) posited earlier that this strategy was behind the success of the Physician Shortage Area Programme (PSAP) in Philadelphia. Whilst not limiting the subject of education to the formal formative stages of education for acquiring and keeping staff, it has been suggested that it is still possible under employer branding to use induction to ensure that employees stay longer in the organisation, regardless of the form of formative education, because it makes them know more about it and become self-motivated and committed (Mapolisa, 2014; Armstrong, 2006). Mandatory induction could therefore be a policy option for all new recruits.

3.4.1.2 Regulations that Affect Attraction and Retention of Medical Doctors to Deprived Areas.

Regulation as a policy option in branding to attract and retain health workers to deprived areas has also been explored as a viable option. In Japan, students that attended its Jichi Medical University (JMU) had their entire education funded by the prefecture governments and in return are bonded to a nine year service in their prefectures, five to six years of which must be in a rural area. Any default attracts a one-time lump sum payment of all the expenses (Matsumoto et al., 2008). The policy saw prefectures having an average of 69.8% of JMU products stay back with 95% of them completing their contracts.

Also, under their incentivised compulsory service scheme, the Nepalese government ensured that licenses of doctors were withheld until an indeterminate period of rural public service is undertaken (Butterworth et al., 2008), similar to South Africa's compulsory community service for its new graduate health professionals, where a one year mandatory service is required for one to be able to register with his professional council (Hatcher et al., 2014). And in India, a reservation of specialist training seats in medical schools in exchange for some years of rural service proved effective (Rao et al., 2013). Though the Nepalese measure appeared to have gotten doctors to deprived areas, the mandatory nature of the scheme made doctors feel 'trapped' in remote areas (Butterworth et al., 2008). In South Africa, however, satisfaction with the scheme appeared to be high, though as noted by Hatcher et al., for compulsory schemes to make the desired impact on "health workforce capacity development, distribution and retention to rural, underserved areas" then they must be implemented "with good planning, transparency and clarity, and support..."(p.1). Also, it has been shown that when regulations are used in the design of strategies that are compulsory in nature, they tend to be inefficient in the long term (WHO, 2010; Wilson et al., 2009) because they are coercive and alienate health care professionals from willing to take up rural service in future (Wilson et al., 2009).

3.4.1.3 Financial Incentives that Affect Attraction and Retention of Medical Doctors to Deprived Areas.

Many have argued that financial incentives are the most important for attracting and retaining health professionals to remote and deprived areas (Goma et al., 2014; Mohamed, 2013; Matsumoto et al., 2010), though others think they are not the most essential especially when they are not substantial or are just moderate (Rao et al., 2013). A visible others posit that it presents mixed results (Adzei & Atinga, 2012).

Some of the financial incentives include salary supplements, rural and remote allowance, commensurate remuneration, salary top-up, commuted overtime allowance, child education allowance, car loans (Goma et al., 2014; Adzei & Atinga, 2012), rural bonus (Janes & Dowell, 2004), incentives from cost-sharing funds (Kipp et al., 2001), bursaries (Hatcher et al., 2014), financial support for relocation (Lee et al., 2011), sponsorship for further education (Snow et al., 2011), or tuition waiver (Matsumoto et al., 2010). Also Goma et al. (2014) found that though nineteen strategies were adopted under the Zambian Health Worker Retention Strategy (ZHWRS), the only one that appeared effective was salary top-ups. Similarly, Mohamed found in his study of the willingness of medical students in working in rural Alexandria (Egypt) that 96.7% of them were ready for rural service if salaries were significantly high.

Profit sharing and pay for performance have also been considered elsewhere. For instance, in Vietnam staff of health facilities are either allowed to take part of profits made and share as bonuses to staff, or doctors are paid according to their performance of specific quantifiable services such as surgery (Witter et al., 2011). Witter et al., however, argued that in the case of the bonus payment, it was based on local capacity to pay and therefore bigger facilities tended to attract more health professionals to the detriment of the poor rural facilities. However, Rao et al (2013) point out in their work in India that doctors were only ready for salary as the sole incentive for rural work if the levels were five times more than moderate increases; reserving seats for their specialist training was of better value to them than salary. It should however be pointed out that seeking specialist training now in lieu of salary could only be a smart investment because gaining specialist status comes, in most jurisdictions, with higher promotions and higher salary or more opportunities for

private practice. To deal with the challenge of capacity to pay, Mapolisa (2014) has suggested that it would be prudent for organizations that seek to attract and retain staff to target those who have ability to work and pay themselves. In the light of the above therefore StrategiCom (2010) has suggested that for an organisation to properly brand itself as the employer of choice, then it must focus the provision of “attractive overall compensation and benefit package”. The effectiveness of financial incentives as a long term strategy for retention has, however, been questioned by the work of Osasona (2005) who argued that they are only effective in the short term as compared to non-financial incentives.

3.4.1.4 Factor Consideration that Affect Attraction and Retention of Medical Doctors to Deprived Areas

Various factors have been adopted at different times in different contexts aimed at boosting the supply and retention of health workers in rural areas. But as noted by Ramani et al. (2013) in their proposed framework for attracting and retaining health workers to deprived areas, these factors are largely grouped into three; individual, organisational and contextual. These are a further expansion on the financial and non-financial categorisation done by Adzei and Atinga (2012) and also Henderson and Tulloch (2008). These factors are discussed as follows;

3.4.1.4a Individual Factors that Affect Attraction and Retention of Medical Doctors to Deprived Areas

It has been argued that age has a bearing on the decision to take up rural appointment. Younger professionals largely are unwilling to take up rural appointments as opposed to those in their advanced ages (Goma et al., 2014; Ramani et al., 2013; Daniels, VanLeit, Skipper, & Rhyne, 2007). Goma et al. in their study on recruitment and retention in Zambia found that health professional aged between 20-29 years were less satisfied with rural work than those between the ages of 50 and

59. Therefore the younger that they are the less likelihood there is that they would take up rural postings. Leon and Kolstad (2010), Stenger et al. (2008), and Daniels et al. (2007) respectively, find similar evidence in Tanzania, Massachusetts, and New Mexico.

Also, gender is critical in the recruitment of rural health professionals. Males are generally seen to be more inclined to rural jobs than their female counterparts (Hatcher et al., 2014; Mohamed, 2013; Dussault & Franceschini, 2006) with females 3.3 times more likely to leave rural practice (Goma et al., 2014) or even want to have a regulatory policy that compels them to do so scrapped (Bocoum et al., 2014). To this end, Mohamed (2013, p.15) has cautioned that “it is likely that the supply of health staff to rural under-served areas will remain a major setback if professional motivations are designed to attract more female students to rural practice”. But this view stands contrary to earlier findings by Stenger et al (2008) in their work where they argued that females had a better possibility of taking up rural appointment.

Further on the individual factors, it is established that respect and recognition from employers, colleagues and the host communities are variables that are of immense importance to rural health workers (Snow et al., 2011; Witter et al., 2011). For instance, Snow et al. (2011) found in Ghana that doctors valued the respect and recognition they got from community members in how they are easily identified in the community. This according to the researchers made doctors deemphasise the value of salary and stress the satisfaction they derived from a simple ‘thank you’ from patients. Witter et al. also reported that “social recognition and respect” (p.4) were the prime reasons for some people choosing to become medical doctors in Vietnam and therefore valued them more than salary. Studies in the field of employer branding point out therefore that recognising and appreciating people’s

work is a good strategy for branding an organisation as a place of choice for employment for employees (Sokro, 2012; StrategiCom, 2010; Crous, 2007) and even potential employees (Preuss et al, 2009).

The origin and background of health professionals have a bearing on rural recruitment and retention. Hailing from or living in rural setting influences the choice of rural practice by health professionals (Thammatacharee et al., 2013; Mohamed, 2013; Ramani et al., 2011; Leon & Kolstad, 2010). Thammatacharee et al. found in their work on the attitudes of dental, medical and pharmacy graduates towards rural service that dentists with rural upbringing were 15% more likely in taking up rural postings than their urban counterparts. Rurality of origin or upbringing as a predictor of rural attraction has however been challenged by the works of Rao et al. (2013) who contend that accepting a rural job was less associated with rural upbringing, and thus concluded that “For doctors ... individual characteristics had small effects on increasing the percent of respondents opting for a rural job” (p. 6).

Personal values or what has been described as “Ideational Incentives” by Snow et al (2011, p.7) also have a role in the choices rural service. Where an individual believes that he has to serve people (particularly his own people) to give back what they have invested in him, make a difference, reconnect with his community or fulfil a certain religious or political ideological obligation (Snow et al., 2011; Couper, Hugo, Conradie, & Mfenyana, 2007), then taking up rural appointment may not be subject to any demands on the health system but a choice that is borne out of an innate desire. Though this factor appears good for attention, it may be difficult to actualise because the considerations are more personal and may not be that easy to fish out physicians with such values. In spite of the above skepticism, it has been

suggested that where an organization consciously develops its value propositions and markets them as its branding strategy to make itself the ‘employer of choice’ it could appeal to applicants who share in such values (Armstrong 2006; Sears 2003, as cited in Sokro, 2012).

3.4.1.4b Organisational Factors that Affect Attraction and Retention of Medical Doctors to Deprived Areas

Formulating policies to attract health professionals to remote areas may be important but ultimately the overriding goal is for those policies to deliver the desired impact. Hence how health care organisations and their subsidiary facilities manage issues such as salary, health care infrastructure, physical work environment, supporting and mentoring staff, and workload (Ramani et al., 2013; Adzei & Atinga. 2012), can contribute to the success or failure of policies. Also the handling of policies on transfer, promotion, job security, leave, and the general style of management (Rao et al., 2013; Snow et al., 2011) could produce acceptable or distasteful results. Tarusikirwa (2000) for instance found in Zimbabwe that managers appeal to employees and they work to them if managers have charisma, dignity and good relations with workers.

It is worth adding that one of the biggest challenges of most rural health professionals is the support and mentoring they receive from their employers, managers, and colleagues. Support and mentoring provide the opportunity to gain experience from colleagues (Thammatacharee et al., 2013), but is often poor or non-existent (Kruk et al., 2010; Richards et al., 2005). Where this has, however, been well structured and executed, the response has been phenomenal. For instance in South Africa, Hatcher et al. (2014) established that 87% of community service officers felt that they received adequate orientation on the job, had their seniors

when they were actually needed (82%), clinical supervision was good (71%), and were generally satisfied with the mentorship and support received (72%). As a result, most of them reported they had developed themselves professionally during the community service period. It also helped reduce potential emigrants, and increased the number of this cadre that decided to stay in their rural facilities after completing their community service (ibid). In Ghana, however, it has been found that mentoring and supportive supervision is poor for doctors in rural areas. Most of them suffer professional isolation and ‘imprisonment’ whilst acting as both “the captain of the boat, and the only sailor as well” (Snow et al., 2011, p. 4). This compels most of them to offer “services in areas where [they] are not fully trained” (ibid, p.5) with the attendant risk of “making mistakes in diagnosis and treatment” (Ramani et al., 2013, p. 6) because they have no colleagues to turn to for help (Ramani et al., 2013; Smith, 2005). To overcome similar difficulties in Vietnam, a deliberate policy (Decree 1816) was enacted that ensured that higher level doctors were sent to lower level facilities to offer support on rotational basis (Witter et al., 2011). The value of mentoring for competence cannot however be downplayed under any circumstance. For instance a study by the Copenhagen Business School (2009) cited in Skro (2012) found that offering challenging work responsibilities and consciously developing the competence of employees was a good employer brand that not only retained employees but attracted new applicants.

Excessive workload has also been reported as the hallmark of rural practice (Bonenberger et al., 2014; Hatcher et al., 2014; Thammatacharee et al., 2013). Thammatacharee et al. suggest that workload is more eminent where the financial barrier to health care has been removed, thus motivating the quest for health care by the citizenry. Indeed the introduction of the National Health Insurance Scheme in

Ghana gives credence to this assertion (Dalinjong & Laar, 2012). Perkins et al. (2007) earlier also revealed that the decision of most health workers to leave rural practice is largely influenced by the extent of workload in those areas. It is worth noting, however, that workload is not entirely bad as portrayed. Hatcher et al. (2014) in South Africa have established in their research that “those reporting they had worked overtime were nearly ten times as likely to report professional development” (p.8), which “suggest overtime work is associated with better development” (p. 11). It is however worth adding that organisations that seek to portray themselves as employers of choice strive had to make it a value to have a good work/life balance because employees and applicants demand it (Priyadarshi, 2011).

Transfers as a means of moving professionals from one work location to the other has featured prominently in the attraction and retention literature. It is a way of ensuring fairness and evenly spreading staff for equitable health care delivery (Rao et al., 2013; Witter et al., 2011). Rao et al. for instance found in India that though doctors were generally not in favour of rural postings, they were amenable to it if there was the assurance that they would be transferred out of their rural locations after three years of service. In Ghana, however, matters concerning transfers are not clear and health professionals cannot guarantee when they will move out of the rural settings once they move in (Snow et al., 2011). Clarity in transfer policies is therefore considered key to engender trust and certainty (Mohamed, 2013). The importance of this factor has led many to suggest that rural appointments should be based on a fixed contract term so as to offer some certainty (Snow et al., 2011; Kruk et al., 2010). Recent findings by Bocoum et al. (2014) in Burkina Faso, however, suggest that rural health professionals rather would prefer decent housing to term

limits in rural practice. This finding may emphasise the importance rural health workers attach to living conditions.

Promotion is another factor that comes up strongly in the literature of attraction and retention; a major source of dissatisfaction in many countries (Bonenberger et al., 2014; Ramani et al., 2013; Snow et al., 2011). It has been suggested for instance that in Ghana, the system of promotion is so defective that those who serve in deprived areas rather have difficulties in receiving promotions whilst their counterparts in the Teaching Hospitals and urban centres, rather receive faster promotions (Snow et al., 2011). Promotions impinge greatly on the motivation of health professionals because they have an overbearing impact on the value and prestige of their statuses on the job, career opportunities and ultimately income levels (Bonenberger et al. 2014; Adzei & Atinga, 2012). Therefore the efficiency of the promotion system would be highly valued (Adzei & Atinga, 2012). In India, it was found that health professionals who stayed longer in rural areas without the needed political leanings were easily forgotten of and their promotions denied (Ramani et al., 2013). In his work on employer branding in Ghana for instance, Sokro (2012) found that top-most among employer brand qualities that employees considered in working with organisations was the opportunities for growth. Therefore to be seen as a place of choice for employment, the opportunity to grow professionally and personally must exist, to allow employees “work toward the next level of responsibility” (Mapolisa, 2014, p. 142). And this is best achieved when there is ‘institutional transparency’ in how these things are done (Griffeth et al., 2000; Cotton & Tuttle, 1986; Spector, 1985, and Porter & Steers, 1973 cited in Pitts et al., 2011)

The ability of rural health professionals, particularly medical doctors, to take their leave in the course of their work to rest and also have time for their families has a

major impact on how rural work is perceived (Ramani et al., 2013; Kwansah, et al., 2012; Snow et al., 2011; Kruk et al., 2010). For instance Ramani et al. have suggested that doctors in India's rural health care practice had difficulties going on leave because relievers can either not be found or there are delays in processing leave applications whilst impromptu leave would not be granted to attend to emergencies. Earlier studies in Ghana revealed such difficulties encountered by rural health workers (Kwansah, et al., 2012; Snow et al., 2011; Kruk et al., 2010). But to be an employer of choice to attract and retain employees, one value that ought to be proposed and enforced is work flexibility (Sokro, 2012).

3.4.1.5 Bundled Policies that affect Attraction and Retention of Medical Doctors

Policy makers could also consider the adoption of bundled policies. This will involve the simultaneous adoption and implementation of policies and not the disjointed application of singleton measures. As noted by Thammatacharee et al. (2013, p.9) "implementing a single policy without other supporting strategies might not be effective in addressing health workforce shortages". When Thailand in the 1970s was faced with the difficult challenge of severe shortages of doctors in rural areas, the country adopted one of the most comprehensive bundled strategies to tackle the problem. This involved policies that cut across health infrastructural development, education, professional replacement, financial incentives, and measures that offered social support and recognition. Medical education was reformed to increase the numbers with emphasis on rural students and placing them back in their hometown on completion. Scholarships were voluntary but rural service was compulsory for all graduates or one has to pay back high tuition fees in lieu of public service in a rural settings. These efforts were backed up with support systems such as the formation of the Rural Doctors Society that fought to gain

recognition through the systems and structures they designed to support rural health care (Wibulpolprasert & Pengpaibon, 2003). Though the two admit that the strategy had some implementation difficulties, they nonetheless agreed that it succeeded largely in keeping doctors in rural areas up to a minimum of three years. This view has gained support from the works of many others (Rao et al., 2013; Ramani et al., 2013; Snow et al., 2011) who contended that health professionals and for that matter doctors are better induced with ‘packages’ or what Mapolisa (2014) described as ‘strategy-diversity’ of both financial and non-financial nature. Earlier in Canada a similar strategy was introduced to improve the spatial distribution of physicians (Press, 1998).

3.4.2 Policy Implementers in the Attraction and Retention of Doctors

Policies are of no use if they are not implemented. As noted by van Meter and van Horn (1975, p.447) “Policy implementation encompasses those actions by public and private individuals (or groups) that are directed at the achievement of goals and objectives set forth in prior policy decisions”. Therefore the meanings and the desired effects of policies would not be realised if those tasked to execute them lack the knowledge and tact to do so, thus rendering the organizations and the policies they formulate “piles of stone and metal and blobs of ink on pieces of paper” (Eddy, 1981 in Asamoah, Osei-Kojo, & Yeboah-Assiamah, 2013, p.28). Also, as noted by Goulette (2015), “People join organisations, but they leave managers”. Formulating policies on remote area service may be an important first step, but meeting the overriding goal of the policies would depend on execution.

