

UNIVERSITY OF GHANA

CENTER FOR MIGRATION STUDIES

MIGRATION INTENTIONS OF HEALTH PROFESSIONALS:

THE CASE OF FINAL YEAR MEDICAL STUDENTS,

UNIVERSITY OF GHANA

BY

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**A LONG ESSAY SUBMITTED TO THE UNIVERSITY OF
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DECLARATION

I, Priscilla Nkansah, hereby declare that, except for references to other people's work, which have been duly acknowledged, this long essay is the outcome of my independent research conducted at the Centre for Migration Studies, University of Ghana, Legon, under the supervision of Prof. Joseph Teye. I, therefore, declare that this long essay has neither in part nor in whole been presented to any other institution for an academic award.

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Priscilla Nkansah

Date

(Student)

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Prof. Joseph Teye

Date

(Supervisor)

DEDICATION

This work is dedicated to my mother Mrs. Rosemary Nkansah and my supervisor Prof Joseph Kofi Teye. Without their endless love and encouragement, I would never have been able to complete my graduate studies. I love you both and truly appreciate all that you have done for me.

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My special thanks go to Jehovah for his guidance and protection throughout my educational journey. I would also like to express my profound gratitude to my supervisor Prof. Joseph Teye. Special thanks goes to my lovely parents Mr and Mrs. Nkansah as well as my awesome sibling Maxwell Nkansah and Nicolas Abouy who contributed immensely to my success. Lastly I would like to thank Daniel Nkansah, Diana Assuman and George Fiifi Botchey for their support.

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LIST OF ABBREVIATIONS

WHO	World Health Organization
IOM	International Organization for Migration
CIA	Central Intelligence Agency
MDG	Millennium Development Goals
UNDESA	Economic Community of West African States
OECD	Organization for Economic Cooperation for Development
UN	United Nation
UNDP	United Nation Development Programme
SPSS	Statistical Package for Social Sciences

ABSTRACT

The continuous migration of health professionals, including medical students after school has negative effects on the health system in Ghana. The role of doctors is very paramount in health care delivery as it is reflective in the quality of services given. It is in this vein that a study was conducted to examine the migration intentions of final year medical students and the factors that influence their intentions. The research design that was adopted for the study was mixed method. The sample size was made up of 104 respondents selected through the purposive sampling technique. Instruments used for the study were semi-structured questionnaires and in-depth interview guide. The quantitative data were analysed using SPSS and the qualitative through the use of thematic analysis. Students filled a questionnaire on their migration intentions and this was followed by an in-depth interview with five (5) students and two (2) lecturers based on their availability and willingness to be interviewed to understand the factors that influence medical student's migration intentions. The study revealed that majority of the final year medical students had the intention to emigrate after completion of their studies. Three main reasons accounted for their desire to move out of Ghana, these are quality and variety of specialization training being offered, higher wages in destination countries and availability of good jobs abroad. With regards to return intentions, large portion responded yes but within the duration of about 5 years. Nevertheless, the decision to move out of the country could be hindering government policies in destination countries as well as better policies in the country to retain most of them. Some of the strategies put in place to improve retention of doctors include improvement of salaries and improved working conditions. Based on the findings of the study, it is recommended that retention is likely to be successful when salaries are improved coupled with stable economic conditions.

CHAPTER ONE

1.0 Introduction

Although human migration from one geographical area to another has been in existence for many years, the right to move was recognized globally over half a century ago with the implementation of the Universal Declaration of Human Rights (UDHR). The UDHR states in Article 13 that “Everyone has the right to freedom of movement and residence within the borders of each state” and “Everyone has the right to leave any country, including his own, and to return to his country” (UN, 2003). This form of movement in recent times has attracted the attention of policymakers and researchers (Anarfi et al., 2005; Teye et al. 2014). Globalization has made the world grow smaller and the movement of labour around the globe has become much easier than ever before. Historically, labour movements were often a result of political disagreement (Chogugudza, 2017)) and economic failure .The movement of people may also be to escape from oppression or simply to make lifestyle changes. Health worker shortages across countries are some of the consequences of globalization. It is evident that the movement of health professionals has raised a lot of concerns right from the 1970s to date due to research on the subject (Pang et al, 2002, Asampong et al, 2013; Walton-Roberts, 2015; Cooper et al., 2016). One of the factors for this great concern is due to the essential role human capital plays in every health system. Often times health systems in developed countries tend to attract health professionals from developing countries who are less resourced in terms of human capital. Typically, low wages and poor working conditions often described as “push” factors are examples of factors which cause health professionals to move to developed countries where they can get better wages and improved working conditions among others (Boon & Ahenkan, 2008; Easterly & Nyarko, 2008; WHO, 2006). The migration of health professionals can lead to weakness in the health system of a particular country when it comes to conditions of service. There are relative shortages of health workers in places where they are needed the most. According to the World Health Organization report, migration results in a compromise in health service delivery and service quality especially when the gap created by migration is not filled (WHO, 2006). This has accounted for some challenges in

attaining some of the Millennium Development Goals in developing countries especially those directly related to health (IOM, 2005; Liese & Dussault, 2004). Unless something drastic is done to avert the Human Resource for Health (HRH) crisis in Africa, it is highly unlikely that the health-related Millennium Development Goals (MDGs) will be attained. Whether it is providing skilled attendants to reduce child mortality or for maternal services to achieve goal four and five or scaling up the provision of antiretroviral (ARVs) for HIV and AIDS treatment towards achieving goal six, the major challenge is making available suitably qualified staff in sufficient quantities to support these services (WHO, 2006).

Although labour migration has some benefits such as brain gain and sending of remittances (Teye et al, 2014), the large-scale emigration of health professionals from developing countries is a source of worry to many development thinkers (Anarfi et al, 2010). While many African countries have very poor health systems that are characterized by a shortage of equipment and qualified health professionals, about 30,000 doctors educated in sub-Saharan Africa have migrated to work in developed countries (WHO, 2006). The out-migration of health professionals including doctors to developed countries has increased in recent years, as a result of globalization and shortage of health professionals in some developed countries (Anarfi et al, 2010). Several factors, including low wages and lack of training opportunities contribute to the migration of doctors from sub-Saharan Africa to developed countries (Kingma, 2006; WHO, 2006). As discussed for the entire African continent, migration of doctors and other health professionals is a serious development challenge in Ghana. Although Ghana has trained several health professionals with the taxpayers' money, the doctor personnel density per 10,000 populations was 28% (WHO, 2006).

However, thousands of doctors trained in Ghana migrate each year in search of better working salaries, social amenities, and professional development (Dovlo, 2005). To salvage the situation, attempts have been made in recent years to improve the working conditions of health

workers in Ghana. It is, however, not clear if these measures have achieved the desired goal of reducing emigration of doctors. As a way of evaluating the impacts of these measures, the current study aims at exploring the international migration intentions of potential doctors (medical students) at University of Ghana.

1.1 Statement of problem

Consistent with the situation in many African countries Ghana is one of the Sub-Sahara African countries faced with health worker shortages. Hagopian et al. (2004) stated that 5,334 doctors from Sub-Saharan Africa were practicing in the US; of this, 86% were from Nigeria, South Africa, and Ghana. It is estimated that outmigration of doctors decreased from 72 in 1990 to 40 in 2004 (Awumbila et al., 2008). Again, Mensah et al. (2005) opined that this significant drop in doctor's migration can be attributed to the implementation of the Health Sector Salary Scheme (HSS) (Mensah et al, 2005). Even though evidence to support this result is scarce, UK's implementation of the code of practice for recruitment of health care professionals might have been a great factor. Despite this decrease in out-migration of doctors it was estimated that vacancy levels for doctors increased from 43% to 47% between 1998 and 2002 in the Ghana Health Service (Dovlo, 2002) Notwithstanding the above assertion, work done by Anarfi et al. (2010), indicated that out of 60 doctors sampled, 13.3% had migrated and 30% constituted those with intentions to migrate. It was projected by Kotha et al. (2012) that out of 228 Ghanaian students in their fourth year study, 64.9% had migration intentions.

The Central Intelligence Agency (CIA) stated in 2006 a doctor to patient ratio was 14, 732 people in 2006 and in 2009 it was one doctor to 11,929 people (CIA, 2011). It ranked Ghana at 164 out of 192 countries for doctor density (CIA, 2011). This shows that doctor density is still low in Ghana from a global perspective. The distribution of doctors is also skewed to highly populated areas and to the South. Even though Ghana has a low doctor density, the health

indicators point to the urgent need for more supply of doctors. Statistics show that the emigration of health professionals poses challenges to the health sector of Ghana, and effort aimed at retention of a greater number of doctors will be essential to improve the situation.

The health sector depends on a lot of human resources and some level of expertise to effectively manage patients' health. However, it is faced with limited human resource capacity due to migration and poor retention of workers because of low incomes especially in developing countries (World Health Report, 2006). According to the Ministry of health, in 2005 the doctor to patient ratio was 1:10,700 whilst in South Africa, United States and Cuba it was 1:1449, 1:820 and 1:169 respectively (Ministry of Health, 2007). This shows that Ghana is lagging behind compared to these countries. There is a lot of strain on doctors worldwide. It is in view of this that all effort needs to be made to retain the doctors that are in the country. There has been extensive research on the benefits of migration to both the origin country and the destination country (Boon & Ahenkan, 2008; Overseas Development Institute, 2008). Most of these studies seek to reverse the perception that migration is disadvantageous to source countries.

According to these studies, origin countries benefit from remittances from migrants who contribute to the economic development of their countries (Overseas Development Institute, 2008; Boon & Ahenkan, 2008). Although origin countries benefit from migration through remittance to family from abroad, international migration can lead to origin countries' unwillingness to continue to subsidize the studies of health professionals only to lose them to the developed world. The loss to developing countries can be estimated not only financially but also in lives lost as a result of the shortage of staff (WHO, 2006; IOM, 2005). A lot of focus has been given to certain individual factors that are likely to make people move and the extent to which they can influence the mobility of migrants (Okeke, 2009). Some research has been carried out on the intentions of physicians to emigrate. However, most of it is country-specific (Dalena & Henkens, 2008). Dalena and Henkens (2008) examined the emigration intentions of Netherland inhabitants and the steps they took in the subsequent two years to ascertain whether their intentions were a true reflection of their actions. Their findings revealed that three percent of the Dutch population who had had intentions to emigrate actually fulfilled their intentions in 2005, two years after. There seems to be a lot of research on migration of doctors from their country of training and the migration intentions of doctors to migrate back to their origin countries from their destination countries (Dovlo, 2003; Dovlo & Nyonator, 1999; Muula, 2006; Price & Weiner, 2008; Asampong, 2013). Many researchers have focus have paid attention to the study of the issue after the act of migration has actively occurred. The literature on migration intentions of medical students is few and they are country-specific (Aysit and Nil, 2002; Burch et al, 2011; De Vries & Reid, 2010; Dambisya, 2003; Kotha, 2012). There is limited research on the migration intentions of medical students in the origin country which is the focus of this research. This study seeks to address this need by providing answers to the migration intentions of medical students after their studies, the effect on some demographic characteristics on their intentions as well as preferred destinations of their choice and factors propelling such decisions. The findings of the study may serve as a source of useful

information for stakeholders of health to formulate and implement policies that will seek to retain a greater number of doctors.