Policy implementers impact the attraction and retention process in many ways. First it has been established that the flexibility and friendliness of rural work environments play crucial roles in the decisions of health professionals to accept

postings there (Heikkilä, et al., 2014; Ramani et al., 2013; Perkins et al., 2007; Couper et al., 2007; Richards et al., 2005). Flexibility and friendliness could be achieved by; ensuring proper workload management (Perkins et al, 2007), flexible working hours (Ebuehi & Campbell, 2011), involvement in both clinical and administrative decision making, (Heikkilä, et al., 2014), dealing tactfully and decisively with workplace politics (Perkins et al., 2007), and ensuring clarity and removing bureaucratic processes surrounding leave, promotions and transfers (Mohamed, 2013; Adzei & Atinga, 2012; Perkins et al., 2007). Flexibility will also make it possible for people take their leave to visit families and friends (Ramani et al., 2013; Richards et al., 2005). But these things are probably possible with a competent management that appreciates the implications of their poor handling of such issues. As Sokro (2012) found, flexibility in work schedule is not only desirable but an employer branding quality that attracts employees.

A further area of impact for policy implementers is the provision of decent and fitting accommodation facilities for rural health workers. Snow et al. (2011) posited for instance that in Ghana issues of accommodation were a prime source of complaints and disappointment for health workers. The inadequacy of accommodation units and the delays in getting the few available retrofitted for new health professionals have often led many to refuse appointments to the deprived areas. This has therefore led to the suggestion that health partners wishing to bridge the urban-rural divide in health professionals' availability should consider funding lower level facilities, particularly district hospitals to put up more decent accommodation units (Adzei & Atinga, 2012).

Also, a system that is receptive of political influence allows professionals with political connections, to avoid rural work and stay in the more desirable areas, thus

leaving those without such connections stuck in rural areas (Ramani et al., 2013). Furthermore, the lack of clarity on how rural health professionals connect with superiors and specialists for assistance influences their commitment to rural work. In Australia, for instance rural doctors are always anxious as to whom to contact for advice when they are on their own (Smith, 2005) whilst rural doctors in Ghana have expressed concern about the absence of a well-structured system that guarantees regular visits by policy makers to rural areas to know their concerns and make them feel valued rather than feel isolated, forgotten or neglected (Snow et al., 2011; Kruk et al., 2010).

Furthermore the preparation received through orientation by rural health workers before their deployment plays a crucial role in their accepting the conditions in the rural environment because they expose and give clarity and understanding to existing policies on rural work and also help dispel uninformed expectations and build the needed resilience to cope with reality shock (Smith, 2005). Failure in this regard could result in ignorance of issues on transport regulations, accommodation, and cultural variables in communities (Smith, 2005) or even being totally oblivious of the policies meant for them as happened under the Zambian Health Workers Retention Strategy (Goma et al., 2014) where health workers in Zambia reported that they did not understand most of the strategies and blamed it on “poor communication about them from an organisational level” and therefore “the criteria for eligibility were not clear to them” (p.7). In recent times, however the value of orientation or induction cannot be underestimated. It markets the organisation internally and generates commitment among employees because it exposes employees “to the organizations core values, reward systems, working conditions and other opportunities” (Sokro, 2012 p.168) thereby helping them to fit into their

work environment. This creates a positive image of the organization in the employees and also let them know their employer more (Armstrong, 2006). It is worth adding, however, that inasmuch as showing interest in the induction for new staff is important, it is equally important that organizations show interest in what exiting employees have to say by offering them the opportunity to complete an exit interview questionnaire. It has even been argued that the reaction of exiting staff to the completion of the exit interview questionnaire could indicate their feelings about the organization (Mapolisa, 2014).

Lastly, the management and leadership style of policy implementers is of enormous importance in ensuring that people are recruited, placed and motivated to stay in rural areas. As noted by Adei (2004) “leadership is cause; everything else is effect”. A supportive management style is said to influence the decision of health workers in staying in remote areas (Leonardia et al., 2012; Couper et al., 2007). In the Philippines for instance rural doctors who stayed beyond their mandatory service under their ‘Doctors to the Barrios’ programme did so because of the supportive management style of their regional health department and also the municipal government. Those who left said lack of management support was the reason (Leonardia et al., 2012). Where the style of management is defective and workers are faced with accommodation and security challenges, for example, few would recommend the facilities to others or even choose to stay further (Hatcher et al., 2014). A good employer branding however requires that organisational leadership at all levels value and treat their employees fairly, recognise and appreciate the good works of employees, foster excellent employer/employee relationships, and aspire to be employers that prospective employees are desirous to work with and current staff remain loyal (Sokro, 2012).

3.4.3 The Community's Role in the Attraction and Retention of Medical Doctors

It has been established that the context (i.e. community) of work and its environment largely determine the levels of motivation among rural professionals, after they have taken up their appointments (Bocoum et al 2014; Couper et al., 2007). This is because “The contextual realities vary from one region to another, as the content of a package brings satisfaction depending on the environment in which the health officer resides” (Bocoum et al., 2014, p.8).

Literature is awash with evidence that rural health workers cherish the recognition, respect and appreciation that they receive from community members and indeed they are key factors that can determine the longevity of their stay in such settings (Ramani et al., 2013; Adzei & Atinga, 2012; Leonardia et al., 2012). Ramani et al. indicate in their work on the attitudes of health professionals towards rural work in India that because of the low prestige of rural work, health professionals tend to value more how their self-esteem is built by the recognition they receive for their work which gives them a sense of fulfilment and prestige. For Adzei and Atinga (2012), recognition and appreciation are so essential that they mediate the relationship between motivation and retention. It is even said that social recognition and respect are the incentives that drive rural physicians in Vietnam into choosing the profession in the first place (Witter et al., 2011). And as Snow et al. (2011) revealed in Ghana, such doctors value the respect and recognition they receive from their clients and community more than financial rewards. When appreciation, recognition and respect reach the stage “reciprocity or mutual benefit” (Cameron et al, 2010, p.81) and both parties feel that they owe it to each other, then motivation is reinforced and retention increases (ibid). This is the crust od Equity Theory.

Leisure and recreation are other vital community attributes cherished by rural health professionals because they offer opportunities for affiliation with friends and peers (Gwynne, 1997) and thus deal partly with the complaints of isolation by remote area health workers (Richards et al., 2005). Fewer options for leisure and entertainment in the Philippines were reasons for dissatisfaction with rural work, particularly for doctors trained in urban areas but those zealous of rural work found the options satisfactory (Leonardia et al., 2012). In the Canadian situation, Mayo and Mathews (2006) found that for health professionals who were less integrated into their host communities with limited recreational facilities, commitment to rural work was badly influenced. They also argued that the presence of attractive recreational and leisure facilities in a rural setting has the potential of making spouses and children of rural health professionals happy and committed to the community and by extension, the health professional because they are “supportive of a family-oriented lifestyle” (p.275), and their motivation is reinforced and they become advocates for the community (Couper et al., 2007).

Another critical factor that borders most health professionals in deprived areas has always been the quality of education for their children (Goma et al., 2014; Rao et al., 2013; Adzei & Atinga, 2012; Couper et al., 2007). Goma et al. for instance found in the Zambia that a major source of dissatisfaction for health professionals in rural settings was the “little access to educational opportunities for children” (p.8), and the urge to leave gets stronger where tuition in public schools is poor and children are getting older with no private schools to offer the quality tuition desired by health professionals (Adzei & Atinga, 2012; Couper et al., 2007).

The availability of amenities such as telephone and internet connectivity to facilitate communication and learning and also utilities such as water and electricity in

communities has considerable effects on the decisions of health professionals in taking up rural and remote appointment. In India, it was found that rural areas that had considerably good amenities were more acceptable to health professionals whilst the acceptability reduced with the dwindling availability of these amenities (Rao et al., 20013). Staff morale is, however, boosted with the availability of such amenities which creates the needed congenial atmosphere required for rural work (Leonardia et al., 2012). This is because workers are able to live lives comparable to those in the cities and also connect well with their distant families and friends (Rao et al., 2013). Transportation and the conditions of rural roads are also of enormous importance to rural workers because they have some influence on connectivity (Ramani et al., 2013) or even could prevent rural professionals from taking part in crucial trainings as was the case in Ghana (Snow et al., 2011).

Security and safety of person and property are very critical in the attraction and retention effort. Health professionals are sometimes attacked by community members for alleged poor services or just walking alone on the streets (Mohamed, 2013; Ramani et al., 2013; Smith, 2005). In Egypt, Mohamed reported that 71.9% of medical students saw physical security and the protection from political interference as essential for their taking up rural appointment. To enhance this sense of security, local authorities and politicians must refrain from creating situations that seek to intimidate health professionals and prevent them from critiquing to correct the system (Leonardia et al., 2012)

The community's role could further extend to direct incentives either in support of would-be health professionals in exchange for their services later or directly to those already in service or to attract new ones. For Daniels et al. (2007), however, the responsibility of communities should not just focus on financial and material

incentives but on such other matters as the professional development opportunities of health professionals and the conscious effort at raising awareness about their health needs. Also in Japan, collaborative efforts of the central government, municipalities, prefectures, and medical schools resulted in massive budgetary allocations by municipalities in support of physician incentives and the retooling of health facilities. This led to higher salaries for rural doctors than their urban colleagues and therefore higher satisfaction (Matsumoto et al., 2010).

3.5 Inputs of Medical Doctors into the Attraction and Retention Exchange Relationship

Inputs into rural and remote health care are those things that parties contribute to the system, deprive themselves of or lose in the relationship. Inputs as earlier noted come in two forms, contributory and deprivation. For this segment, however, deprivation inputs will be considered. Deprivation inputs could be looked at from two perspectives; loss inputs and risk inputs. Loss inputs could be seen as those things that a party loses clearly in taking up rural appointments whilst risk inputs are the potential things to be lost or suffered in taking up rural postings. In this work, however, the focus would dwell on the loss inputs of medical doctors into the rural attraction and retention relationship.

On the loss inputs category, it has been established that health professionals who take up rural appointment lose additional incomes aside salary. For instance in Vietnam, Witter et al. (2011) found that whilst doctors in the cities did private practice in hospitals to earn income, rural doctors had to supplement their incomes by harvesting rice for a fee or raise chicken either because there were no private hospitals or the people were too poor to pay for private practice. Similar studies in Ghana confirm the loss of additional income by rural doctors (Adzei & Atinga., 2012; Snow et al., 2011).

Again, Smith (2005) earlier reported the risk of violence to the person of health professionals in some aboriginal rural communities in Australia where it was not safe for one to even walk alone on the streets. Physical attacks for perceived poor quality of care have also been documented (Ramani et al., 2013) and though said to be uncommon in Vietnam, “Sometimes patients who are drunk come to the hospital, abuse and scold the doctors, or beat the doctors if they are not happy with the treatment they have given” (Witter et al., 2011, p.8). Common or uncommon, once the potential exists then it is likely.

It has further been indicated that health professionals who take up jobs in rural and remote areas risk slowed or no career development and growth (Hatcher et al., 2014; Smith, 2005). This is because staff in such areas are isolated, neglected or forgotten and therefore may suffer ‘career death’ or the loss of critical skills due to an overextended period of rural work without the opportunity for postgraduate training or the lack of mentoring, supervision and support from colleagues and specialists (Hatcher et al., 2014; Snow et al., 2011). As Hatcher et al. stated “Rural placement was negatively associated with professional development” (p.7). The inference therefore is that in the absence of any structured system that guarantees career development after rural service, accepting rural appointment would be consent to career death.

3.6 Determination of Equitable and Inequitable Outcomes in Deprived Area Work

Outcomes in an exchange relationship, such as the attraction and retention of medical professionals to deprived areas, are the things that people get in return for deciding to take up rural appointments and making some inputs into the health system. Equitable outcomes are those things that rural health professionals gain and

consider them to be fair, in comparison to their urban counterparts. Conversely, therefore, inequitable outcomes are the things health professionals gain and consider unfair in agreeing to work in remote areas. As noted by Lehmann et al. (2008), in the relationship between the push and pull factors of deprived area work, equitable and inequitable outcomes are mirror images of each other. But as pointed out in the review of motivation and retention studies by Willis-Shattuck et al. (2008), outcomes centre around seven main subjects: career development, continuing education, financial inducements, health facility infrastructure, personal gratitude, resource availability, and management factors. The discussion of outcomes in this work, in their mirror images, would therefore be done around such themes.

Extant literature point to the fact that professional career development and continuous education remain one of the topmost things health professionals expect in return for taking up rural appointments (Hatcher et al., 2014; Heikkilä, et al., 2014). This crave by rural health workers could most likely be because constant advances continue to be made in several fields of medicine (Murray, Pépin, Nutman, Hoffman, & Mahmoud, 2000) and also “The organization and delivery of health care... is undergoing significant social, organizational, economic, political, and cultural changes with important implications for the future of medicine as a profession” (Hafferty & Light, 1995, p.132). To Leonardia et al. (2012), nonetheless, postgraduate specialisation for rural health professionals is a sure licence to leaving rural practice because their advanced skills tend to be underutilised in rural settings whilst specialist care is in high demand in the cities. Where however one’s stay closer to authorities gives undue advantage for enrolment into postgraduate training and or with scholarship (Snow et al., 2011; Leon & Kolstad, 2010) or agreeing to work in a deprived area limits, poses difficulties or denies one career development

and growth opportunities (Goma et al., 2014; Hatcher et al., 2014; Ramani et al., 2013; Smith, 2005), then the rural health professional would have suffered inequitable outcomes. For instance Hatcher et al. found in South Africa that rural doctors lost critical skills as a result of extended rural stay. But to be identified as an organisation of choice for employment and also obtain the needed effort and flexibility from employees, it has been suggested that employers should equip their workers with marketable skills through career development opportunities that create room for growth (Sokro. 2012; Baruch, 2004).

As earlier noted, enhanced financial incentives such as salary top-ups, rural and commuted allowances have arguably been touted as probably the most used and effective outcome variables in the attraction and retention of health professionals to rural settings (Goma et al., 2014; Matsumoto et al., 2010; Henderson & Tulloch, 2008), probably because of the income lost to private practice and other career opportunities in the cities. Inequities in outcomes would exist where remuneration is considered unfair because it is low and insufficient to survive on, is uniform for both rural and urban doctors and where private practice for public sector physicians is permitted which benefits urban doctors (Bonemberger et al., 2014; Witter et al., 2011; Johnson et al., 2011). Hutchings, De Cieri, and Shea (2009) have however argued that for financial incentives to be effective in branding an employer, particularly those in deprived areas, they it must take into account relativities in what pertains in urban areas and other sectors.

Also, good quality health care infrastructure, work environment and supplies in rural settings are perceived equitable and positively impact the decisions of health care professionals in deciding where they work and stay (Bonemberger et al., 2014; Mohamed, 2013), because they are good predictors of motivation among health

workers (Adzei & Atinga, 2012). Mohamed found for instance that 69.5% of medical students saw the availability good physical structures of the health facility, equipment, diagnostics, drugs, and staffing as very crucial for their future allopathic care, regardless of curriculum design. This is especially so for those who loved rural work (Johnson et al., 2011). But the finding of Johnson et al. stands contrary to the findings of Snow et al. (2011, p.7) that “GA [Greater Accra] doctors complained more about infrastructure failings in general than did doctors in BA [Brong Ahafo] or UW [Upper West]”. Conversely therefore, the non-availability or poor quality of it could be perceived inequitable and has the propensity to even derail whatever gains would have been chalked in other measures in attracting health workers to deprived areas (Mohamed, 2013). The disenchantment of health workers with their work environments could be attributed to their absence or inadequacy (Bonenberger et al., 2014) and also their management (Agyapong et al., 2004).

Resource availability in the areas of education for children, recreational facilities and living accommodation and amenities are also considered equitable to health professionals in rural settings (Adzei & Atinga, 2012; Cameron et al., 2010). However, where poor educational facilities are provided for children (Ramani et al., 2013; Witter et al., 2011) and there limited recreational facilities and leisure, they make health professionals feel less integrated and thus suffer inequities (Mayo & Mathews, 2006).

Another critical outcome expected by rural health worker is an effective and efficient management and leadership systems manifested in the areas of; a fair system that guarantees endpoint appointment and transfers to rural service, quicker and shorter promotions, good working and living conditions, reduced workload and flexible working life (Rao et al., 2013; Adzei & Atinga, 2012; Stenger et al 2008).

Outcomes related to management and leadership could be described as the ‘anchor’ factors that really keep or drive away rural health workers (Lucas, 2005; Bach, 2004) because “leadership skill and supervision ... are significant determining factors of motivation and retention” (Adzei & Atinga, 2012, p.476). Conversely, outcomes would be considered inequitable when as a result of a defective management and leadership style; working and living conditions are poor (Goma et al., 2014), personal safety is not guaranteed (Hatcher et al., 2014), biases and lack of clarity engulf appointments, deployment, promotions and leave (Ramani et al., 2013; Richards et al., 2005), and people get isolated, neglected and forgotten (Snow et al., 2011; Leon & Kolstad, 2010).

A further factor seen as a vital outcome to rural workers is the amount of recognition, respect and appreciation that they receive from their managers, colleagues and particularly their clients and community (Bonenberger et al., 2014; Snow et al., 2011; Cameron et al., 2010). Snow et al. reported for instance that some rural doctors valued appreciation from their clients than salary. Where however rural jobs are made to look less respected and less prestigious without the needed appreciation (Ramani et al., 2013; Witter et al., 2011; Cameron et al., 2010), then those who accept to go to rural areas would have been inequitably treated. Literature however abound that organizations that seek distinguish themselves as places of choice for employment must focus attention on recognising and appreciating the efforts of their employees because that makes them feel valued and elicit loyalty from them (StrategiCom, 2010; Crous, 2007; The Economist, 1988).

3.7 Influences of Endowed Area Doctors (Referent Other) on Attraction and Retention of Medical Doctors to Deprived Areas

The relationship in the attraction and retention of health professionals to deprived areas would have been easier to manage if it were between just the employers and rural health professionals. Knowledge of the conditions of urban colleagues makes any decision on rural health professionals difficult because their options would be in reference to those others in the endowed places. The factors that serve as the basis of comparison can be categorised into; financial, career development, management and leadership, and family support.