1.2 General objectives of the Study

The main aim of the study is to assess the international migration intentions of health professionals with the emphasis on medical students from University of Ghana.

1.3 Specific objectives

1. To examine the migration intention of final year medical students in the University of Ghana after studies
2. To identify the preferred destinations of the medical students who want to migrate from Ghana and outline the factors that influence their choice of destinations.
3. To examine the relationship between socio-demographic characteristics and intentions of final year medical students to migrate from Ghana.

1.4 Research questions

1. Do final year medical students of the University of Ghana have an intention to migrate after their studies?
2. What are the preferred destinations and the factors influencing the choice of destinations?
3. What is the relationship between demographic characteristics and migration intention of the final year medical students?

1.5. The rationale of the study

The study set out to understand the migration intentions of students. This research may inform policy direction in the formulation of strategies for students before they become physicians and improve on interventions to retain a greater chunk of medical students who graduate in Ghana.

The main importance of this study lies in the fact that it will help to establish whether or not

recent policies adopted to prevent health professionals including doctors from migrating from Ghana are achieving desired goals. The study is also intended to add to existing knowledge concerning migration of health workers from Africa. In particular, the study will help to understand the main determinants of intention to migrate. Furthermore, the study will inform researchers, policymakers, stakeholders and the general public of the intensity of the challenges associated with migration of health professionals from Ghana.

1.6 Organization of the dissertation

The dissertation is structured into five chapters. The first chapter presents the background of the study, delineates the research problem, and outlines the specific research objectives as well as the rationale of the study. Chapter two covers the literature on migration and its effect on health professionals. Chapter three focuses on the methodology used for the study while chapter four highlights the findings emanating from the field. Chapter five which is the final chapter presents the summary, conclusion, and recommendations drawn from the study.

1.7 Operational definitions

1. Migration is the movement of people across national borders
2. Push factors constitute the factors in the origin country influencing the decision of an individual to migrate to another country
3. Pull factors are factors in the destination country that attracts an individual to move there
4. Intervening factors are factors that impede an individual from moving to another country

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents a review of existing body of knowledge which is relevant to this study. The literature review covers the migration of health professionals, migration of skilled labour as well as migration dynamics in sub-Saharan Africa. It ends with the theoretical perspective of this migration process.

2.1 Global migration of health professionals

The migration of health professionals is an issue of international importance due to globalization. People across the world are now connected and dependent on each other through integration, communication, cultural and travel (Labonte et al., 2015). People move for many reasons some of it includes searching for work, escape from oppression or for a desire to change one's lifestyle. Rising income levels, new medical technology, increased specialization of health services, and population aging are also pushing up demand for healthcare workers in OECD countries (OECD, 2010; Kuehn, 2007). An international migrant worker is defined by the 1990 United Nations (UN) International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families as "a person who is to be engaged, is engaged or has been engaged in remunerated activity in a State of which he or she is not a national" (UN, 1990). Statistics indicate that there is a total of about 175 million international migrants constituting about 2.9 percent of the world population. It is estimated that the majority of the world's migrants live in Europe (56 million), Asia (50 million) and North America (41 million) of these, about 60-65 million are economically active (United Nations Population Division, 2003).

International migration is not a new phenomenon however, the significant growth, especially in terms of size and velocity, indicates a new pattern in movement of people (IOM, 2002). The focus of policymakers is on the migration of skilled labour. The occupational categories that are on the move raise the concerns of ensuring fair distribution of human resources among source and destination countries (OECD, 2002). Health professionals have new opportunities opening up for them with the potential of getting better pay and career opportunities due to the liberalization of trade as a result of the General Agreement on Trade in Services (GATS), (OECD, 2002b). Notwithstanding the above assertion, many countries began to employ health workers from foreign countries during the 1950s and 1960s in order to improve their health systems. This raised the general concern for initial steps against brain drain syndrome which caused the World Health Organization (WHO) to embark on a study on the movement and stock of health worker migration (Short, 2016).

The research brought out the fact that as of 1972 about 6 percent of the world's physicians (140,000) were located in countries other than those of which they were nationals. Considerably, about 86 percent of all migrant physicians were working in five countries (Australia, Canada, the Federal Republic of Germany, the United Kingdom (UK) and the United States (US)). The stock of nurses overseas was estimated to be lower, at about 5 percent, but the key recipient countries were the same as for physicians with the exception of Australia (Short, 2016).

Statistics from a recent study indicate that countries such as the USA, UK, Canada, and Australia engage about 23-28 % of all internationally trained physicians and this further emphasizes the dependence of developed countries on foreign-trained and educated medical graduates (Sampath, 2019; Mullan, 2005). Specifically low-income countries contribute between 40-75% of graduates from their medical schools to the countries indicated earlier, where UK and USA are the first and second beneficiaries respectively (Mullan, 2005). Further

evidence suggests that about 5% of increase in migration of medical professionals is in UK and 20% in Organization for Economic Co-operation and Development (OECD) countries originated from abroad (WHO, 2006). Despite these trends it is significant to emphasize the fact that not all developed countries depend on medical professionals from developing countries; Switzerland and Norway recruit mainly from Europe and only 1% from abroad (Mullan, 2005).

According to OECD (2000), there was a report of shortages of doctors in some parts of the country. The study showed that the recruiting of health professionals from abroad was a short-term measure employed by some OECD countries to meet their demand for health workers. Thus the increase in migration can be explained as a measure perceived to be a 'quick fix' for unexpected high demand for health workforce as training extra doctors takes many more years compared to recruiting from abroad. The global health workforce shortages present a great challenge for source countries from which health professionals are trained.

2.2 Migration of skilled labour in sub-Saharan Africa

Literature shows that many African countries, especially in Sub-Sahara Africa, are experiencing migration of highly skilled workers in the health industry. Studies reveal that there is poor official record-keeping of health professionals that migrate to other countries, thus making it more challenging to estimate the magnitudes and trends (Chibango, 2013).

In recent times, the migration of health professionals has led to a human resource management crisis globally (Joint Learning Initiative, 2004). The crisis is overwhelming the world and the need for medical professionals is greatest in Africa. The continent is facing a human resource crisis following the emigration of health professionals coupled with increase in population and disease burden especially recurrent communicable diseases and increased incidence of non-communicable diseases. Thus the demand for health services is high while the supply is low

due to emigration. Conceptualizing these, Africa has about 86.24% of the share of the world's population and shoulders about 75% of the world's disease burden and has 1.3% of the world's health workforce (Joint Learning Initiative, 2004). This shows the global imbalance in healthcare workforce capacity between Africa and the developed world. It further suggests that the poorest countries with the worst shortages and health outcomes contribute the greatest percentage of physicians and medical graduates to high-income countries (Taché, 2009).

The loss of medical professionals is gaining much precedence in countries in Sub-Sahara Africa and it is mostly preferred to as brain drain. A report by the United Nations Development Program (UNDP) stated data to show that about 21 000 Nigerian doctors were practicing in the United States of America (USA) while their home country was understaffed (UNDP, 2013). According to the statistics about 60% of doctors who had their training during the period of the 1980s from Ghana migrated by the close of the year 2000. Literature shows that Sudan suffered from brain drain close to about 17% by the year 1978. According to the World Migration Report (2010; cited by Acheampong (2013), 214 million people migrate worldwide and majority them are from developing countries and it has been noticed that economic hardships, poverty, and unemployment, conflicts of arms, uneven distribution of scarce resource, income differences, poor living conditions, social network contribute to the motivation that influences a households decision to migrate (Awases et al. 2004). Under these conditions, migration still remains a major livelihood strategy for most migrants to meet up with the declining socio-economic conditions in their places of origin.

Migration in Ghana comes in different ways. Mostly, highly trained and educated professionals including doctors, engineers, pharmacists, nurses, and teachers migrated to rich countries to seek higher remuneration jobs in other to better their financial condition and family standard (Anarfi, et al., 2010). The United States of America, Canada, Germany, the United Kingdom,

Australia among others has been seen as countries that attract more highly skilled professionals from low-income countries into their labour market (Awumbila et al, 2011).

According to the International Organization for Migration (IOM), a good number of Africa's human capital had been lost and the loss still going on at an increasing rate with about 20,000 doctors, university lecturers, engineers and other professionals leaving every year since 1990. Migration had been seen as a way to fill out vacuum on the labour market in response to market needs in most countries especially countries experiencing low fertility (Anarfi, 2010). It had been found that currently, there are over 175 million migrants who move out from their country of origin to other countries for different reasons, an increasing number of these migrants were nurses and the majority of those were women. It was also stated that the countries from which these health professionals (nurses) emigrated from are Ghana, Ethiopia, Nigeria, and South Africa. Over the last 30 years or so, most migrant health workers move to European countries. Nurses from the Philippines constituting 110 000 and doctors from India summing up to 56 000 accounts for the largest share of migrant health workforce in the developed world (WHO, 2006). Zambia's situation was no different, records show that Zambia recorded about 1600 doctors practicing only few years prior to 2002 when it indicated a reduction to 400 (Sako, 2002). About 61% of doctors who graduated from one medical school in Ghana left the country between 1986 and 1995 to South Africa (6%), the United Kingdom (55%) and the United States of America (35%), (Dovlo and Nyonator, 1999, Dovlo, 2005). In 2006, research conducted by Labonte Packer and Klassen indicated that Canada was a major receiver of most foreign-trained health professionals especially nurses and doctors from Sub-Saharan Africa (Labonte, Packer and Klassen, 2006). Clemens and Pettersson (2008) found that about 65,000 African-born physicians and 70,000 African-born professional nurses were working overseas in a developed country. The findings showed that about 20% of physicians

were born in Africa as well as nurses who practice in developed countries (Clemens & Pettersson, 2008).