Financially, it has been established that working with urban private health facilities is more profitable than public sector jobs (mostly located in deprived areas), and there are also locum opportunities with higher value items of appreciation in the cities than rural areas (Thammatacharee et al., 2013; Witter et al., 2011). Health facilities in cities have also been found to offer higher additional income from internal sources (Johnson et al., 2011; Dussault & Franceschini, 2006) whilst rural practice faces a constrained economy (Leonardia et al., 2012). It has been argued however, that cost of living is generally cheaper in rural settings (Witter et al., 2011), implying that lower rural earnings may be better managed.

For career development, better opportunities exist in the cities because training facilities and personnel abound and also one gets closer to those who take the decisions that border on doctors' career development and mobility in comparison to rural areas (Snow et al., 2011; Dussault & Franceschini, 2006), where doctors have to trek difficult long journeys in order to acquire just five CPD credits, needed for professional growth. However, merely participating in routine clinical meetings by their urban counterparts attains that. This has led to the suggestion that rural

practitioners could be offered similar opportunities through mentoring and regional trainings (Snow et al., 2011). However some rural doctors are reported to find more diversity and experience in rural work than in urban work because urban doctors are restricted to specialised areas (Couper et al., 2007).

Managerially, there are better working conditions, manifested in the quality and quantity of equipment, staff and medical supplies in urban work (Goma et al., 2014; Ramani et al., 2013) and thus issues of leave and workload are easily dealt with. But the peculiarity of good working conditions to urban areas has been challenged by the work of Snow et al. (2011) who discovered that infrastructural failings and broken down equipment are things that some urban doctors are coping with and complaining about.

Lastly, family wellbeing and support in urban settings appear to be much better than rural areas. For instance the view is held that spouses of health professionals are best positioned to get better employment in urban areas than they will do in rural areas (Dussault & Franceschini, 2006). Also, the best schools are thought to be in urban areas and therefore a better exposure and future for children of health care professionals could be guaranteed in cities than remote settings (Ramani et al., 2013).

3.8 Employer Branding

Employer branding according to Ambler and Barrow (1996) is a concept that recognises the employer as the brand whilst treating employees as customers and it embodies all the benefits associated with the psychology, function and economics of employment with a particular company. This may include a long-term strategy targeted at managing a particular organization's employees, prospective employees and other stakeholders' perceptions and awareness (Sullivan, 2004).

3.8.1 When Employer Branding is Necessary

Whilst some have argued that employer branding is necessary in the context of employment (Ambler & Barrow, 1996), others think its necessity is found where the supply of skilled employees are limited, particularly in a knowledge-based economy (Ewing, Pitt, de Bussy & Berthon, 2002). It is also necessary where there is the need to attract new employees whilst ensuring that existing ones find reason to stick to the organization (Sokro, 2012).

3.8.2 The Benefits of Employer Branding

Employer branding offers organizations numerous benefits. In the market of numerous employers, employer branding sticks out an organization and shows its uniqueness thus offering every member of the organization a firm grip of who they are and give clarity in the expectations of prospective entrants. This facilitates the attraction of recruits and further ensures that the strategy and culture of the organization are ingrained in current employees (Gilliver, 2009 in Sokro, 2012). Ultimately, it has been suggested that good employer branding results in employer brand loyalty, shaped by the culture and identity of the organization. Employee loyalty then generates commitment out of the internalization of the values of the organization which makes the cost of switching brand expensive and thus increases talent retention (Davies, 2008; Backhaus & Tikoo, 2004; Conference Board, 2001). This is best achieved when applicants put up with the image they carried at entry throughout their working life with the organization (Knox & Freeman, 2006). Also, how an organization brands itself can inform how it tackles issues such as induction, performance management and compensation (Sokro, 2012). Branding could also help reduce the cost of acquiring employees, enhance employee relations and

retention, and as compared to those with poor brands, even offer lower rewards (Ritson. 2002).

3.8.3 Undertaking Employer Branding

There is no consensus as yet as to how employer branding should be done but Backhaus and Tikoo (2004) suggest for instance that it could be done in a three stage process. First, the particular values that the organization intends offering to both applicants and employees should be developed into a concept. The proposed values must carry the central message of the employer brand which emanate from an exhaustive review of the qualities that present a firm or organization as the preferred place of work. Second, the organization must market the proposed values externally to the targeted hopefuls to attract them. Third, incorporate the ‘brand promise’ to applicants into the culture of the organization. For Berthon et al. (2005), however, employer branding could be done in five steps. First, make a conscious effort to understand your organization. Second, fashion a convincing brand promise that is in sync with the promise to customers. Third, develop a criterion to measure the brand promise accomplishment. Fourth, strengthen the brand promise by aligning it to organizational culture (i.e. people’s practices) to support it. Fifth, implement the promise.

3.8.4 Ensuring the Success of Employer Branding

For the above approaches to employer branding to be successful, however, it is suggested that the support of top management with a structured strategy is necessary. The structured approach could include building a brand team that includes creative staff with responsibility for the strategic direction of the organization. Such a team could look at the organization’s strength and weaknesses and identify that singular characteristic that attracts, motivates and retains the quality

of employees required (Keller, 1993). For such a team approach to succeed, however, Bretz et al. (1989) have suggested that decision making and reward systems must be decentralized. It has also been argued that building an employer brand image is not the sole responsibility of company managers, employees have important roles to play and therefore deciding on who is recruited is critical (Ewing *et. al.*, 2002). To further strengthen employees in that respect, Ambler and Barrow (1996) have suggested the need for internal marketing that will open up employees to the values and culture of the employer brand and therefore create a unique workforce that is loyal and difficult to imitate, thus increase retention. But all these are possible with a proactive rather than a reactive leadership (Mapolisa, 2014) ready to position their brand of employment in the competitive job market.

3.8.5 Employer Brand Qualities that Attract Employees

For an employer to be seen to be attractive as an employer of choice, research evidence indicates that such entities must exhibit some qualities that distinguish them from others and make them admirable to prospective employees because attraction is propelled by expectation (Bilodeau & Leduc, 2003). Good service conditions and environment, opportunities for career advancement or competence development (termed by Seehra, 2013, as ‘talent pipeline management’), organizational core values, reward systems, brand name, and good will (Sokro, 2012), flexible work schedule that ensures good work-life balance particularly for staff of rural settings, challenging responsibilities and the effectiveness of practices surrounding recruitment, engagement and retention (Hutchings et al., 2009; Copenhagen Business School, 2009; The Economist, 2008). It has however been found that where a brand image is inconsistent with the reality experienced in employment, employees leave such organisations (Copenhagen Business School,

2009), because the desire of every employee is to associate with institutions that are highly rated publicly.

3.8.6 Employer Brand Qualities that Retain Employees

Efforts at attracting employees to an organisation may overlap those aimed at retaining them but whether they become loyal and committed to the organisation for a considerably longer period of time is a function of their real living and working experience (Bilodeau & Leeduc, 2003) and therefore ‘strategy-diversity’ may be critical to achieve the two ends. For instance Sokro, (2012) found that belief in an organization as a good place to work, pride enjoyed from the public reputation of the firm, positive organizational values, job security, and growth opportunities, good employer/employee relations are good brand qualities that tend to retain staff. Similarly for StrategiCom (2010) cited in Sokro (2012, p. 170), the five brand qualities that retain talent are “attractive overall compensation and benefit package, opportunity for long-term career progression, recognition and appreciation of employees' work, job security, and provide work life balance”. These are factors that commit the employee to the organization and make him loyal, what Backhaus and Tikoo (2004) described as “behavioural element relating to organizational culture and attitudinal element relating to organizational identity”. This identity, some have argued can be found in the leadership style of the organization, one treats employees with dignity and respect (Tarusikirwa, 2000), trust people, create teams and company culture (McCord, 2014).

Again, Mapolisa (2014) argues that organizations that have brands that retain staff show much interest in the intelligence offered by exit interviews because it gives the opportunity to know the reasons for quitting and to deal with them. He argues further that with good induction policies, the roles and functions of employees are

well understood and also make them feel part of the organization. Mapolisa adds that good brands tend to be good collaborators in securing partnerships that work to the benefit of employees, for instance securing scholarship funding for staff development. Lastly, Mapolisa found in his study that organizations with brands that retain staff strongly believe in and uphold employee differentiation at different levels and also apply the principles of equity and merit in reward management to account for effort.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.0 Introduction

This Chapter focuses on the research paradigm for the study, research approach, study design, scope of the study, study population, sample size, sampling technique, data collection instruments, sources of data, data management and analysis, and ethical considerations.

4.1 Research Paradigm

Research paradigm has been defined to mean “A way of examining social phenomenon from which particular understandings of these phenomena can be gained and explanations attempted” (Saunders et al., 2012, p. 140). This research adopted the phenomenology paradigm. Phenomenology is a research philosophy that sees social phenomena as socially constructed and is particularly concerned with generating meanings and gaining insights into those occurrences. It is the way in which humans make sense of the world around them because context has a bearing on human behaviour (Saunders et al., 2012). It is therefore important that in seeking to understand a complex social phenomenon like the attraction and retention of medical doctors to a context specific region like the Upper West, one adopts an approach that will permit conclusions borne out of specific facts through detailed data gathering from limited multiple samples (Taylor & Bogdan, 1984).

The appropriateness of phenomenology for this study is based on the fact that it enabled the study of smaller samples in detail and therefore made it possible to focus specifically on the attraction and retention of medical doctors to the Upper West Region. In doing so, it helped frame the appropriate questions to ask, how to ask them and also offered guidance on the interpretation rules adopted in dealing with

the responses obtained. This is because for the phenomenologists truth is a subjective concept and therefore multiple responses to the same question help obtain reality because behavioural matters such as the subject of this study are a function of particular set of circumstances

4.2 Research Approach

The approach to this research was qualitative. Qualitative research emphasizes words rather than numbers in the collection and analysis of data and could be inductive, constructive or interpretive (Bryman, 2001). It also addresses the meanings that individuals or groups attach to social or human problems. To study these problems one has to collect data in their natural settings that are sensitive to the people and places under study, and also undertake data analysis that is both inductive and deductive to establish patterns and themes that are informed by assumptions and the use of interpretive/theoretical frameworks (Creswell, 2013).

The approach made it possible to investigate the phenomenon of attraction and retention of medical doctors to the Upper West Region in its context in detail. This was done by conducting in-depth interviews with a limited number of sixteen key respondents out of a targeted sample size of nineteen from various levels and backgrounds in the Ministry of Health, Ghana Health Service and the Local government system, relevant to understanding the subject of the research. Both past and present doctors of the Region, with experiential knowledge, were also interviewed. The approach enabled the researcher use semi-structured interview guides modelled around the four objectives of the study. This made it possible to ask probing questions to get meanings attached to issues in their cultural context. Also, the open-ended questions made it possible to avoid predetermined responses and thus obtained the exact understanding of the issues from the words of the

respondents. This therefore gave the research explanatory power on the strength of the contextual understanding of respondents.

4.3 Context of the Study Area

The Upper West Region was created in 1983 with Wa as its capital. The Region shares borders to the north with Burkina Faso, to the east with the Upper East Region, to the south with the Northern Region and with Côte d'Ivoire to the west. Its landmass covers an area of 18,476 square kilometres (i.e. 12.7% of the total land area of Ghana) (GSS, 2013b).

4.3.1 Annotated Map of the Upper West Region

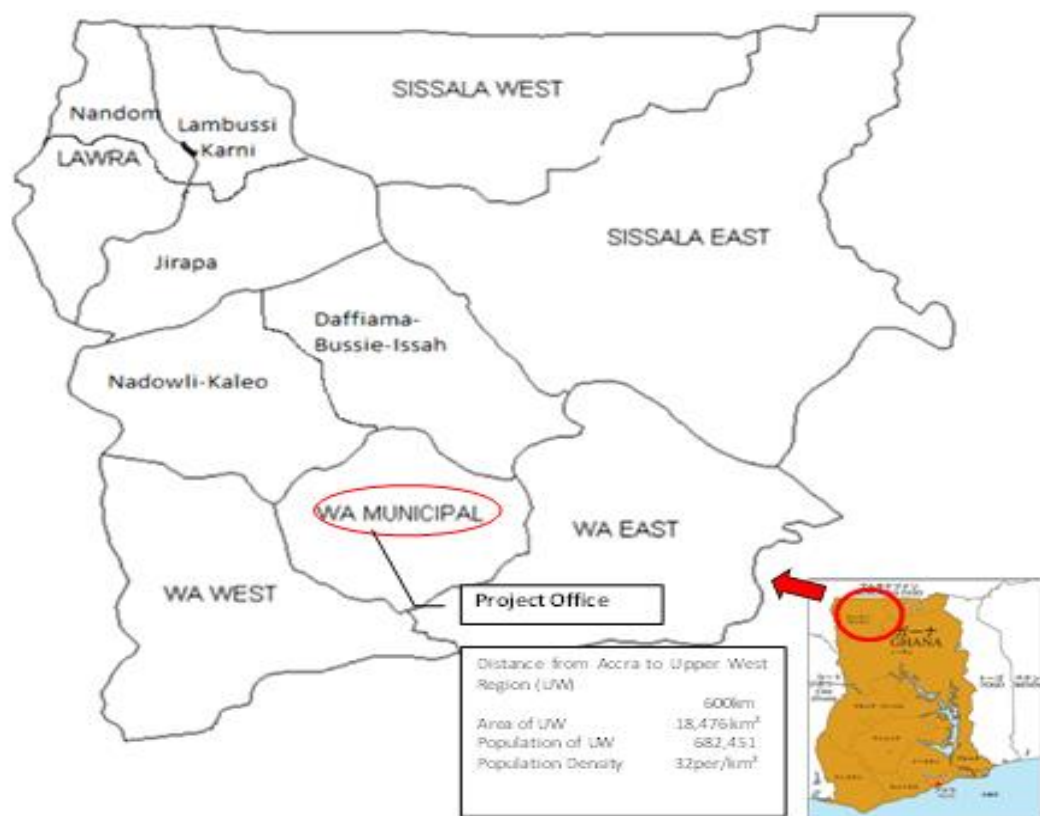


Figure 2: Map of the Upper West Region. Source JICA Website

Most inhabitants of the Region are largely peasant farmers and do crop farming and animal rearing. Tourist attractions in the Region include the Wa Na's Palace and the

George Ekem Ferguson's tomb (GSS, 2013b). Demographic wise, the population of the Region stood at 702,110 as at 2010 with an average annual growth rate of 2.5%, which brings the population to 774, 998 in 2014. Over forty-eight percent (48.6%) are males and 51.4 females. The population aged less than 15 years constitutes 41.7 percent of the total, while those aged between 15 and 64 constitute 52.3 percent. The rest (6.0%) were persons 65 years and older. Urban population was 16.3 per cent as at 2010 with population density of 38.0 persons per square kilometre. Wa Municipality is the most populous (15.3%) with Sissala West District as the least populous (7.1%) (GSS, 2013b). Considering that nearly half of the Region's population belong to the vulnerable group coupled with the fact that the UWR, with its two sister regions, are the ones with the highest incidence of poverty in Ghana (Adjasi & Osei, 2007), it is obvious that demand for health care is likely to be high. Health wise the Region has Total Fertility Rate (TFR) of 3.45 and also 128 Under Five Mortality (U5M) and 81 Infant Mortality Rate (IMR) per 1000 live births (GSS, 2013b).

4.4 Study Design

In the quest to understand the phenomenon of attracting and retaining medical doctors to the Upper West Region, a single case study design was adopted. A case study is "research strategy that involves the empirical investigation of a particular contemporary phenomenon within its real-life context, using multiple sources of evidence" (Saunders et al., 2012, p.666). In this respect therefore the phenomenon of attraction and retention of medical doctors to the Upper West Region was investigated by conducting sixteen in-depth interviews using semi-structured interview guides. The interviews covered multiple respondents at the levels of policy, implementation, community leadership and doctors who have practiced and

practicing in the Region. This made it possible to obtain varied views and experiences regarding the phenomenon from respondents by asking the ‘why’ and ‘how’ questions. That made it possible to describe the existing situation (Yin, 2009) of attracting and retaining medical doctors to the Region. With the why and how questions therefore, it became impossible to manipulate the responses of respondents and therefore elicited first hand context specific information. Also because the interviews centred around the same objectives and the phenomenon of study, it made it possible to judge the strength of the dominant views among respondents from their multi-perspectives. This contributed greatly towards a better understanding of the phenomenon and the outcome of this research because attention was limited to the particular issue of attracting and retaining doctors to the Upper West Region, an attribute of a case study (Babbie, 2007).

4.5 Scope of the Study

This study involved only doctors practicing in the Region, doctors who have practiced or worked in the Region and managers who have the mandate and authority to devise and implement policy decisions to ensure the equitable distribution of medical doctors in Ghana at both the national and regional levels. In this respect, other health workers at the national and regional levels who did not fall in this category were not involved in the study. The reason was to help obtain information from those who have lived the experience of working in the Region and directly taking decisions on the phenomenon. The study also concentrated on the Upper West Region and assessed the prospects and challenges of attracting and retaining medical doctors to the Region.

4.6 Study Population

The study population was all past and present health workers of the Region, staff of the Upper West Regional Coordinating Council, staff of all District Assemblies (DAs) in the Region, and the staff of the Ministry of Health (MoH) and Ghana Health Service Headquarters. Past and present health employees were considered an important population to study because of their familiarity with the context and the subject of study. They have interacted with, lived and experienced the challenges of attracting and retaining medical doctors to the Region and therefore were well placed in offering valuable information. The Regional Coordinating Council is the administrative and political body in the Region mandated to coordinate all activities to ensure the total wellbeing, including health, of the citizenry in its jurisdiction. Therefore it was important that their consciousness, understanding and interventions in the attraction and retention of medical doctors to the Region were interrogated. The District Assemblies are at the lowest level of the political administrative ladder mandated and resourced to ensure the welfare of all residents in their jurisdiction, including health. The Ministry of Health is the national policy making body on all aspects of health in Ghana. This includes ensuring that there is equitable distribution of health professionals across the country to provide health care to all persons living in Ghana. Therefore, in seeking to understand the challenges associated with attracting and retaining medical doctors to a part of the country, it is natural that those with the mandate to formulate policy are contacted on what policies exist, how effective they have been and how to improve on them. The Ghana Health Service is the implementation arm of the Ministry of Health that oversees the Region and the health facilities in it. It was therefore prudent that those who actualise policy are involved to understand their perspectives on the phenomenon.

4.7 Sample Size

Sixteen (16) persons were interviewed for this study. This comprised eight (8) practicing doctors in the Region, three (3) former doctors, the Regional Director of Health Service, a representative of the Upper West Regional Coordinating Council, and two (2) District Coordinating Directors (DCDs). This meant 84.21% response rate. The Director of Human Resource at the Ghana Health Service could not be reached because she was out of the country at the time of gathering data whilst the two serving doctors were out of the Region. For the DCD who was scheduled to be interviewed but could not be reached, he indicated that he was on a national assignment that had taken him out of the jurisdiction and did not also agree to a suggested telephone interview.

4.8 Sampling Technique

The technique adopted in this study was purposive sampling. This involves the use of one's judgement to select cases that will best answer your research questions and also meet the research objectives (Suanders et al., 2012). In other words, who is chosen to participate in the study is purely at the discretion of the researcher. The choice of the five broad categories, viz. policy makers, policy implementers, community leadership, former doctors and practicing doctors was because it was thought that the phenomenon had dimensions that bordered, respectively, on policy decisions, policy implementation, community involvement and action, reflective experiential knowledge, and current knowledge. For the individual respondents from the five categories, however, it was the considered opinion of the researcher that they were the most informative for the purpose of the study. Purposive sampling was therefore found suitable for a case study research such as this that sought to engage a limited sample size with the requisite information (Neuman, 2005)

4.9 Data Collection Instruments

A semi-structured interview guide was used to collect the data. This involved a list of themes and possible key questions that centred on the four main objectives of the study. All the interviews were personally conducted by the researcher. Fourteen interviews were face-to-face whilst two were conducted via telephone-interview due to distance and security concerns on the road. The average time spent with each respondent was 43 minutes with the least being 13 minutes and the highest one hour 24 minutes. Apart from the Regional Director of Health Service and the director at the Ministry of Health who were personally contacted, all other respondents were contacted first on phone and informed of the study. Thereafter the time and venue were agreed upon for the interviews. This was done for all the six categories of participants. The biggest challenge with data collection was the extensive travelling that was embarked on to meet particularly former doctors. But it paid off as various views were received which helped shape the findings. Considering that the study was context specific, the researcher took notes on observations, experiences and perceptions in the course of gathering the primary data. This was meant to help the researcher fully describe phenomenon of study.

4.10 Sources of Data

The main sources of data for this study were primary and secondary. The primary source emanated from the responses of the semi-structured interviews that were conducted on the field. This formed the basis of analysis for the study. The secondary sources of data were three strands; academic and peer reviewed journal articles, internet sources and policy documents, reports and papers. The journal articles were obtained from two main online portals, Google Scholar and Emerald Insight. The search was done using active search phrases in the research topic such

as “attraction and retention of doctors in deprived areas”, “attraction and retention of health professionals in rural and deprived areas”, “reasons doctors are unwilling to take up postings in rural areas” and “health worker retention in rural areas”. For the policy documents and reports some were obtained from official websites, mostly using Google Search. Those that could not be obtained online were picked directly from their offices in Accra and the Upper West Regional Health Administration.

4.11 Data Management and Analysis

The digitally taped-recorded primary data obtained through interviews from the field were transcribed verbatim into a 91 paged document. As required of qualitative studies, to draw inferences adequately data has to be dismantled, split and reconstructed (Boeije 2010). Using the data analysis approach of Miles & Huberman (1994), the data were then coded and categorised into themes that reflected the views of the respondents and also in tandem with the objectives of the study. There was continuous coding and categorisation throughout the process of data analysis to refine the major ideas. This facilitated a qualitative analysis of the phenomenon of study. The study objectives and the theoretical framework informed the pattern of analysis and discussion. As a guard against data loss, all recorded materials were backed up on other electronic devices and the transcribed document printed.

4.12 Ethical Considerations

Research ethics is concerned with “the standards of the researcher’s behaviour in relation to the rights of those who become the subject of a research project, or who are affected by it” (Saunders, et al., 2012, p. 680). Therefore access to the study site, participants and data was granted following an approval obtained from the Ethical Review Committee of the Ghana Health Service. The essence of the study was explained to all participants and their consent sought by their signing of the consent

form, except for the two telephone interviews that the form could not be signed. But they were informed well in advance and they consented to the interviews. The need for their active participation was sought from the angle of persuasion for participants to understand the mutual benefits of the study. They were assured of confidentiality and were made aware that the findings were purely for academic purposes. Indeed to actualise the confidentiality bit, generic references have been adopted in their description. Only official titles were used where specific offices were concerned.

CHAPTER FIVE

FINDINGS AND DISCUSSIONS

5.0 Introduction

In Chapter Five, the findings and discussions are presented. This will focus on the reasons for the unwillingness of medical doctors to accept postings to the Upper West Region (UWR), reasons doctors want to remain in urban areas, initiatives taken by stakeholders to address the situation and their effectiveness, and the factors considered fair and equitable in ensuring that medical doctors are attracted to and retained in the Region. These issues are presented and discussed as follows.

5.1 Reasons Medical Doctors are Unwilling to Accept Postings to and Remain in the Upper West Region

Reasons for the unwillingness of doctors in accepting postings to the Region are the factors they consider to be inequitable and unfair to them as compared to staying in the endowed parts of the country. First, this study has revealed that the quality of training received by newly qualified doctors, including some specialists, was insufficient and therefore did not equip them adequately for rural work. Nine (56%) respondents who alluded to this fact added that this development was made worse by the urban oriented curricula that made doctors think they were trained for the urban setting. Also, the limited opportunities for continuous professional development in the Region exacerbated this. One of the respondents expressed this view as follows;

“I think most of the younger ones are not well equipped nowadays and so imagine that you are taken to a district hospital, you are the only person and the things that happen in the district hospital. You have to be the obstetrician, the gynaecologist, paediatrician, the surgeon and so if you are not very talented, and your skills are not up there, it’s going to be a huge problem for you and that is what is happening. Because of the training most people really do not take time to go through the mill very well so they come out not as refined as [the] days past”.

The situation, according to respondents, further compounded where doctors have to take up managerial duties because medical education does not include managerial training. Extant literature gives support to this finding that the quest for early postgraduate specialisation by doctors is the result of inadequate preparation for rural work (Mohamed, 2013; Snow et al., 2011). The reference to managerial incompetence to handle facilities may call for a rethink of the institutional managerial arrangements and also the value placed on professional managerial training in the management of health facilities in the Region. Also, considering that opportunities for continuous professional development is a quality of a well branded employer (Mapolisa, 2012; Sokro, 2012), its limited availability in the Region may suggest that the Region is not positioning itself as a destination of choice for medical doctors in Ghana.

Closely related to the above is the revelation in this study that the lack of confidence in taking up rural postings may not just be the result of the insufficiency in medical training but the lack of induction or orientation for new doctors, particularly those that assume management responsibility without the requisite skills. Two respondents put it thus;

“When you come in it’s like you are left alone to manage a facility. The medical training does not include leadership. So apart from your technical or your clinical work you are hassling to catch up with administrative work. There is no any orientation anywhere. All is that you are a head of a facility and you know nothing about management. If you are not careful you have problems with your other colleagues in management because it’s like you don’t trust anybody. It’s like you don’t have the skill to be able to tackle certain issues”

“Some came and within a year they left. Because of misunderstanding between them and the managers, they left. They felt the managers were toying with their lives so they just left. They could not see their way clear in terms of prospects in working here”

Orientation has been found in earlier studies to help oust uninformed expectations, build the needed resilience to cope with contextual realities, open employees up to their duties and responsibilities and as well point out limitations on their activities (Leonardia et al., 2012; Smith, 2005). This view is equally shared by scholars in the field of employer branding. Mapolisa (2014) for instance argues that with good induction policies, the roles and functions of employees are well understood and make them feel part of the organization. Where employer branding is adequately managed, it could inform how an organization tackles issues such as induction, performance management and compensation (Sokro, 2012). The lack of induction therefore means that the Region is missing out on the opportunity to market itself as an employer of choice.

This study also found that for indigenous doctors (i.e. doctors who hail from the Region) who were not prepared to come to the Region, the reason was high dependency rate from relations and friends. For the thirteen (81%) respondents who made this argument, the situation of indigenous doctors was worsened by the lack of locum opportunities to make additional money in the Region and also the limited respect they enjoyed from the local populace due to familiarity. This dependency comes in three forms; preferential treatment in service delivery, free services and resource demands. For preferential treatment it was said to be caused by familiarity in the environment which made relatives and friends asking to be seen early even if they came late to the hospital. One respondent painted a vivid picture of the other two;

“Sometimes some relatives, when they come and they see you working they think that you are the head of the place and if you are the head of the place then the place must be yours and their treatment should be free [i.e. free services]. If you tell them [they] have to go and buy this medicine, some will even be expecting you to dip into your pocket again and give them the money to go and buy it [i.e. resource dependency]. And you have that connection

because probably the person helped you one day, gave you one cedi or something, so he feels that this is payback time and you will be paying back until you have nothing to pay”.

The most stressed of these, however, has been the resource dependence. What was however revealing was that for indigenous doctors who did not grow up in the Region, the dependency factor did not wholly apply to them because as one doctor respondent put it “Some of us we are fortunate, we didn’t grow up with them, so even though they know you are one of them, that connection is not there so I can be spared”. Though rural origin has been found to impact the choice of rural practice positively (Ramani et al., 2011; Leon & Kolstad, 2010), this dependency finding appears to stand contrary to previous conclusions about rural indigenes. Also, since the most stressed dependence was the resource dependence, it is unclear what will happen if there was adequate monetary compensation for indigenous doctors who take up appointments to the Region. Dependence is a social burden that could destabilise even the most focused employee.

It is worth adding that this study has shown that finding suitable partners was a reason female doctors in particular were not taking up postings to the Region and particularly the districts. Four (25%) respondents who raised this issue averred that considering the social status of doctors, it will be difficult for female doctors to find partners of their calibre or even above them in the Region. A serving doctor respondent shared the view below;

“Take females for instance during your prelab training you are learning hard thinking that when you come out you will take your time and choose the man you want to be with, [then] you land yourself in the village, there are no suitors, nobody is qualified, perhaps the chief or the chief’s son ... there are no marriage opportunities”

This finding agrees with earlier ones that females were less likely to take up postings to deprived areas (Hatcher et al., 2014; Dussault & Franceschini, 2006). Therefore any attempts at getting doctors to the Region that target female doctors could fail. It

could also mean that the more female doctors that are trained than male doctors, the more places like the Upper West Region would continue to receive inadequate numbers of doctors.

Additionally, this study has found that there was general weakness in leadership style and language at the regional level in the drive at getting doctors to work there. Respondents indicated that this weakness transcended both the Ghana Health Service and its institutional managers and also the administrative political bodies that represented the communities in the Region. The twelve (75%) respondents who argued this way contended that leadership weakness was the reason issues such as high workload, poor reception and orientation, and the general misconception about the Region have not been dealt with but they subtly affected the decisions of doctors in coming to the Region. One respondent intimated the following about the phenomenon;

“I think it has to do with leadership in general in the Region. [By] leadership I mean everybody that matters in taking steps to attract medical doctors to the Region and also taking steps to motivate them and keep them when they come”

For some of the respondents, however, the challenge with most of these leaders is the lack of adequate training and therefore they lacked the necessary skills and competences to deal with this challenge. An adherent of the position on leadership weakness put it thus;

“Most of the leaders we have truly they have not gone through any formal training so they really don’t know how to handle issues. So how to attract [the] younger ones is a huge problem. Even when you have attracted them, how to retain them is another major problem”.

The essence of good leadership support by regional health departments and local government authorities in the attraction and retention of health professionals to deprived areas has not been lost on previous researchers (Rao et al., 2013; Leonardia et al., 2012). Indeed it has been suggested that proactive leadership (Mapolisa, 2014)

and top management support (Keller, 1993) in handling matters such as induction and the positioning of a firm in job market as an employer of choice are good qualities of a well branded organisation. Keller added that management support alone was not enough but that it is best when it comes in a team approach that encompasses those who matter in branding an organisation. Therefore with concerns being expressed about the collective weakness of leadership of the Region in respect of getting doctors there, one is left in the dark as to how this challenge can be surmounted, given that the effort required to brand the Region is virtually non-existent.

Additionally, the study also uncovered a system that could best be described as a “systemic lock-in” in the Region. This involved the conscious or unconscious actions by the Ghana Health Service not to have any coordinated programme that ensured that practicing clinical doctors are transferred across regions, unlike their counterparts in regional managerial positions. “Once they come and dump you there everybody forgets about you. Whatever you do, unless you have a problem or you go to them ... nobody comes”, stated a serving doctors. Another respondent stated it thus;

“For some key managers, particularly if you are a Regional Director, Ghana Health Service has this well organised way of moving them round where after four years or so you are given the opportunity to be reassigned or you are transferred to another region ... But for the clinicians that was not the case. As long as you are ready to stay on nobody talks to you about transfer and even when you ask for transfer, it becomes a tag of war. So it brought about a lot of frustration”

It may be worth saying that such happenings could be manifestations of leadership failure in attracting enough doctors to the Region and therefore giving up the few that go there would mean not getting replacement. But that also sends wrong signals to those yet to come that if you go to such a region you may be ‘locked-in’ by the

system. But as a good employer branding strategy, flexibility in the work environment (Sokro, 2012), which include the opportunity to change working environment, reduced workload and enjoy leave, is necessary in portraying an organisation as an employer of choice. Having a sense of being ‘locked-in’ could therefore send wrong signals about your brand.

Again, the study has revealed that one of the reasons for the difficulty in retaining doctors in the Upper West Region was the internal disparities that existed between doctors who were managers and their colleagues who did not function as such. The four (25%) respondents who made this argument stated that medical doctors in management were privileged with resources that gave them some leverage, especially the unlimited use of official vehicles and fuel to the detriment of their colleagues who may have to travel by public transport. This fact is reflected in the following view from a respondent;

“At a point I was a manager, it was easy to move. If you are a manager it is easy ... [and] most often the managers stay longer than the clinicians who are not managers. That is what I have noticed. ... managers have resources that really leverage them to improve upon their social network than the clinicians ... There were many occasions [in] most hospitals where they [i.e. clinicians] had to travel with public transport and I felt really, really bad but the managers will go in a pick-up ... It’s really something that they complained about seriously. That disparity was there”.

Whilst it is certainly not possible under any regular compensation theory to have subordinates and their superiors have the same level of incentives, it is however possible that where the disparities are so wide they could create disaffection and pose retention challenges. This appears to be the case in the Region. However, branding an organisation as an employer of choice requires that the principles of equity and merit in reward management are fairly upheld (Mapolisa, 2014). This is especially so where both doctors are on the same professional grade and one becomes an institutional head by dint of the fact that he was first to come. What is peculiar of the

low response rate was that most of the practicing doctors in the Region were themselves managers and likely beneficiaries of the inequities and therefore could not have raised issues about it.

It was also found in this study that there was lack of a policy that clarifies and gives direction on the conditions for working in deprived areas in Ghana and in particular the Upper West Region. This is especially so for career development, a fundamental reason for the unwillingness of doctors in taking up postings to the Region. A respondent stated this as follows;

“There is no clear cut direction when you come to the Region, that if I come to Upper West to work, after this number of years this is what is there for me. Maybe after two years I can enter into a programme or this is what is there two, three years. It’s not clear”

Explaining this lack, however, a policy maker indicated that attempts were made at such a policy but the efforts were thwarted with the difficulty in clearly defining which part of the country was deprived and which was not. The relevance of policy clarity in the attraction and retention of health professionals in deprived areas has been established by previous researchers (Goma et al., 2014; Wibulpolprasert & Pengpaiboon, 2003). Though the criteria respectively used in Zambia and Thailand have not been ascertained in this work, it is quite intriguing that just demarcation challenges could thwart the effort of a whole health system in defining which parts of the country were deprived and which parts were not. It may also point to the sort of value placed on health statistics as indicators such as doctor/population ratios should give indications of this. In failing to do so, proper targeting with health interventions would merely be speculative. However, to appear as a serious organisation that should be seen as an employer of choice as against others, one should not only have a policy but one that is well structured and diverse (Mapolisa,

2014; Keller, 1993), to offer current employees a sense of what they are and for prospective employees, clarity in expectations (Barney, 1991).

Added to the above, this study has found that one of the reasons that kept particularly indigenous medical doctors from coming to the Region was superstition and cultural beliefs that ‘threaten’ their lives and fortunes. An adherent of this view posited that the reasons for indigenous medical doctors not coming to the Region were;

“A combination of so many factors; tradition, culture, financial, and amenities ... but if you ask me to pick one I think the issue is to do with cultural practices and tradition. Once you have become a medical doctor and you are a native they think that you are all in all, you should be able to solve all their problems and so when you fail to do that you become a target and this area actually witchcraft and all the activities related to spiritualism are very high in the area, and so they start working you all angles, fighting you from every angle, spiritually, physically and what have you”.

Though some practicing indigenous medical doctors in this study did not agree entirely with the view, they did not dismiss it either. They blamed it on childhood indoctrination about such beliefs. One of such medical doctors stated thus;

“Whether it’s true or not before you even become a doctor these beliefs ... are put in your head [such] that you are so much afraid of where you come from because either you are seeing examples of them or you are seeing the behaviour and the practices of the people and therefore you are scared. You don’t know anything. It’s just your book and medical knowledge. So why would you want to come and maybe die for serving your people?”

Though it was said that this factor affected mostly indigenous doctors, some respondents have argued that using such reasons could also scare away non-indigenes. For adherents and reluctant supporters of this view, the failure of traditional leaders to deal with the matter head-on and parents of medical doctors who scare away their children were to blame for the survival of such beliefs. They added though, that some doctors could be overly exploiting it as an excuse not to come to the Region, adding such beliefs could be made ‘friendly’ by traditional leaders.