Statistics indicate that Sub-Sahara Africa, the Indian subcontinent and the Caribbean have the greatest incidence of health worker migration even though these areas are poor in resources (Mullan, 2005). These statistics reiterate the global imbalance which turns to affect the resource-poor areas. The imbalance will continue to grow due to the high demand for health workers by high-income countries like the USA and UK. Some of the reasons behind this are the development of European Union in the region, which has reduced the barriers and further created another source of health worker migration for the less developed countries (Wismar et al., 2011). Additionally, the health reform in USA which targets to supply health to a great number of uninsured persons will undeniably draw international health worker emigration because of the increased demand for services. Even though USA health system has taken into consideration measures to control cost so as to make the impact of this increased in the provision of health services less on health expenditure, emphasis must be laid on the fact that additional health workers will be needed to provide services for the additional millions of people (Orszag & Emanuel, 2010; Foster, 2010). The increase in demand creates an increase in the challenges resource-poor countries encounter when it comes to health workers.

Appreciating the health worker crisis from the global, regional and national levels, it is essential to know the causes of emigration. Some scholars have referred to this as the pull and push factors of international migration. These are the factors that are in the source country which drive health workers away due to attraction from factors in recipient or destination countries.

The next sub-heading contains literature on the causes of health worker migration

2.3 Antecedents factors amongst health professionals

The push and pull model is the dominant framework for explaining nurse migration (Bach, 2007). According to Kline (2003), the antecedents for nurse migration are the political, social (personal), economic, legal, historical and educational forces that comprise this framework. The pull factors are conditions in the destination country that attract and facilitate the migration of health professionals; the push factors are conditions that encourage health professionals including nurses and doctors to leave their own country (Kingma, 2018). These factors usually mirror each other; for example, a doctor or a nurse from a country making a low salary will be pulled to a country offering higher wages (Kingma, 2018). For the purpose of this study, the antecedents of migration of health workers have been categorized.

Literature abounds on the extent to which individuals' personal characteristics could lead them to migrate from their home country into a foreign land. In a study conducted by Zaiceva and Zimmermann (2008), the researchers contended that young individuals tend to express a higher willingness to migrate since the time to reap the expected returns from migration is longer for them compared to the older generation. This position is held by Mace (1990) in consistence with the Matching concept. Similarly, Zaiceva and Zimmermann (2008) posit that individuals who are more educated are more likely to migrate considering the fact that they probably face lower costs of migration and job search. Additionally, Kotha et al. (2012) and Kaushik (2008) found that intention to emigrate is likely to be more predominant among medical students and even more in elite institutions or institutions in the city capital (Kotha et al., 2012; Kaushik, 2008). This assertion confirms that of Zaiceva and Zimmermann (2008) since these individuals are highly educated people. On the other hand, married individuals and those with children are expected to have lower willingness to migrate because of the psychic costs of separating from their families (Zaiceva & Zimmermann, 2008; Abuosi & Abor 2014).

According to Mincer (1978), migration may also lead to increased marital instability. Likewise, homeowners are expected to have lower migration intentions, because of their greater attachment to the region and since they may face the additional costs of selling their property. Several studies including that of Blanchflower et al. (2007) and Wadensjö (2007) have reported that the majority of migrants are male, young and have relatively higher medium skill levels and are concentrated in low-skilled sectors. This is confirmed by Brenke and Zimmermann (2007) who documented an increase in net immigration flows from the new member states into Germany despite the “closed-door” policy. The authors showed that females constituted the majority of these immigrants and that these immigrants were underrepresented in highly qualified jobs despite high qualifications

Research has also indicated economic factors as a major antecedent of migration amongst individuals. Migration is often linked to more and better employment opportunities (encompassing salaries, working conditions, career advancement, etc.) abroad. Wage differentials across countries play an important role, but are not the only determinant, as other factors such as the possibility to offer a better and safer future to their children may also be a determinant. For instance, in a study on determinants of migration in Europe by Zaiceva and Zimmermann (2008), the authors found that regarding labour market status, unemployed individuals may be more willing to look for a job abroad, however, they may also be attached strongly to the social networks and experience liquidity constraints that could preclude them from moving.

Similarly, studies by Blanchflower et al. (2007) revealed that one’s propensity to migrate correlates with his/her income per capita, unemployment rates and life satisfaction in their environment. Again, Wadensjö (2007) provided a remarkable increase in the number of foreigners in Ireland between 2003 and 2005, and the majority of this flow in 2005 consisted of nationals from the new member states the authors argued that the immigration to Ireland was

primarily demand-driven and very often, migration of health workers becomes a symptom of the difficulties faced by the health system, and more generally the society, of the country of origin rather than its direct cause (OECD, 2010). Contrastingly, in a study by Gilpin et al. (2006), the authors reported that in the United Kingdom, the number of nationals that migrate from the new member states increased substantially, but they did not find a statistically significant relationship between increased immigration and the rise in the United Kingdom claimant unemployment.