What should be pointed out here is that superstition is a matter of belief and therefore it is possible that those who might strongly share in this belief would not take up appointment back home. This is particularly so when those there are not discounting it completely. Again the revelation that it was those who did not want to come home that used such issues as their excuse is quite instructive. It could be an easy excuse adopted by indigenes, knowing well that the people are so gullible and would accept that excuse as against an excuse of dependency or poor pay, which may portray them as greedy or placing money over human lives.

Findings from this research also shows medical doctors in urban areas, particularly those at the Teaching Hospitals (THs) had excess time for private activities as against their counterparts in the Region. The fifteen (94%) respondents who made these assertions attributed this to the larger numbers of doctors in the cities which permitted them to run shifts. Indeed some respondents were of the opinion that this factor was the singular most important reason doctors tended to stay in the endowed cities. One of such respondent stated this as follows;

“Most people will want to hang around the Teaching Hospitals and the bigger facilities where their absence will not be felt. Whether they are there or not, nobody knows and then they can use those opportunities to do other things. Not that the facilities there are better off or something. It’s just because of the numbers. A few people will do the job [and] the rest will be ‘lazying’ around.”

Respondents further argued that the excess time available to doctors gave them the opportunity to private practice to supplement their income and also combine work with career development because most higher learning centres were in the bigger cities, privileges unavailable to their counterparts in the Region. It must be noted, however, that the reference to some doctors ‘lazying’ around is instructive. This could be indicative that a lot of idle hands are being paid for in the cities whilst others in the Upper West Region are overstretched. An enquiry into how much time

public sector doctors in the bigger cities actually work in their hospitals may be worth it.

This research further found that the lack of complementary skills and services, respectively, from their senior colleagues and the private sector in the Region scared doctors off the Region as against their in urban counterparts. Senior colleagues offer them the needed mentoring and support whilst the complimentary services such laboratory, X-Ray and pharmacies in the endowed areas helped them achieve the needed results, thus boosting their morale and motivation as against what exist in the Region. A respondent represented this as follows;

“Sometimes you are saddened when you write a prescription for a patient and you yourself [you] know that the patient cannot get the medicine. The person has to roam, one week, two weeks [and] go to Kumasi, Tamale, Accra [and] by the time they get the medication a lot of time [has] passed. So it’s like you are working, yes, but you are not seeing results... you are not happy. But in Kumasi, Accra ... the drugs are easily available, labs are easily available. You ask somebody to go and something, they bring [it] you see it, you help them further [and] everybody is happy”.

In order not to go through all these frustrations, respondents have argued that, most medical doctors would prefer staying in the cities where these services are readily available. Whilst admitting the genuineness of some of these claims, it may be equally important to state that sometimes the challenge might not be with the non-availability of these facilities in institutions but their functionality which is moderated by managerial competence and systemic arrangements for their maintenance (Agyapong et al., 2004). For instance two respondents indicated that they have had their X-Ray machine and haematology analyser broken down for over six months and the technicians to work on them have to come from Accra and for more than six month the technicians would not turn up. The value of mentoring for competence cannot however be downplayed under any circumstance. Offering

challenging work responsibilities and consciously developing the competence of employees was a good employer brand that not only retained employees but attracted new applicants (Copenhagen Business School, 2009, cited in Sokro, 2012).

5.2 Specific Initiatives by the Ministry of Health and Other Health-Related Partner Organisations to Attract Medical Doctors to the Region

Current policy initiatives are those measures and strategies already on the ground by the various stakeholders aimed at making the Region a destination of choice for employment in order to attract and retain medical doctors. These could be seen as the available outcomes in the attraction and retention exchange relationship and are discussed below.

5.2.1 Ghana Health Service's Directed Sponsorship for Postgraduate Training

The study found that there had been a national directive by Ghana Health Service since September 2014 aimed at offering support to doctors in their postgraduate education in the three regions of the north. For both local and foreign postgraduate studies, the facilities in which doctors worked were mandated to respectively offer GHC8000 and GHC12000 per annum for the duration of the course in addition to paid study leave. In return, the Region may bond the beneficiary for further service after training. Some respondents, however, saw the sponsorship more as 'trapping' doctors rather than attracting them. This is because the condition precedent for the sponsorship was mandatory work in particular areas and that made it 'trapping' rather than attraction. A doctor respondent stated this position as follows;

"What I know is that it's more like trapping than attracting. ... If you are going back to school to specialise [and] you are not being sponsored you will not be on salary during your programme. So doctors are taking MOships [i.e. Medical Officer Postings] in district hospitals so that those facilities will sponsor them to go back to school. That is a way of trying to trap you at the district. It is not attraction".

Both serving doctors and health policy managers in the Region agreed that the policy promises to be effective, though it was less than a year old as at the time of the study. This is because two doctors had left for specialisation on account of that. Indeed it was indicated that it contributed to getting some doctors to the Region. It is known, however, is that those two beneficiaries were in the Region long before the introduction of the policy. Their attraction bit cannot therefore be wholly attributed to this measure. Care must also be taken in ensuring that stronger and enforceable bonds are entered into to ensure that they returned to the Region since specialist skills are known to favour urban rather than rural work (Leonardia et al., 2012). Though the measure is aimed at offering opportunities to doctors who serve in the Region, using internally generated funds may be limited by financial difficulties. A well branded organisation, according to Mapolisa (2014) should be able to secure scholarships from partnerships to do this. Resorting to internal funds may mean that the service is poor at collaboration and partnership in this respect.

5.2.2 Ghana Health Service Directed Financial Incentive Package

It was revealed in this study that Ghana Health Service had issued directives for the payment of monthly incentives by health facilities to critical staff including doctors as follows; specialists (GHC1500), doctors (GHC1,200). Key conditions associated with its implementation were management's approval and ability to pay. Some respondents have however indicated that these conditions might stall the implementation of the policy. This is because other management members who are not beneficiaries could use the excuse of 'not enough funds' to thwart it. Respondents have also questioned the sustainability and smooth operation of the directive as a tool for motivation. They cite the erratic reimbursement of claims by National Health Insurance Authority (NHIA) which could delay payment and thus

cause frustrations. “Even though Director General has released that document ... when the health insurance is not paying timely, it’s not smooth to implement the policy”, stated a respondent. This incentive is akin to the profit sharing scheme earlier found in Vietnam (Witter et al., 2011) and therefore endowed facilities could end up pulling more personnel if care is not taken. Osasona (2005) has, however, questioned the effectiveness of financial incentives as a long term branding strategy for retention. He argued that they are only effective in the short term as compared to non-financial incentives.

5.2.3 Declaration of Vacancies in Deprived Areas

The study revealed also that there has been a policy that required Ghana Health Service (GHS) to specifically declare vacancies in rural areas and the appointment of medical doctors will be dependent on the doctors accepting postings there. It was explained that under the policy newly qualified doctors were required to report to institutions where vacancies had been declared by GHS. One would only be appointed only after his assumption of duty has been reported from the respective institutions. Indications were that the policy has shown some promise and indeed had started yielding results. A respondent stated as follows;

“I think for now we can say [it is] working because the doctor that we just had it’s through such [a] policy. ... Immediately after the house job, we got him here and quickly reported his assumption of duty and he was quickly worked on. Had it not been that, we would still be looking for a doctor. I believe it is a good policy that we need to strengthen and let it work. It will help, at least in a region like Upper West”.

This policy appears to be one of the bold steps toward the distribution of doctors in the country. It may, however, not yield much as long as there are no scientifically determined staffing norms that limit how many doctors endowed facilities can take on. It could also be exploited by doctors seeking employment if the loose ends are not tightened to ensure their retention.

5.2.4 Free Accommodation and Utilities

This study further revealed that the Regional Coordinating Council (RCC) had issued directives to all assemblies and health institutions since 2007 for all public sector doctors in the Region to be offered free accommodation and utilities for as long as they were in the Region. Indications from doctors and managers were that no doctor in the Region paid for accommodation and utilities; “Your accommodation is free for you ... you have a huge bungalow to yourself, you don’t pay electricity, you don’t pay light bills and things like that”, stated one doctor respondent. Some doctor respondents have hinted, however, that the quality of the accommodation may have to be improved; “The accommodation should be stepped up. It’s just not enough to come and paint the place and then within four months it’s going [bad]. It’s not enough”, another doctor respondent indicated. The reasons for this were not known but managerial ineptitude and financial challenges could be contributory factors. But good conditions of service, which includes issues of accommodation, have been touted as worthy employer branding tools (Sokro, 2012). However, having the decency of the free accommodation questioned could mean that accommodation may not be adding to the brand image of the Region.

5.2.5 Regional Coordinating Council’s Directed Salary Top-up

This study further revealed that the Regional Coordinating Council (RCC) in 2007 gave a directive to all assemblies to pay an amount of GHC500, monthly, to every Ghanaian doctor in the Region. Its implementation is reported to be mixed across assemblies. Whilst some are paying, others have since stopped; “That rule is working in some places but others have killed it long time ago”, a beneficiary doctor stated. What was more revealing about this was the lack of awareness displayed by respondents from the institution that issued that directive (i.e. the RCC) and some

assemblies in response to a question on their awareness of the RCC's directive; "I was not here so I cannot remember", the respondent of the RCC stated, and "This one I have not heard of that. Am hearing it for the first time but I don't think we do it. Since I came ... I have not heard about it", one district assembly respondent indicated. The contrasting views from the RCC and the assemblies may be indicative of the disjointed manner in which the whole package has been handled by the local political administrative heads. It may also indicate a certain weakness in the enforcement of the RCC's own directives on issues such as these in the Region. It therefore raises questions about the effectiveness of any initiative that may emanate from or assigned to them for implementation.

5.2.6 Regional Coordinating Council's Directed sponsorship for Health Professionals

The study found also that the Regional Coordinating Council (RCC) had directed all assemblies in the Region to budget for the sponsorship of health professionals such as doctors, nurses and midwives. Though indications were that some nurses and midwives were being sponsored by assemblies, only one assembly was reported to have used such a directive to sponsor one doctor for a specialist course who has since completed and serving his district. The difficulty in getting doctors for sponsorship, respondents indicated, was because doctors did not want to be tied to districts for longer periods. A district respondent stated thus;

"Because of the high value attached to them, few of them will accept to be sponsored by the various districts. And because they don't want to be tied to our areas they are not even forthcoming for this negotiation between them and the assembly".

The assemblies reported, however, that financial constraints impacted greatly their effort at sponsorship because their main source of income, the Common Fund, was erratic in its releases. They added that owing to competing demands, political will

was important in making such expenditures, an attribute which seemed lacking in the Region. Also the claim that doctors were not forthcoming for sponsorship could be due to a lack of proactive search and policy clarity on conditions for such a sponsorship by the assemblies. But earlier findings indicate that a deliberate policy with an aggressive implementation plan, backed with the highest level of managerial support, was essential for local authorities to succeed in presenting an image as the employers of choice (Mapolisa, 2014; Matsumoto et al., 2010; Keller, 1993). Lacking political will and proactive leadership in respectively making expenditure decisions and searching for doctors for sponsorship portends a weak employer branding effort from the Region.

What appeared curious about these initiatives was the lack of knowledge of some respondents of some the incentives available to doctors in the Region such as free accommodation and utilities, particularly at the policy level. Some respondents appeared completely oblivious of them and did not even know that doctors in the Region were given free accommodation and utilities. Similar observations were also made of policy level respondents about the Ghana Health Service directives on both salary top-up and sponsorship packages. This may be an indication of the lack of coordination even within the health system on how various parties were working towards solving the problem. And just maybe, a manifestation of weak leadership, both at the policy and implementation levels, in developing a comprehensive policy document that will synthesise all the initiatives to be used for any branding for recruitment drive. For doctor respondents however, their lack of knowledge appears to have official manoeuvring, as stated by one of them; “It’s like if the policy is there [but] it’s not known to the doctors. They have hidden it somewhere. Until you get close to them you will never know”. The lack of knowledge could account for poor

patronage of such schemes as the sponsorship by assembles, as earlier studies in Zambia also found (Goma et al., 2014). It for some of these coordination challenges that it has been suggested that for employer branding to be successful in attracting the needed talent, it requires a brand team that is supported by a proactive top management with a structured strategy to identify that singular characteristic capable of delivering (Mapolisa, 2014; Keller, 1993), in an environment that decentralizes decision making and reward systems (Bretz et al., 1989). The lack of knowledge only demonstrates that efforts in the Region geared towards attracting and retaining doctors fall far below expectations of what is required to present a good brand image.

5.2.7 The Sole Reasons for Taking up Postings to the Region

This study has shown intriguing findings about the above initiatives taken by the Ministry of Health and its partners. None of them was mentioned as the sole reason or a combination of them for any doctor in taking up appointment to the Region. Other reasons were mentioned. First was the moribund scholarship for foreign training in exchange for service, mentioned by former doctors. The scheme offered doctors the opportunity to do their specialisation outside the country if they agreed to serve in any of the three regions of the north for a specified contract period. Such contract service for scholarships has been found to be more effective with graduate training (Matsumoto et al., 2008), but postgraduate specialisation has also proven to be ‘a sure license’ to exiting rural practice because specialists tended to find their skills underutilised in rural areas (Leornadia et al., 2012). Therefore, to adopt a postgraduate scholarship as an attraction strategy, it must target service before sponsorship as did under this scheme to be seen by those interested as a ‘post-service incentive’ with a voluntary option to return to the Region. This may help reduce any

feeling of imprisonment or lock-in. Indeed those who indicated they went to the Region on account of this scholarship did not return there on completion.

The quest for professional experience was the second sole factor that motivated some doctors in taking up appointment to the Region. As stated by a serving doctor respondent;

“For me after school I wanted a lot of exposure because I had the opportunity of doing my clinical attachments in some of the districts that I think that when you go there you will be exposed a lot. You will see a lot of things that your colleagues will not see”.

Though literature indicates that doctors found more diversity and experience in rural work, this was usually under the guidance of senior colleagues (Hatcher et al., 2014; Couper et al., 2007). But in this study those who indicated that it was their quest for experience that led them to the Region, likely did so based on their desire for personal hands-on practice and not because of their knowledge of the presence of senior colleagues. This could expose patients to overzealous doctors who may be tempted to go beyond their capacities. Challenging work responsibilities has however featured prominently in the literature of employer branding to be a good tool for attracting employees to organisations (Copenhagen Business School, 2009). What may hold the key is how it is managed.

Lastly, this study found that for a great number of doctors (10/63%), past and present, their sole motivation for taking up postings to the Region was their personal desire to serve people. One of such respondents put it thus;

“The most important factor was the desire to serve my people. Because I realised that at a point one will just have to serve your people and at the personal level I thought that let me start from home, spend the first part of my life to serve my people and then move on”

The influence of personal values have been previously found by other studies (Snow et al., 2011; Couper et al., 2007) to impact the decisions of some doctors in taking up rural appointment. Snow et al. described such incentives as ‘ideational incentives’.

However, a personal value such as the desire to serve people is an individual's innate variable that cannot easily be determined and acted on to attract such persons to the Region. Such persons take their independent decisions and therefore using such attributes in any attraction effort may involve moral suasion.

5.3 Critical Success Factors in Attracting and Retaining Doctors to the Upper West Region

Findings from this study show that several factors are critical in helping to brand the Region as an employer of choice to attract the adequate numbers and quality of doctors. Alongside these factors, key institutions and other stakeholders have also been identified to possess the necessary competencies in seeing through these factors to ensure that the Region is well branded as a destination of choice for employment for medical doctors. To give clarity and make them action focused, the critical success factors are presented per the institutions and stakeholders identified to hold the keys to their implementation. The study, however, found that sponsorship and bonding became a key factor seen by many respondents to require attention from nearly all stakeholders. It has therefore been isolated and discussed separately to avoid duplication. The success factors are therefore discussed as follows.

5.3.1 Ministry of Health (MoH)

Majority of the respondents in this study expressed the need for a clear national policy on rural and deprived area service in Ghana, if any meaningful headway has to be made in attracting and retaining medical doctors in deprived areas, including the Upper West Region (UWR). Such a policy, according to thirteen (81%) respondents, should clearly define which parts of the country are deprived and the appropriate incentive packages needed thereof. This includes factoring peculiarities of particular locations into remuneration instead of the current uniform salary system. A respondent intimated this as follows;

“A policy that will give them a clear picture of what will happen to them in their career development will really enhance [their attraction]. Then timelines of when to move and when not to move are well-defined. Money may not necessarily be the issue but people just want to feel secured about their future. When they are certain about what will happen in five years’ time, people don’t worry where they stay”

Respondents suggested, however that for any such policy to be effective, it should be district focused so that benefactors and beneficiaries can hold themselves accountable. The value of national policies on attraction and retention of health professionals to deprived areas has long been established (Goma et al., 2014; Wibulpolprasert & Pengpaiboon, 2003). This finding is also in sync with the dictates of employer branding which requires that there should be top management support with a clear brand team and strategy that will differentiate various employees at different levels and factor in their peculiarities, on the basis of equity and merit into their overall conditions of service (Mapolisa, 2014; Keller, 1993). Having a national policy will give clarity and build trust among parties. This is because roles will be determined and responsibilities assigned, thus making parties accountable to each other, and also presenting a common brand image in the job market.

Findings from this study also indicate that earmarked funding for the payment of remuneration of doctors who accept postings to the Region could greatly help. This would involve paying doctors, taking into account the staffing requirements of individual facilities and tying the money to it. It was suggested this could come in two forms. First, it could involve the payment of a percentage of the deficit number of doctors in the institution to those working there to cater for the excess workload that they are compelled to take up for the shortfall. This view is noted by a policy implementer as follows;

“If the hospital is supposed to have two doctors and there is one doctor doing all those things, I think a percentage of the second doctor’s salary should be paid to him and at least he would know that he is doing two or three people’s work and that he is also being paid for that”.

It was suggested therefore that a 50 to 70 per cent of the second person's salary to the one at post would be reasonable to compensate for the extra work being done. The second form involves the payment of the entire salary of the requisite number of doctors to the facility with clear performance targets so that the number of doctors present in the facility could share the money voted to that facility, regardless of their number, but would be held to account for non-performance. Proponents argued that if such a measure is stretched across the country, overstuffed facilities would be compelled to push out the excess staff to ensure the even distribution of doctors across the country, including the Upper West Region. A respondent described the second option as follows;

“The government [could] assess the complement personnel that you need for a particular facility and say ... [Hospital A] for instance you need a minimum of eight doctors, so here is the funding for eight doctors, use it and the targets are clear, your maternal mortality rate and other indices that will be used to show that you are really working. So I can easily go out and look for a colleague and say ... there is money for eight doctors here. Come, we are two and we can easily share that money”

Though the suggestion appears to be a novelty in the attraction and retention effort, implementation challenges may exist. In the first option, it is possible that the few doctors at post and willing to benefit from the excess money could collude to make it impossible for their colleagues to join. With the second option, where enforcement is weak, it is still possible that institutions that are capable of generating enough money to pay for additional doctors beyond their norm could still do that and thus defeat the essence of any such policy in ensuring fair distribution of doctors. This could however be averted if no option is given for institutions to employ beyond their norm. In the light of this therefore there have been calls for the development scientifically determined staffing norms and the enforcement of postings regulation to facilitate this. Promising as it may be, Osasona (2005) has cautioned the

overreliance on financial incentives as employer branding tools because they are only effective in the short term as compared to non-financial incentives.

5.3.2 Ghana Health Service (GHS)

Findings from this study indicate that a critical factor necessary to retain clinical doctors in the Region will be the availability of at least a specialist in each hospital in the Region to guarantee professional support for colleagues and boost their confidence. One of the eight (50%) respondents that proposed this stated as follows;

“All the other hospitals should at least have [a] specialist. So if Nandom has a gynaecologist may be Lawra should have a paediatrician, Jirapa could have an orthopaedic surgeon or internal medicines person in that way so that at the end of it all, the whole Region is covered. When that happens, if you post a young one he knows that he is coming to work under senior colleagues who will take responsibility for whatever happens or who will teach him and cover him up should there be any eventuality”.

To achieve this, it has been suggested that fellows of the various colleges could be promoted to consultants, if they accepted posting to the Region, without them going through the long years of post-qualification practice before getting promoted as consultants. The support offered by senior colleagues to doctors in deprived areas has featured in previous studies (Hatcher et al., 2014; Perkins et al., 2007). Though this may turn out to be effective, its singleton application may not work because that would only guarantee them their professional confidence and knowledge but not their welfare and those of their families. It is worth adding that this proposal agrees with earlier works on employer branding that suggested that consciously developing the competence of employees was a good employer brand that not only retained employees but attracted new applicants (Copenhagen Business School, 2009, cited in Sokro, 2012).

This study has also revealed that to deal with the concerns of education for children, Ghana Health Service could liaise with the Ghana Education Service at all levels to

ensure that dedicated model basic schools are established in the Region to cater for the educational needs of health professionals' children. They suggested that these schools could be developed from existing public schools and not necessarily building new ones by concentrating on one school in each location and providing it with the needed logistics, infrastructure and personnel. A respondent painted a picture of this model school as follows;

“Schools which have teachers who are really, really serious, who can give assignments to kids [and] mark them. When I came down that was the only difference I noticed. These kids are given a lot of assignments and they mark them. They will do the corrections. They even push parents to even sign the assignments and put dates that they have inspected the assignments. ... They will mark and it will come back to you, you will see it marked. In Wa they hardly bring home any assignment. They will sleep and sleep, wake up the following morning and go back to school”.

Respondents further suggested that to deal with quality issues in education, doctors could be assisted financially by their local institutions of work to take on private teachers and pay for extra classes for the children. Having a model school for children of health professionals in deprived areas could help attract and retain doctors. However, any such move, if not properly managed, could be resisted as it could be interpreted to mean the creation of a class society. This could alienate health professionals from their communities and thus create mistrust and hostilities that could lead to the withdrawal of community support for health professionals and their work.

5.3.3 Medical and Dental Council

This study has found further that the Medical and Dental Council as the regulator of medical education and practice in the country can influence the attraction and retention of doctors to the Upper West Region. Nine (56%) respondents in the study have suggested that to make it easier for doctors who accepted postings to the Region to pursue their career development without being disadvantaged, regulations

should be altered to make some concessions to them. First is to exempt them from writing the primaries and receive automatic admission due their inability to learn as a result of workload. Second, a model programme could be introduced with specialists visiting them in the Region and offering hands-on clinical skills and refresher trainings over a defined period of time such that when they are ready to move into specialisation, admission is guaranteed and they will not be required to take any exams. Third, the study showed that due to the level of experience acquired by doctors in the Region, from their extensive exposure to medical practice, the duration for postgraduate specialisation could be reduced by half for them. Fourth, others have argued that medical doctors who accept postings to the Region could be allowed to pursue ‘on-site’ specialisation where doctors will be working and studying at the same time. This they believed will keep doctors at post instead of working for a number of years and staying off work for some more years in postgraduate education. A respondent stated this as follows;

“Why then don’t they decentralise the training? Make sure that you have cases you can easily invite the consultant each month and you go through. Occasionally go for lectures at the College and finally you are working and specialising. It is done. Uganda is a very good country that has done that and produced a lot of specialists, very good specialists. So if that is done then you will be much comfortable staying where you are and specialising because it is the specialisation that takes most of us to the cities”.

It is believed that in doing so there would be extended retention as earlier found (Perkins et al., 2007). It must however be stated that if such a programme is introduced and the necessary checks are not put in place to ensure that doctors stay on after their specialisation the Region, it could be used as a training ground and the people may never benefit from their specialised skills on completion. Again given that doctors are already complaining of their inability to learn as a result of excessive workload it is unclear how they would now combine specialisation with the same

workload. Regardless of the anticipated bottlenecks in the implementation of these regulations, ensuring that employees do not stall at particular levels of knowledge and responsibility by offering them the opportunities for career growth and support to work towards the next level of responsibility (Pitts et al. (2011) are considered valuable attributes of a good employer. Therefore ensuring some regulatory flexibility to allow for this in the Region could present it as a destination of employment for doctors in the country.

Furthermore, findings from the study showed that nine respondents (56.25%) have proposed that, due to the depth of experience gained clinically in working in the Region, the Medical and Dental Council could vary the regulation on residency training and in collaboration with the various Colleges of medical specialisation, institute a rotation system that will require part two residents to mandatorily take up their residence in the Region, especially in surgery and obstetrics and gynaecology, for a limited period. They argued that would enable them acquire hands-on practical experience in the Region after their taught course whilst serving the people. This could also expose a lot more of them to the Region to help deal with the general misconception about it, and probably that could entice some of them to opt to stay afterwards. A former doctor respondent stated this as follows;

“Let’s send one [of] such doctors, two months to go and stay in the Upper West then after that you come back. ... You the doctor who is even going there you will even benefit more. You are going to get a lot of practice ... [and] this misconception thing will be taken away. ... You know that you are not going to be there forever ... Just for two months, everybody will want to go for that feel”.

Though the proposal may appear good to consider because it would make doctors available and also help them learn, it would require a lot of logistical support in terms of accommodation, finance and transportation for both students and their supervisors. Beneficiary institutions could however be made to take up such

logistical support since they would be generating income from such residents. Leaving it to any national or regional structures to fund could pose challenges.

5.3.4 Regional Director of Health Service (RDHS)

To deal with the shortage of specialists in the Regional Hospital to support doctors in the districts, this study has found that it is necessary for the Regional Director of Health Service to, in collaboration with the hospital, design a deliberate regional plan that will bring in blends of specialists on locum basis, in monthly successions. As one respondent put it this will ensure that; "... at any point in time we have specialists at the Regional Hospital so that even if you have one [doctor in the districts] ... they know that there is somebody there who will cover them up". Such an approach was earlier adopted in Vietnam and even legislated to make it mandatory (Witter et al., 2011).

Again, evidence from this research indicates that the introduction of a system of 'baiting locum' could help in getting more doctors into the Region. 'Baiting locum' is where newly qualified doctors will be 'physically hunted' by a regional team, led by the Regional Director of Health Service, and offered a one month locum service immediately following their graduation so that they would use that opportunity to familiarise themselves with the Region and decide afterwards. A respondent said the following of the finding;

"If it means going to Tamale Teaching Hospital, all of you when you finish we give you locum for one month, you come and work in our facility for one month and come and familiarise yourself for a month. If after one month you think that you are not satisfied with the things [you] have seen and you want to go back, then you can go back."

Proponents of this view argued that such an initiative could also help in the effort at marketing the Region and clearing the misconceptions about it. Though the proposal appears to be one of the novelties in the study, implementing it will require that the

needed incentives and support systems are well organised because as earlier observed by Somers and Strasser (2002), with rural rotation for medical trainees, a first time bad impression could prove more detrimental to their future decisions for rural service. In spite of the above, marketing the brand promise is a key step towards branding an organisation as an employer of choice but this can be actualised if there is a clear concept of the brand promise incorporated in the working culture of the health system of the Region (Backhaus & Tikoo, 2004).

The study further revealed that doctors in the Region were not quite enthused about the attention paid to their work and welfare. They intimated the neglect and lack of concern for what they do. One respondent thus reported; “Professionally even the Regional Director doesn’t even know you exist. Ones they come and dump you there everybody forgets about you”. They have therefore indicated that to encourage and motivate doctors to stay and also help send good signals about the Region to attract others, it was important that some attention is given them by the Regional Director.

A doctor respondent asserted thus;

“The Regional Director has to ... oversee that the doctors are happy. ... He can give you a call, doctor I know you are here [and] you are doing a good [job]. That’s all. That makes you know that the Regional Director knows about you And then they should try to listen to the doctors when they are telling them certain things.”

In furtherance of the welfare of medical doctors in the Region, this study found also that there was the need to have a well-coordinated orientation programme for all newly posted doctors so that the peculiarities of the Region including all privileges, opportunities and responsibilities are laid bare to them. Support from the regional health departments as a tool in keeping doctors in deprived areas has long been established (Leonardia et al., 2012) and Sokro (2012, p.169) describes this support as “good will”, making people feel valued (Conference Board, 2001), a quality of a well

branded employer that will make employees opt for them. What was intriguing about this concern from doctors in the Region was the fact that there is an elaborate structure at the regional level with a deputy director solely in-charge of clinical care who is required to pay regular visits to the facilities in the Region. Why doctors should be complaining of neglect despite all these structures is a matter deserving of consideration.

5.3.5 Institutional managers

This study further found that there was the need for institutional managers to demonstrate real leadership in receiving and managing doctors at the facility level, particularly in checking the attitudes of other staff towards doctors. Six (38%) of the respondents who proposed this posited that some doctors have left the Region, not on account of anything but the attitudes of some staff, particularly those in management. By checking such negative attitudes, a doctor respondent stated that it will ensure that;

“People don’t just talk any how about the doctor on any issue that they don’t understand; the culture [should be] such that we are welcoming. Not that there are not issues but when they come we should know how we handle them because some doctors leave just because of how people talk, the behaviour of one manager or the other ... You realise that it has nothing to do with the financial, it’s just the behaviour of key staff or management people of a particular hospital”.

The above view points to the fact that doctors in the Region cherished both formal and informal relationships that existed between them, their management and colleagues at work. Therefore any behaviour that tends to jeopardise that could cause disaffection and thus affect their decisions about rural service. Previous studies have equally established this fact elsewhere (Ebuehi & Campbell, 2011; Richards et al., 2005). But to be an employer of choice, Berthon et al. (2005) have argued that such people practices must be ruthlessly aligned to buttress and strengthen the brand

promise. However, according to Ewing et al. (2002), is possible when employees are fully integrated into the process to building the brand image.

Beside the above, the study also pointed out that institutional managers have a responsibility, according to findings from this study, to lobby their district assemblies to take steps to get doctors for their respective hospitals. Respondents indicated that every assembly had a responsibility of ensuring and guaranteeing the health of its residents whilst managements of the hospitals were mandated to ensure the availability of both material and human resources in providing such quality health care. Therefore dealing with the shortage of doctors in any hospital in the Region should be the joint responsibility of the two institutions because, as noted below by a serving doctor;

“You are measured by the quality of care in the hospital and as management, you are there and there is no doctor and you are there. Even people will question the kind of management you are. You may have to look for the doctors and discuss with the DCE[i.e. District Chief Executive]) that we don't have doctors, we need one or two doctors, this is where we can get them, then [the] rest will all come together and say this is what we can all put together to keep the doctor”

Respondents argued further that because most institutional managers have failed to involve the assemblies to even appreciate the enormity of the problem and its consequences for the few doctors and the health of the populace, most assemblies have come to assume that the lone or few doctors are adequate and capable. Therefore, raising the consciousness of institutional managers to this fact could prove helpful, particularly where the assemblies are in the known that they have such a responsibility. This proposal for partnership with the assemblies agrees with Mapolisa's (2014) view that good employers explore partnership to the benefit of their employees.

5.3.6 Serving doctors

This study has found that whilst all the efforts by other stakeholders are towards attracting and retaining doctors to the Region, doctor respondents did not leave themselves out as stakeholders in ensuring that more of their colleagues joined them. They believed that what they said when they met, particularly their younger graduating colleagues, had an effect on their willingness to come to the Region. As stated by a doctor respondent; “Sometimes when you go out and you hear comments some of our colleagues make about the Region, it’s a little bit demoralising”. Serving doctors therefore admit that they had an advocacy role to play in getting others to join them but they acknowledge also that their individual efforts would not yield much in the absence of any policy on working in the Region. The acknowledgement by serving doctors that they have a role to play supports the argument by Ewing et al. (2002) that in the development of brand image, employees play a very vital role. They do this if they are able to sustain the image organization that attracted them through their stay. This advocacy will also be much stronger where serving doctors and their families are treated well and they feel committed to their communities (Mayo & Mathews, 2006; Richards et al., 2005)

5.3.7 Indigenous Doctors outside the Region

This research has made revelations that medical specialists who hail from the Region but are working elsewhere could play a fundamental role in alleviating the precarious shortage of doctors in the Region. Proponents of this view contended that the Regional Coordinating Council and the Regional Health Administration (RHA) could collaborate to rally these diaspora indigenous doctors to form an association and come on monthly outreaches in blends of specialties, using their

annual leaves in a sequential and programmed manner, to ensure that all year round they visited the Region to offer medical services. One of such advocates stated it as follows;

“The specialists from the Region should form an association and organise themselves into groups of specialisations, that will cover all the fields, so that it can be arranged in such a way that they take their annual leaves in succession ... [and] have a programme to serve the Region with their annual leaves”

It should be indicated, however that this initiative could be made more effective if these doctors do not serve in their districts of origin so as to take away the fear of dependents. Indeed it could start by limiting it to the Regional Hospital and gradually scaled up. To make it more attractive for such doctors, their coming should be treated as locum to be paid for by the facilities in which they work and not as free services.

5.3.8 Regional Coordinating Council

This study has revealed that for any meaningful effort to be made at the regional level, the Regional Coordinating Council as the umbrella body of all the districts in the Region should lead a process to develop a comprehensive regional incentive package, attractive enough to retain doctors already in the Region and also help attract new ones. They suggested that this could be done by bringing all assemblies and stakeholders together to explore new and more viable options and also harmonise all existing initiatives to avoid duplications. Participants further stated that such a policy could be pursued even beyond the Region to affect national policy decisions that will favour the Region for this peculiar challenge. A study respondent posited this as follows;

“... If there are some packages in place in the Region, it might not necessarily be monetary policy, it can be a number of them for doctors to enjoy here that other doctors somewhere are not getting, it will encourage a lot of them to come ... The Regional Minister should meet the Minister of Health,

maybe with the Minister of Finance and they agree that for this particular region because we want to attract doctors there, let's give them this. You know that is not what is going on in other places, but we have a reason for doing that. Some form of preferential treatment"

In view of the high level decisions involved in some of these initiatives, respondents have proposed that the Regional Coordinating Council (RCC) should involve political leaders from the Region to gain their support and also use their influence to facilitate the process of getting these decisions through at all levels. Respondents argued that such a move will let them claim ownership and follow through the final policies. Regionalised policies on attraction and retention are well known to literature in this field (Bocoum et al., 2014; Press, 1998). For them to succeed, however, the Regional Coordinating Council could help secure the commitment of all the assemblies towards such a policy but leave its development to the Regional Health Administration, the assemblies and hospital managers so that there is local ownership with accountability to the Regional Coordinating Council. Better still, the RCC should secure broad political consensus, if that is possible, because the influence of politicians on rural postings has long been recognized by previous researchers (Ramani et al., 2013). The above factor reflects coherence in strategy and focus, attributes necessary for employer branding, because as Keller (1993) pointed out, to brand properly would require the support of top management with a structured approach that includes building a brand team that is all encompassing of creative staff and partners with responsibility for the strategic direction of the organization, best done in a decentralized decision making and reward systems (Bretz et al., 1989).

Additionally, this study has revealed that doctors in the Region placed value on the level of appreciation shown for their work and therefore a necessary factor to exploit to ensure their longer stay in the Region and probably attract more. For

some doctors as long as they were appreciated they were prepared to stay whilst others would continue to reminisce the kind of appreciation, respect and support they have received from the community and clients long after they have left. As one serving doctor respondent put it;

“You stay as long as you feel appreciated. If people get up one day and think that you have outlived your usefulness, it means that you should start thinking [of leaving] but so long as they still think that they need your services, I think I will be willing to offer my services”.

Some respondents have however argued that appreciation should not be by word of mouth but must be demonstrated materially. A former doctor explained such a position;

“Appreciation should come with a demonstration, not just mouth. For the period I stayed in [that District], I never bought a goat. I hardly bought foodstuffs. ... People were very generous. You see the generosity and it’s like, look at the little I did and look at how they are showing that love. Not money but you see that this is what they have”.