According to Luck et al.(2000), migration is primarily a response to globally uneven development, but usually explained in terms of factors such as low wages, few incentives or poor working conditions (e.g. Poor promotion possibilities, inadequate management support, heavy workloads, limited access to good technology and even to medicines). Similarly, Buchan et al. (2004) contend that poor working conditions are core factors motivating health workers to leave their country of origin and this is supported by the studies of Bach (2003) which found working conditions of health workers as major predictor of health workers' intention to migrate. In Ghana, 71% of health workers interviewed in destination countries mentioned living conditions and economic decline as the reasons for leaving their home country (Vujicic et al, 2004). Also studies conducted by Buchan *et al.* (2006) and Muula & Maseko (2006) have also confirmed this position of literature from different cultural perspectives. Poor working conditions are intensified in rural areas, where health workers feel they and their institutions are too often ignored and this category of people has been described by Dussault and Franceschini (2006) as victims of institutionalized urban bias in Development Policy. Although health workers may stay in rural areas, where it is easier to hold other jobs or engage in corrupt practices (Muula & Maseko, 2006), the intention to migrate will persist so long as they experience poor working conditions.

2.4 Theoretical perspective

The optimist's views on migration traverse that of pessimists in most cases, hence it has been seen to contribute significantly towards the wellbeing of migrants including health professionals, their dependents as well as the countries of origin and destination. Evidence emanating from migration literature includes how remittances have been used to aid development in origin countries of migrants and its impact on migrant-sending areas. The migration phenomenon cannot be explained by one single theory due to the multifaceted characteristics surrounding it. Massey et al. (1993) and Castle and Miller (2008) have alluded to the fact that there is no single, robust theory of international migration that can handle the complex dynamics associated with migration and calls for both theoretical and empirical understanding of the migration process. Hence push-pull and social network theories and will be used to explain migration of health professionals the case of medical students.

2.4.1 Push-pull theory

This theory explains migration in terms of push factors at the origin and pull factors at the destination. There have been a lot of discussions on the "push" and "pull" factors on migration (Lee, 1966). Research continues to find the major reasons behind health workers migration with attractive factors such as better remuneration, safer environment, improved living conditions in the destination countries, advancing their education while the push factors constituting this form of migration emanates from lack of support from supervisors, low motivation for career advancement, rural postage without incentives, lack of facilities, lack of promotions, low social security, and heavy workloads in their home countries. This confirms the WHO report (2006) which emphasizes that movement of health professionals to developed countries span from economic to social factors. Again other non-financial factors, such as political forces, poverty, age of the migrant, past colonial and cultural ties between source and destination countries also aide emigration processes of health professionals (Dovlo, 2005).

According to Anarfi et al. (2010), most of these health professionals including doctors and nurses migrate to upgrade their career that was not attainable in their current job or country. This shows that education is one of the factors that trigger migration. The desire to practice their skills or to work in more developed countries, where the necessary tools for the work are available and also the opportunity to expand their knowledge is possible. All of these factors propel health workers to migrate for greener pastures elsewhere especially the developed countries.

2.4.2 Social network theory

Several studies have indicated that network theory seeks to focus on the individual ties that connect migrants, non-migrants in both sending and receiving areas through bonds of kinship, friendship and shared community of origin (Massey et al., 1993). This consistently helps to reduce the burden associated with economic, social and psychological cost of migration. Social network and its connections aids in the migration process for example family and friends can influence migration decisions, other information pertinent to their wellbeings such as availability of jobs or emerging business with profitable outcome. Others extend privileges such as securing accommodation for new migrants till they finally settle down.

This helps to explain what propagates migration in time and space instead of finding out the determinants of migration realities (Massey et al., 1993). This theory gives further understanding of why attractive factors or policies do not terminate onward movement into destination countries as well as migrant distribution in terms of which destination country to choose. The attention is on one's available networks and its reliance when one is making migration decisions.

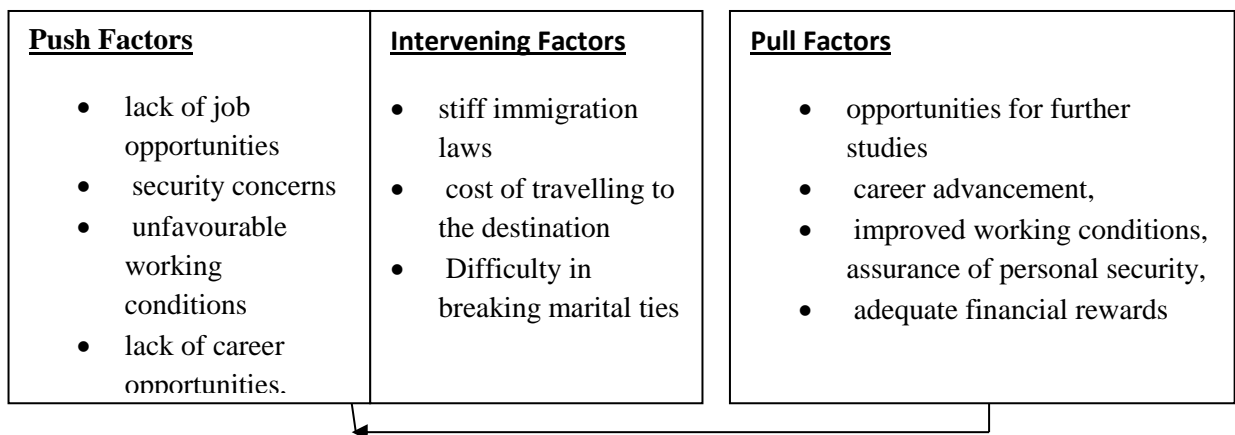
In this regard, major factors that influence migration encompass social relations, common language, and trade flow as well as available opportunities (Castle and Miller, 2009). This revelation is in line with Anarfi et al. (2003) study on immigrants where he suggested that significant proportion of Ghanaians emigrated because of their family members present at the destination and the likelihood of securing employment. This has been the case for many health professionals including potential doctors since their network gives them prior information on the area they are come into and their ability to secure better jobs upon arrival. This assertion confirms that many of these migrants including health workers depend on their social capital for pertinent information for their survival.

2.4.3 Conceptual framework

The conceptual framework in Figure 2.5 for this study is based on the push-pull theory, which states that migration of health professionals from Ghana is influenced by push factors at the origin and pull factors at the destinations. Generally, many push factors exist but the essential ones deemed to be propelling health professionals to emigrate includes lack of job opportunities, security concerns, unfavourable working conditions, and lack of career opportunities, poor remuneration, and heavy workloads. This is in line with Stewart et al. (2007) elucidation of factors the trigger migration from the source countries. On the other hand, attractive factors within the destination countries such as opportunities for further studies, career advancement, improved working conditions, assurance of personal security, and adequate financial rewards (Dovlo, 2005). The framework also shows that between the origin and destination are intervening obstacles that tend to slow the movement of nurses between the two areas (Ghana and popular destinations). Intervening obstacles span from factors emanating from both within and outside the origin country. This includes acquisition of travel documents, stiff immigration laws, and cost of traveling to the destination, physical barriers and other

personal factors that restrict migration (Anarfi et al, 2010). In this study, I will examine both the push factors that force doctors (medical students) to leave Ghana and pull factors that attract them to developed countries. These strands push factors, intervening obstacles and pull factors are key in the migration of health workers including potential doctors especially developing countries like Ghana.

Figure 1: Conceptual framework



Source: Author's own construct, 2019 base on Lee (1966)

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter is on the study area, the methodological design used, the sampling technique employed and the data collection techniques used data analyses and interpretation. Ethical issues relevant to this study are also presented. The chapter concludes with limitations of the study.

3.1 Study institution

The University of Ghana is one of the oldest and largest of all Ghanaian universities and tertiary institutions. It was founded in 1948 as the University College of the Gold Coast and was originally an affiliated college of the University of London, which supervised the day to day running of academic programs and awarded degrees. It gained full university status in 1961 and has a population of about 40,000 students.

The original emphasis was on the liberal arts, social sciences, basic science, agriculture, and medicine, which was expanded to provide more technology-based and vocational courses and postgraduate training. The university is mainly based at Legon, about twelve kilometers northeast of the center of Accra. The medical school is in Korle Bu, with a teaching hospital and secondary campus in the city of Accra as well as a basic school. It also has a graduate school of nuclear and allied sciences at the Ghana Atomic Energy Commission, making it one of the few universities in the Africa continent offering programs in nuclear physics and nuclear engineering.

3.2 Research design

A blend of quantitative and qualitative research methods commonly referred to as a mixed-method approach (Creswell, 2009) was adopted in data gathering, analysis and reporting. The choice of the approach was based on the fact that good social research requires the use of more than one research approach since they complement the strength and weaknesses of each other (Ennew & Boyden, 1997; Teye, 2012). The quantitative focused on making statistical generalization based on a large number of responses obtained on some demographic variables (age, sex, educational attainment, and marital status) influences on migration intention.

The qualitative approach, on the other hand, focused on key informant interviews with some medical students and few lecturers within the department to ascertain vital information that was not captured by the quantitative approach. The use of both research approaches simultaneously made it easier for comprehensive analysis and provided a better understanding of the drivers of migration of health professionals from the country.

3.2.1 Questionnaire survey

For the quantitative data, a structured questionnaire was administered to gather data. Hence the questions were closed and open-ended. With the close-ended questions, respondents were given a range of options to choose the most appropriate answer from. The quantitative survey questionnaire was used for the purpose of generalization of results of the findings (Babbie, 1990). The questionnaire used was administered by the researcher and his assistant and was structured to gain responses in the following areas:

- The socio-demographic characteristics of the respondents

- Relationship between some demographic characteristics and migration intentions
- Preferred destination and factors influencing such destinations

3.2.2 Sampling technique and sample size for the quantitative approach

Purposive sampling was used to select the final year medical students who were on the verge of completing medical school to become doctors within a period of less than a year. The final year class was selected because the study sought to find out their migration intention prior to their becoming doctors. All final year students consisting of 104 persons were sampled from the population.

3.2.3 Pretesting of instruments

Prior to the administration of the instruments, pretesting was conducted at Accra College of medicine a private medical institution in the Greater Accra Region instead of the study institution in order to get a different perspective regarding the issues to be investigated. This enabled the researcher to determine the clarity of the questions, reliability, and precision of the instrument before the actual data collection commenced. Sanders et al (2007) noted that pretesting helps to check the appropriateness of a questionnaire or interview guide to lessen the likeness of respondents not to understand or not answering questions correctly.

Furthermore, the pre-testing was used to predict the amount of time to allocate to each respondent and the number of interviews the researcher would be able to carry out in a day in order to organize the schedule of activities. The duration for the interviews was between 30 to 45 minutes. The experiences from the pretesting aided in improving the final questions before the actual survey.

3.2.4 In-depth interviews

For the qualitative data, an in-depth interview guide was used to gather data from five students and two lecturers who were further selected purposively based on their availability to be interviewed. This enabled the researcher to obtain information in a lengthy conversation with respondents in a one-on-one interaction. The researcher sought insight on information which was not captured by the questionnaire in order to achieve the aim of the study. One disadvantage of in-depth interview is that just a section of the respondents can participate in the interview, thus its outcomes cannot be generalized.