Cognizant of the above, respondents have suggested that the Regional Coordinating Council, Regional Health Administration and District Assemblies should jointly institute an annual award system to recognise the contribution of health professionals in the Region. These awards it was suggested could be in the form of “certificates, and perhaps some token of money to support them”, a community actor stated. It should, however, be added that if such awards are not made transparently competitive and valuable, their essence could be lost in no time or even create dissatisfaction and disconnect for the Region. It is also instructive to add that appreciation from individual community members, particularly clients, was highly talked about by doctor respondents and some indeed attributed their continuous stay to that factor. However, using this factor as a deliberate strategy is quite tricky and should be watched because appreciation must be voluntary and not coercive. If it is extracted it could turn into sycophantic cacophony and therefore lose its value. In

consonance with the foregoing, the value of recognition and appreciation of employees for what they do has come up strongly in the employer branding literature as good attributes worth pursuing (Sokro, 2012). What is critical though is how such recognition and appreciation should be structured to make the Upper West Health Service attractive and make the Region a place of choice for prospective health professionals, especially doctors.

5.3.9 District Assemblies

This study has shown that health facilities that are hit by critical shortages of medical doctors are located in the Municipality and the Districts in in the Region and therefore they have a responsibility in ensuring that doctors are attracted there and retained. First, though most respondents admitted that some forms of salary top-ups were being paid by health facilities to doctors in addition to the Regional Coordinating Council's directed allowance in some districts, it would be important that District Assemblies took up the responsibility of paying enhanced salary top-ups, found dedicated and reliable sources of funds for them and be committed to their payment to doctors in their respective districts. Respondents argued that such enhanced payments will not only be an appreciation to doctors in such districts but also serve as financial compensation for the things that they have denied themselves of in coming to the Region. It has further been argued that the essence of salary top-ups should not be lost on anyone because doctors in endowed areas were always ready to come to the Region as locum for money but were not ready to stay; "what it means is that they can stay in the Region but it's just because there is nothing to add up to their salaries", stated a serving doctor respondent. Yet significant others have contended that salary top-ups were not only gestures aimed at getting doctors to the

districts but also tools of accountability for the people and the assembly to hold doctors to. A former doctor elaborated this view as follows;

“In fact if I were government I will tell the District Assemblies to raise that money to top up. ... They can generate from their IGF. And in fact they will be stakeholders because they will then guarantee and make sure the doctors work because you are paying that money”.

This finding on the value of salary top-ups in rural service for health professionals is akin to earlier ones by other researchers (Goma et al., 2014; Adzei & Atinga, 2012). Throughout this work the relevance of financial incentives has not been lost on any respondent. For most of them enough financial compensation was capable of dealing with many of the other challenges associated with working in the Region. The use of monetary incentives as tools for employer branding has, however, been found to have short term value and therefore may have to be adopted with caution.

Findings from this study also suggest that District Assemblies in the Region needed to develop their individual incentive packages, peculiar to their districts by rallying all stakeholders (i.e. Members of Parliament, chiefs and other opinion leaders) to gain their commitment and support for any such initiatives. They argued that having such packages would recognise district specific challenges and therefore empower them to actively move out to recruit themselves. They stressed that most doctors would be comfortable with such arrangements because those to hold responsible, if anything went wrong would be within their reach. A respondent offered a justification for the need for the assemblies to lead the recruitment crusade;

“The assemblies should actively take up the initiative in advocating and going round to recruit doctors. I think sometimes when they see people who are going to be in the district coming to tell them that, ... if you come we will make your life comfortable [and] we will do this, at the end of the month if you are not getting anything you will see the person and so you know who to hold but if it's coming from Regional Director or those big wigs or the Minister, at the end of the month you know the person, you can't hold him. ... I think once we begin doing that, they will take responsibility for their own health care”.

The direct role of the assemblies in the recruitment drive could prove potent because the source of attraction is known to the doctor and therefore he can squarely place the praise or blame where it should be and not complain without direction. It is in this vein that good employer branding practice requires that decision making and reward systems about attraction and retention should be decentralised (Bretz et al., 1989) so that responsibility can best be assigned and accountability demanded.

5.3.10 Traditional and Religious Leaders of Host Communities

This study has identified both traditional and religious leaders of host communities of health facilities in the Region to also have some roles in the effort at getting doctors to the Upper West Region. Majority of respondents (56.25%) intimated that communities that portrayed themselves as violent and unsecured could not attract doctors. This view is expressed by a policy maker below;

“The community, their demeanour, are they receptive or their attitude is such that they repel? ... Where they are always involved in fighting, you can have everything, but people will not like to go there and in that instance it is not about the salary, it’s about the community”.

Respondents have therefore advocated that for doctors to be attracted to and retained in the Region, their safety and protection have to be guaranteed by community members and leadership. They should also show interest in the work of doctors so as to give them the confidence they have their support. This finding agrees with earlier researchers on the essence of security for doctors in deprived areas (Ramani et al., 2013; Smith, 2005). It is worth adding that no matter the incentives put in place to attract doctors to the Region, security will remain paramount for them. How secured the doctor feels at work and in his interaction with the community may determine his effectiveness and ultimately the decision to come, stay or leave. Sokro (2012) has suggested for instance that making employees feel psychologically secured in their work environment is mark of a good employer brand. Therefore any effort from any

quarters that reinforces that sense of security in doctors in the Region would be a plus towards making the Region a destination of choice for doctors.

Additionally, the study revealed that opinion leaders of host communities could also lead the crusade in their communities to educate the natives, especially the youth, on their overreliance on their relations who are doctors, their lack of respect for them and threats with superstition, which deterred indigenous doctors from working in the Region. To further this initiative, some have proposed that other institutions such as the National Commission for Civic Education (NCCE) in the various districts could be co-opted to assist. Community leadership's role in this education may be possible not only in changing attitudes but also help in integrating doctors into the community.

Lastly, the study has revealed that traditional and religious leaders have a responsibility to work assiduously to bring down the effects of superstition and cultural beliefs that hindered indigenous doctors from working in the Region. As a serving doctor respondent stated "Our traditional leaders will have to take the lead because it's tradition. ... They have to make the beliefs friendly and even put fear in somebody who might be thinking that way". It is, however, unclear how traditional leaders will work to reduce cultural beliefs, in particular, when they also have an obligation to their people to uphold same for posterity, the reason for which they are leaders.

5.3.11 Sponsorship and Bonding

Sponsorship and bonding has been identified to require the attention of several stakeholders and therefore its isolation for special treatment to avoid duplication of discussion. This study has found that to attract and retain medical doctors longer in the Region, sponsorship and bonding should be pursued as a viable option by the

Ministry of Health (MoH), Ghana Health Service and the District Assemblies. At the ministerial level, it has been suggested that the abolished foreign postgraduate specialisation programme, hitherto financed by the Ministry of Health, for doctors who took up appointments to the Region should be reintroduced because it was effective. Indeed two out of the three former doctor respondents who were beneficiaries, indicated it was the sole reason for their coming to the Region. Responding to these concerns, however, a policy maker indicated that the scheme was stopped because it served as a conduit for doctors to emigrate because most doctors who benefitted from such a scheme in the past never returned to the country;

“Between 1998 and 2003... we experienced high international migration of our skilled professionals and one of the attributes was this scheme. When they get scholarship abroad [and] they acquire the skill, they don't come back Others even pay off because by then they have better offers. So government, to stem that problem, decided to establish the Ghana College of Physicians and Surgeons. So that you have the facility locally made which is internationally recognised. Go there and train and you are retained”

On the part of Ghana Health Service (GHS), respondents have suggested that its recently introduced specialisation sponsorship scheme should be expanded into a full scholarship scheme to cover every expense and that could make it more attractive in getting other doctors move to the Region. A serving doctor respondent stated this position as follows;

“Those in Upper West they should let us have full sponsorship. If you know [when] you work in the Upper West you are going to get full sponsorship ... it will be a good thing to let some people who have [the] desire to specialise and thinking that they have limited resources, [to] run here”.

For District Assemblies, however, this study has found that not only are they expected to support in the sponsorship of doctors for specialisation, they have been encouraged to also sponsor and bond undergraduate doctor trainees to serve those districts on completion. They further argued that such sponsorship could focus on interested persons and not necessarily indigenous students. Some have even

suggested that assemblies could explore the fee paying models available in medical schools, since it was difficult obtaining admission these days, in order to be able to train the required numbers in a consistent manner. Because of the longevity of medical education, respondents advised that proper documentation should be done on such sponsorship schemes so that, as posited by one doctor respondent;

“I should be able to have documents to present [to] my successors so that they will follow up. I heard some people say we sponsored this person in medical school but he refused to come. You helped the person and was there any bonding? Did they even follow up?”

Sponsorship by both local and national authorities is a known phenomenon to researchers in this field (Thammatacharee et al., 2013; Matsumoto et al., 2008). It is worth noting, however, that in the instance of Ministry of Health the concerns of emigration notwithstanding, if such a strategy was solely attractive enough, as attested to by beneficiaries, it is still possible to run it and tighten the loose ends not to allow them stay beyond their period of learning. In the instance of district assemblies, though the bonding in itself may be a good enough strategy, it could be more effective if district assemblies backed them with other incentive packages.

CHAPTER SIX

SUMMARY, PROSPECTS, CHALLENGES, THE WAY FORWARD AND CONCLUSIONS

6.0 Introduction

In this Chapter the summary, prospects, challenges and the way forward on the attraction and retention of medical doctors to the Upper West Region are presented. Some conclusions would also be drawn from the findings of this study with appropriate recommendations for practice and research.

6.1 Summary

The summary would be done along the lines of the four objectives of this study. These are to examine the reasons for the unwillingness of medical doctors to accept postings to and remain in the Upper West Region, identify specific initiatives taken by the Ministry of Health and other health-related partners to attract and retain medical doctors to the Region, assess the effectiveness of the interventions of stakeholders to attract and retain medical doctors to the Region, and identify critical success factors in the attraction and retention of medical doctors to the Region. Reasons for the unwillingness to accept postings to the Region include inadequate formative training for doctors, limited financial inducements, high dependency and superstition for indigenous doctors and the leadership weakness in the Region in rising to up the challenge of branding the Region as a destination of choice for employment in the country.

Key institutions identified in this study to have taken some form of action towards attracting doctors to the Upper West Region are the Ghana Health Service (GHS), the Regional Coordinating Council (RCC) and the District Assemblies. For GHS, its key initiatives include directives for institutional sponsorship for postgraduate

specialisation and salary top-ups and the declaration of vacancies. The effectiveness of these measures could not however be established because they were all less than a year in operation as at the time of the study. For the RCC, directives for free accommodation and utilities, salary top-ups and sponsorship to the assemblies were its key initiatives. These measures were however considered ineffective because none or a combination of them constituted the basis of any doctor that relocated to the Region. A medium term plan to build accommodation for doctors over the next five years was the initiative mentioned by respondents from the assemblies but considering that free accommodation and utilities already being provided are not making the needed impact, its effect might be negligible.

6.1.1 Critical Success Factors for Attracting and Retaining Medical Doctors to the Region

Factors found by this study to be critical in branding the Region as an employer of choice to attract and retain medical doctors are summarised in accordance with the stakeholders with the authority to execute them. For the Ministry of Health, the study suggests that the critical things it ought to do attract and retain doctors in deprived areas, particularly the Upper West Region include; developing a comprehensive national policy framework on deprived area work, earmarking remuneration to institutions, reforming the health sector salary regime to take into account the peculiarities of different locations of the country, and reactivating and reforming the foreign specialisation programme in exchange for service in the Region. On the part of Ghana Health Service, the study proposes that it should expand the current institutional sponsorship package into a full scholarship programme.

Whilst the Medical and Dental Council is expected to make concessions for postgraduate specialisation to doctors who accept postings to the Region, the study

suggests that the Regional Director of Health Service ensures effective reception and orientation for newly posted doctors, and as well pay attention to the work and welfare of the doctors in the Region. On the part of the Regional Coordinating Council and the District Assemblies, their critical contribution for success, respectively, are the rallying of regional stakeholders to develop a regional incentive package, and the payment of salary top-ups and sponsorship. Lobbying Assemblies for support in sourcing and caring for doctors was seen as critical for institutional managers. Lastly, for traditional and religious leaders, theirs is to work to guarantee the peace and security of community members, particular doctors whilst also working assiduously to reduce superstition and cultural beliefs that deterred indigenous doctors from home, all these in an effort to present a brand image that is attractive enough to make the Region a destination of choice to the employment of doctors in Ghana.

6.2 Prospects

In the course of this study, it was realised that there were still opportunities to deal with the challenge of attracting doctors to and retaining them in the Upper West Region. First, there appeared to be a sense of awareness of the challenge among the various stakeholders and the realisation that something ought to be done about it. That awareness and zeal would be rallied for a common front and action to rebrand or reposition the Region as a region of choice for employment for doctors. Second, there seemed to be a lot of hope in the measure taken by the Ghana Health Service to declare vacancies in the Region as a basis for appointment of doctors into public service. If properly implemented and enforced, it could do a great deal of good to the challenge. Third, sponsorship and bonding of both graduate and postgraduate doctors, particularly by the District Assemblies and the hospitals also promises to be

a good strategy if well-coordinated, funded and implemented. This is because the two institutions are direct beneficiaries and therefore would track down any such persons sponsored to serve the bond.

6.3 Challenges

Two key challenges stood out in this study. First is the leadership challenge. Though the consciousness appears to exist about the challenge, which person or institution to rise and take up the leadership mantle lacking. There therefore appears to be person or institution that is forcefully rallying others round to push the agenda. The second challenge has to do with the source of funding for any such initiative. This study has shown that there are at least five financial initiatives, three by the Ghana Health Service and two by the Regional Coordinating Council and District Assemblies but the sources of financing appeared unsustainable and less efficient in making the needed drive that will brand the Region as an employer of choice for doctors that will provide a benefit package and compensation that is overall attractive.

6.4 Recommendations

For the Region to rebrand and attract the needed numbers and qualifications across the various fields of medicine, the single most important thing would be to have proper coordination and collaboration among all the stakeholders, and not the seeming disjointed efforts being made without recourse to each other. And that makes the role of leadership key in all of these, particularly from the Ministry of Health and the Regional Coordinating Council. In the light of the above therefore, the following are recommended:

a. The Ministry of Health

- i. It is recommended to the Ministry of Health that urgent steps ought to be taken to develop a comprehensive national framework on deprived area service for

health workers that clearly defines which areas are deprived and what incentive packages are possible by all stakeholders.

- ii. The Ministry should champion a course with the Ministry of Education and the Medical and Dental Council to refashion the curricula for medical training to be more rural focused to expose trainees to rural settings and also allow for concessions in admission into specialisations for doctors in the Region
- iii. The Ministry should also push for the introduction and enforcement of a mandatory rural service for all newly qualified doctors for at least two years to help build their skills and confidence for specialisation before they are registered by the Medical and Dental Council.
- iv. The Ministry should take steps to review and develop a new staffing norm that will serve as a basis for the postings of doctors and also as a foundation for the earmarked emolument payment.
- v. The Ministry should reform its salary administration regime to reflect the peculiarities of the various parts of the country.
- vi. Lastly, is it recommended that the Ministry considers the reintroduction of the foreign specialisation scholarship in exchange for a period of service in the Region

b. Ghana Health Service

- i. This study recommends that Ghana Health Service should use its vacancy declaration programme to post specialists to the Upper West Regional Hospital to provide backing to doctors in the districts in the interim whilst considering same for the district hospitals in the medium term.

- ii. Ghana Health Service should expand its institutional sponsorship scheme into a full scholarship to make it much more attractive by providing additional sources of funding beyond the hospitals.

c. The Regional Coordinating Council

- i. This study recommends that the Regional Minister, through the Regional Coordinating Council should lead the rebranding effort by ensuring the development of a regional employer brand concept that captures the value propositions of the Region by rallying all stakeholders for the purpose.
- ii. The Regional Minister should also lead a process that will ensure the formation of the Upper West Regional Diaspora Doctors' Association that will bring home indigenes outside the Region to assist on regular basis.

d. Regional Health Administration

- i. This study recommends that the Regional Director of Health Services (RDHS) should liaise with the Regional Minister and push for the convening of the regional forum of stakeholders to discuss and fashion a regional branding strategy and market it.
- ii. The Regional Director of Health Services should put together a comprehensive programme of orientation for newly posted doctors that encompasses the prospects and challenges of working in the Region so as to facilitate smoother transitions into the Region's brand and their working lives in the Region.
- iii. The Regional Director of Health Services should also ensure that there is proper periodic monitoring and supportive visits to the hospitals in the Region by a dedicated team led by himself or the Deputy Director Clinical Care, to give technical and moral support to doctors to remove the feeling of being dumped.

- iv. The Regional Director should further develop, in consultation with the hospitals, a regional plan that will bring in specialists on locum in succession and also institute a 'baiting' locum system to get newly qualified doctors in the Region.
- v. Lastly, to deal with the challenge of distance raised by some respondents, it is recommended to the RDHS to consider dedicating a strong and decent vehicle at the regional level solely for the travel of doctors from other regions on a well-planned schedule to be fuelled by facilities as and when they have to travel.

a. District Assemblies

- i. The Assemblies should in collaboration with the hospitals find and pay for locum doctors as a stop gap measure whilst pursuing the more permanent solution of sponsoring and bonding.
- ii. It is recommended that Assemblies in the Region must take charge of the health of their people by ensuring that doctors, graduate and postgraduate, are pursued and convinced to be sponsored and bonded to serve on completion.
- iii. District Assemblies should in consultation with hospital managements discuss and agree on a decent salary top-ups for doctors

e. Institutional Managers

- i. It is recommended by this study that hospital managers in the Region should ensure that they liaise with their assemblies to find and pay for locum services as interim measures.
- ii. They should also pay attention to concerns of poor support services in the areas of accommodation maintenance and general welfare matters.

6.5 Research Limitations and Future Research

The outcome of this study has shed a lot of light on the attraction and retention of medical doctors to the Upper West Region. However, the study was not without

limitations. First the research adopted the single case study design and therefore its findings may have been influenced by the peculiar political, economic and socio-cultural circumstances of the Upper West Region. Therefore generalising or seeking to apply findings from this work may have to done with caution or further probe. It may thus be necessary for a multiple case study on the phenomenon so as to broaden the scope of evidence in the area.

Also, the research did not consider the individual characteristics of the respondents, particularly the doctor respondents in the study. It therefore did not allow for an understanding of the individual characteristics that informed their decisions to come to the Region or leave it. It might therefore be important that further studies are done in this area.

Additionally, though the study was informed by the critical shortage of medical doctors in the Upper West Region, it did not consider the effects of that shortage on health care delivery in the Region. A study into this area would be critical.

Lastly, the purposive selection of the respondents for this study may learn this study to some biases of the researcher and therefore skew the evidence from it. Therefore any future study in this area may want to engage other forms of techniques in the selection of the sample.

CONCLUSION

This study sought to understand the challenges associated with the attraction and retention of medical doctors to the Upper West Region. Using the Equity Theory framework and Employer Branding concept, four objectives were pursued in this study; first, examine the reasons for the unwillingness of medical doctors to accept postings to and remain in the Upper West Region; second, identify specific initiatives taken by the Ministry of Health and other health-related partners to attract and retain medical doctors to the Region; third, assess the effectiveness of the interventions of stakeholders to attract and retain medical doctors to the Region, and; fourth, identify critical success factors in the attraction and retention of medical doctors to the Region.

The outcome of this study has contributed greatly towards the achievement of its objectives. It has helped in establishing that inadequate medical training, limited financial inducements, lack of orientation or induction, high dependency rate, and superstition and cultural beliefs are some of the reasons for the unwillingness of medical doctors in taking up appointments to the Region. Also, the study has facilitated the identification of the key partners that critical roles in creating the desired brand image for the Region. These partners transcend policy, implementation and community levels. Again, the study has brought to light some of the initiatives taken by various stakeholders such as the Ghana Health Service, Regional Coordinating Council and district assemblies in seeking to brand the Region to attract and retain doctors. These initiatives include sponsorship and bonding, salary top-ups, and vacancy declaration. Though some of these initiatives have shown promise, they have not in their singleton or combined application generated the needed response required to close the gap in the doctor/population

ratio in the Region. This is because they do not offer the brand promise and image as an employer of choice due to incoherence in the response approach.

For any meaningful headway to be made in this endeavour therefore, a clear, coordinated and coherent national policy backed by regional and district strategies, concessions for postgraduate medical specialisation, aggressive sponsorship schemes, and the dilution of superstition and negative cultural beliefs would be necessary in positioning the Region as the destination for employment. But as it stands it may be safe to say that though there are semblances of the qualities of a good employer brand such as opportunities for career development, decentralised decision making and reward system, and top management support, the Region lacks the needed leadership that will create a brand promise and good will that offers what is in stock for current and expectant employees to make it the employer of choice for doctors in the country.

This study has, however, made some contributions to the area of employee attraction and retention in deprived areas. First, it has brought to light contextual knowledge in the area of study. It thus made it possible to know that weak leadership, and superstition and cultural beliefs for instance affect brand image in seeking to attract and retain medical doctors in some parts of the country. Also, it has also offered the opportunity to apply the concept of Employer Branding in the attraction and retention of health professionals, particularly medical doctors, in a deprived areas lie the Upper West Region.

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APPENDICES

APPENDIX A

ATTRACTION AND RETENTION OF MEDICAL DOCTORS TO THE UPPER WEST REGION: AN ASSESSMENT OF THE PROSPECTS AND CHALLENGES

INTERVIEW GUIDE FOR DIRECTORS OF HR AT MINISTRY OF HEALTH AND GHANA HEALTH SERVICE

The researcher is a Master of Philosophy (M. Phil) student in Public Administration at the University of Ghana Business School, Legon. The researcher seeks to assess the prospects and challenges of attracting and retaining medical doctors in deprived areas in Ghana with specific reference to the Upper West Region. This is in partial fulfilment of the requirements leading to the award of a master of philosophy degree in public administration. The information you provide shall be used purposely for academic purposes and shall be treated with absolute confidentiality. Your cooperation and assistance will be very much appreciated.

***NB:** Participation is voluntary and you may decline to answer any questions deemed uncomfortable or withdraw from the entire interview at any point in time*

Background Information

Date of Interview.....

Interviewee Code.....

Institution

Gender: Male Female

OBJECTIVE ONE: Examine the reasons for the unwillingness of medical doctors to accept postings to and remain in the Upper West Region

- a. What do you think are the reasons medical doctors are unwilling to accept postings to and remain in the Upper West Region?
- b. Why do doctors want to remain only in the urban areas of Ghana?

OBJECTIVE TWO: Identify the specific initiatives taken by the MoH, other health-related partner organisations to attract and retain medical doctors in the Region.

- a. What key institutions have a direct role to play in attracting and retaining medical officers to the UWR?
- b. Which other stakeholders have a role to play in attracting and retaining medical officers to the UWR?

- c. What are the specific roles of the parties (institutions and other stakeholders) in attracting and retaining doctors to the Region?
- d. What specific policy initiatives have been or are being taken by the Ministry of Health to attract and retain medical doctors to the UWR?
- e. What specific policy initiatives have been or are being taken by other health- related partners to attract and retain medical doctors to the Region?
- f. What organisational factors hinder or prevent doctors from taking up postings in the Region?

OBJECTIVE THREE: Assess the effectiveness of the interventions by the stakeholders to attract and retain medical doctors in the Region.

- a. How effective are the current policies in attracting and retaining medical doctors to the UWR?
- b. What can be done to make these policies work more effectively?

OBJECTIVE FOUR: Identify critical success factors in the attraction and retention of medical doctors in the Region

- a. What policies may be fair and equitable in attracting and retaining medical doctors to the Region?
- b. What preparatory measures are in place to receive doctors to the UWR?

THANK YOU FOR THE TIME AND SUPPORT

APPENDIX B

**ATTRACTION AND RETENTION OF MEDICAL DOCTORS TO THE
UPPER WEST REGION: AN ASSESSMENT OF THE PROSPECTS AND
CHALLENGES**

INTERVIEW GUIDE FOR REGIONAL COORDINATING DIRECTOR

*The researcher is a Master of Philosophy (M. Phil) student in Public Administration at the University of Ghana Business School, Legon. The researcher seeks **to assess the prospects and challenges of attracting and retaining medical doctors in deprived areas in Ghana with specific reference to the Upper West Region.** This is in partial fulfilment of the requirements leading to the award of a master of philosophy degree in public administration. The information you provide shall be used purposely for academic purposes and shall be treated with absolute confidentiality. Your cooperation and assistance will be very much appreciated.*

***NB:** Participation is voluntary and you may decline to answer any questions deemed uncomfortable or withdraw from the entire interview at any point in time*

Background Information

Date of Interview.....

Interviewee Code.....

Institution

Gender: Male Female

OBJECTIVE ONE: Examine the reasons for the unwillingness of medical doctors to accept postings to and remain in the Upper West Region

- a. What do you think are the reasons medical doctors are unwilling to accept postings to and remain in the Upper West Region?
- b. Why do doctors want to remain only in the urban areas of Ghana?

OBJECTIVE TWO: Identify the specific initiatives taken by the MoH, other health-related partner organisations to attract and retain medical doctors in the Region.

- a. What key institutions have a direct role to play in attracting and retaining medical officers to the UWR?
- b. Which other stakeholders have a role to play in attracting and retaining medical officers to the UWR?
- c. What are the specific roles of the parties (institutions and other stakeholders) in attracting and retaining doctors to the Region?

- d. What policies initiatives have been taken by the Regional Coordinating Council (RCC) to attract and retain medical doctors to the UWR?

OBJECTIVE THREE: Assess the effectiveness of the interventions by the stakeholders to attract and retain medical doctors to the Region.

- a. How effective are the current policies in attracting and retaining medical doctors to the UWR?
- b. What can be done to make these policies work more effectively?

OBJECTIVE FOUR: Identify critical success factors in the attraction and retention of medical doctors in the Region

- a. What policies may be fair and equitable in attracting and retaining medical doctors to the Region?
- b. What preparatory measures are in place to receive doctors to the UWR?

THANK YOU FOR THE TIME AND SUPPORT

APPENDIX C

**ATTRACTION AND RETENTION OF MEDICAL DOCTORS TO THE
UPPER WEST REGION: AN ASSESSMENT OF THE PROSPECTS AND
CHALLENGES**

INTERVIEW GUIDE FOR REGIONAL DIRECTOR OF HEALTH SERVICE

The researcher is a Master of Philosophy (M. Phil) student in Public Administration at the University of Ghana Business School, Legon. The researcher seeks to assess the prospects and challenges of attracting and retaining medical doctors in deprived areas in Ghana with specific reference to the Upper West Region. This is in partial fulfilment of the requirements leading to the award of a master of philosophy degree in public administration. The information you provide shall be used purposely for academic purposes and shall be treated with absolute confidentiality. Your cooperation and assistance will be very much appreciated.

***NB:** Participation is voluntary and you may decline to answer any questions deemed uncomfortable or withdraw from the entire interview at any point in time*

Background Information

Date of Interview.....

Interviewee Code.....

Institution.....

Gender: Male Female

OBJECTIVE ONE: Examine the reasons for the unwillingness of medical doctors to accept postings to and remain in the Upper West Region

- a. What do you think are the reasons medical doctors are unwilling to accept postings to and remain in the Upper West Region?
- b. Why do doctors want to remain only in the urban areas of Ghana?

OBJECTIVE TWO: Identify the specific initiatives taken by the MoH, other health-related partner organisations to attract and retain medical doctors in the Region.

- a. What key institutions have a direct role to play in attracting and retaining medical officers to the UWR?
- b. Which other stakeholders have a role to play in attracting and retaining medical officers to the UWR?
- c. What are the specific roles of the parties (institutions and other stakeholders) in attracting and retaining doctors to the Region?

- d. What specific policy initiatives or administrative decisions have been instituted by the RHA to help attract and retain medical doctors to the UWR?

OBJECTIVE THREE: Assess the effectiveness of the interventions by the stakeholders to attract and retain medical doctors in the Region.

- a. How effective are the current policies in attracting and retaining medical doctors to the UWR?
- b. What can be done to make these policies work more effectively?
- c. Are there any organisational and managerial factors that affect the efforts at attracting and retaining doctors in the UWR?

OBJECTIVE FOUR: Identify critical success factors in the attraction and retention of medical doctors in the Region

- a. What policies may be fair and equitable in attracting and retaining medical doctors to the Region?
- b. What preparatory measures are in place to receive doctors to the UWR?

THANK YOU FOR THE TIME AND SUPPORT

APPENDIX D**ATTRACTION AND RETENTION OF MEDICAL DOCTORS TO THE UPPER WEST REGION: AN ASSESSMENT OF THE PROSPECTS AND CHALLENGES****INTERVIEW GUIDE FOR SERVING DOCTORS IN THE REGION**

The researcher is a Master of Philosophy (M. Phil) student in Public Administration at the University of Ghana Business School, Legon. The researcher seeks to assess the prospects and challenges of attracting and retaining medical doctors in deprived areas in Ghana with specific reference to the Upper West Region. This is in partial fulfilment of the requirements leading to the award of a master of philosophy degree in public administration. The information you provide shall be used purposely for academic purposes and shall be treated with absolute confidentiality. Your cooperation and assistance will be very much appreciated.

***NB:** Participation is voluntary and you may decline to answer any questions deemed uncomfortable*

Background Information

Date of Interview.....
 Interviewee Code.....
 Institution

Gender: Male Female Age.....

When posted to the Region.....
 Length of stay in the Region.....
 Region of origin.....

Marital status: Married Not Married

Nature of posting By request Administrative Compelled

OBJECTIVE ONE: Examine the reasons for the unwillingness of medical doctors to accept postings to and remain in the Upper West Region

- a. What do you think are the reasons medical doctors are unwilling to accept postings to and remain in the Upper West Region?
- b. Why do doctors want to remain only in the urban areas of Ghana?
- c. What are your experiences professionally, socially, and financially in working in this Region?

OBJECTIVE TWO: Identify the specific initiatives taken by the MoH, other health-related partner organisations to attract and retain medical doctors in the Region.

- a. What policy initiatives do you know of currently that are aimed at attracting and retaining doctors to the UWR?
- b. What key institutions have a direct role to play in attracting and retaining medical officers to the UWR?
- c. Which other stakeholders have a role to play in attracting and retaining medical officers to the UWR?
- d. What are the specific roles of the parties (institutions and other stakeholders) in attracting and retaining doctors to the Region?
- e. What organisational factors hinder or prevent doctors from taking up postings in the Region?

OBJECTIVE THREE: Assess the effectiveness of the interventions by the stakeholders to attract and retain medical doctors in the Region.

- a. How effective are the current policies in attracting and retaining medical doctors to the UWR?
- b. What can be done to make these policies work more effectively?

OBJECTIVE FOUR: Identify critical success factors in the attraction and retention of medical doctors in the Region

- a. What would you consider to be the most critical factors that attracted you to the Region?
- b. What set of policies would you consider satisfactory, sufficient and necessary for retaining you in the Region?
- c. Under what conditions will you leave the region?

THANK YOU FOR THE TIME AND SUPPORT

APPENDIX E**ATTRACTION AND RETENTION OF MEDICAL DOCTORS TO THE UPPER WEST REGION: AN ASSESSMENT OF THE PROSPECTS AND CHALLENGES****INTERVIEW GUIDE FOR FORMER OR PAST DOCTORS OF THE REGION**

The researcher is a Master of Philosophy (M. Phil) student in Public Administration at the University of Ghana Business School, Legon. The researcher seeks to assess the prospects and challenges of attracting and retaining medical doctors in deprived areas in Ghana with specific reference to the Upper West Region. This is in partial fulfilment of the requirements leading to the award of a master of philosophy degree in public administration. The information you provide shall be used purposely for academic purposes and shall be treated with absolute confidentiality. Your cooperation and assistance will be very much appreciated.

***NB:** Participation is voluntary and you may decline to answer any questions deemed uncomfortable*

Background Information

Date of Interview.....

Interviewee Code.....

Institution

Gender: Male Female Age.....

When posted to the Region.....

When left the Region.....

Region of origin.....

Marital status: Married Not MarriedNature of posting By request Administrative Compelled

OBJECTIVE ONE: Examine the reasons for the unwillingness of medical doctors to accept postings to and remain in the Upper West Region

- a. What do you think are the reasons medical doctors are unwilling to accept postings to and remain in the Upper West Region?
- b. Why do doctors want to remain only in the urban areas of Ghana?
- c. What were your experiences professionally, socially, and financially in working in this Region?
- d. Why did you leave the Region at the time you did?
- e. Do you have any regrets ever working in the UWR?

OBJECTIVE TWO: Identify the specific initiatives taken by the MoH, other health-related partner organisations to attract and retain medical doctors in the Region.

- a. What policy initiatives do you know of currently that are aimed at attracting and retaining doctors to the UWR?
- b. What key institutions have a direct role to play in attracting and retaining medical officers to the UWR?
- c. Which other stakeholders have a role to play in attracting and retaining medical officers to the UWR?
- d. What are the specific roles of the parties (institutions and other stakeholders) in attracting and retaining doctors to the Region?
- e. What organisational factors hinder or prevent doctors from taking up postings in the Region?
- f. Under what conditions would you consider a return to the Region?

OBJECTIVE THREE: Assess the effectiveness of the interventions by the stakeholders to attract and retain medical doctors in the Region.

- a. How effective are the current policies in attracting and retaining medical doctors to the UWR?
- b. What can be done to make these policies work more effectively?

OBJECTIVE FOUR: Identify critical success factors in the attraction and retention of medical doctors in the Region

- a. What policies may be fair and equitable in attracting and retaining medical doctors to the Region?
- b. What preparatory measures were in place to receive doctors to the UWR?
- c. What more could have done, and by who, to keep you longer in the Region?

THANK YOU FOR THE TIME AND SUPPORT

APPENDIX F

**ATTRACTION AND RETENTION OF MEDICAL DOCTORS TO THE
UPPER WEST REGION: AN ASSESSMENT OF THE PROSPECTS AND
CHALLENGES**

INTERVIEW GUIDE FOR MUNICIPAL AND DISTRICT ASSEMBLIES

*The researcher is a Master of Philosophy (M. Phil) student in Public Administration at the University of Ghana Business School, Legon. The researcher seeks **to assess the prospects and challenges of attracting and retaining medical doctors in deprived areas in Ghana with specific reference to the Upper West Region.** This is in partial fulfilment of the requirements leading to the award of a master of philosophy degree in public administration. The information you provide shall be used purposely for academic purposes and shall be treated with absolute confidentiality. Your cooperation and assistance will be very much appreciated.*

***NB:** Participation is voluntary and you may decline to answer any questions deemed uncomfortable or withdraw from the entire interview at any point in time*

Background Information

Date of Interview.....
 Interviewee Code.....
 Institution

Gender: Male Female

OBJECTIVE ONE: Examine the reasons for the unwillingness of medical doctors to accept postings to and remain in the Upper West Region

- a. What do you think are the reasons medical doctors are unwilling to accept postings to and remain in the Upper West Region?
- b. Why do doctors want to remain only in the urban areas of Ghana?

OBJECTIVE TWO: Identify the specific initiatives taken by the MoH, other health-related partner organisations to attract and retain medical doctors in the Region.

- a. What key institutions have a direct role to play in attracting and retaining medical officers to the UWR?
- b. Which other stakeholders have a role to play in attracting and retaining medical officers to the UWR?
- c. What are the specific roles of the parties (institutions and other stakeholders) in attracting and retaining doctors to the Region?

- d. What policies initiatives have been taken by the district to attract and retain medical doctors to the district?

OBJECTIVE THREE: Assess the effectiveness of the interventions by the stakeholders to attract and retain medical doctors to the Region.

- a. How effective would you consider the initiatives by the district in attracting and retaining medical doctors in the district?
- b. What can be done to make the district more attractive to doctors?

OBJECTIVE FOUR: Identify critical success factors in the attraction and retention of medical doctors in the Region

- a. What policies may be fair and equitable in attracting and retaining medical doctors to the Region?
- b. What preparatory measures are in place to receive doctors to the UWR?

THANK YOU FOR THE TIME AND SUPPORT