- The interview guide for the lecturers covered the general perception of the medical doctor's willingness to migrate and why they also explored the preferred destination of potential doctors and the challenges they face and the general effect on the country.
- Again, to ascertain ways to reduce the incidence of health workers migration from the perspective of the students and the lecturers.

3.2.5 Sample size and sampling technique for the qualitative approach

For the qualitative approach, a purposive sampling technique was employed in select seven (7) key informants consisting of five (5) students and two (2) lecturers who were available for the interviews. This technique was appropriate for this study because it aided in selecting persons or an area deliberately to provide important information (Patton, 2000; Tongo, 2007).

3.3 Target population

The target population of this study was medical students in their final year of the University of Ghana Medical School. They were selected because per their training they are potential doctors.

Additionally, some lecturers were selected on board for the purpose of addressing the issue of the strategies put in place to improve retention

3.4 Data collection procedure

3.4.1 Quantitative data collection

For quantitative data, instruments for data collection was structured questionnaires with both open-ended and closed-ended questions, which aided in collecting information from respondents. This was useful in answering the research questions which were structured into three (3) sections namely socio-demographic characteristics, migration intentions and processes as well as return intentions should they migrate. This was done by selecting them base on their readiness and availability.

3.4.2 Qualitative data collection

For the qualitative data, an in-depth interview guide was used to collect the data from lecturers within the department as well as students. Each interview lasted between 20minutes to about 30minutes. This enabled the researcher to obtain detailed information on areas such as mode of acquisition of travel documents, effects of students (medicine) migration in terms of brain drain, brain gain and brain circulation in addition to the challenges likely to be encountered prior to migration. As Preskill and Jones (2009) opined, the interview guide for qualitative data is generally useful for exploring attitudes and feelings and also to highlight issues that have not been captured in the administering of the questionnaires.

3.5 Data analysis

3.5.1 Quantitative data analysis

After the questionnaire administered to respondents was retrieved, each questionnaire was checked, coded and analyzed using the Statistical Package for Social Sciences (SPSS version

20) software. Analytical tools such as descriptive and inferential statistics which included frequency, percentage, cross-tabulation, and chi-square test were used for the analyses.

3.5.2 Qualitative data analysis

In-depth interviews were audio recorded by the researcher. All interviews were carried out in English which was the common language both researcher and respondents could communicate in. Thus interviews recorded were transcribed without any difficulties. The interviews were then coded, put into themes by referring to the objectives. This helped to categorize and analyze the themes thereby reducing many words into coherent and logical phrases. This supported the explanations of the quantitative data.

3.6 Ethical consideration

As human beings were the focal elements of the study, issues of ethics were upheld. This was because, in as much as the researcher intended to solicit views and ideas from respondents to build new knowledge in the area of study, the rights of the respondents were taken into consideration. Ethical considerations of the study were followed as the researcher did a proper introduction of herself by showing her student identification card to the respondents. This aided in obtaining their consent and the need for them to assist in providing credible information for the study.

Also, the respondent's confidentiality was assured during the data collection period. Voices recorded from the interviews were treated with utmost confidentiality at the end of the discussion. The researcher also had discussions with the respondents.

3.7 Limitation

In spite of the study drawing knowledge from many scholars is not without limitations. The purposive selection of students from only the University of Ghana Medical School limits the study as findings cannot be generalized to all medical schools in Ghana. There were some limitations worth stating during the administration of the questionnaires as well as the interviews conducted for the study. Since the study sought to find out from students their migration intentions and the processes they intend to go through before migration, some respondents were reluctant in taking part in the study or sharing some information while others cited unavailability of time. The researcher had to reassure them continuously that any information given will be treated confidential and was for only academic purposes only.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF THE STUDY FINDINGS

4.0 Introduction

The findings of the study are presented in the following thematic areas; background information, the migration intentions, the factors that influence the intentions of final year medical students of UGMS to emigrate as well as return intentions among medical students.

4.1.1 Background characteristics of respondents

Due to the complexities surrounding migration of health professionals in terms of the gains, drains, the effect on both origin and destination countries, respondents consisting of final year medical student's background characteristics were ascertained. Out of the 104 respondents sampled, more than three-quarters (77.9%) were males while the rest constituted the female population. The disparities between males and females are attributed to the availability of student's readiness during the research. In terms of the age of respondents, more than half (52.9%) fall within the workable age cohort (20-39) years while those within the age of (40-49) years constituted 26 percent of the total population. The rest of the age cohorts was a little over a fifth of the total responses. Given the age distribution of the respondents, the minimum and maximum age of the respondents sampled was 20 years and 59 years respectively. On the whole, the mean age was 31 years which is a characteristic of a youthful age group. Additionally, in relation to the marital status of respondents, close to half (49.0%) were married with those never married (single) constituting 31.7 percent followed by the cohabitations (10.6%). Again, respondents with no children were more than two-fifth (42.3%) while those with children range from 1 to 3 constituted more than half (53.8%) of the total responses. The rest of the number of children was less than 5 percent. Lastly, concerning one's ethnicity, large

proportion (38.5%) of the respondents were Akan followed by international students and others (28.8%). The rest of the respondent's ethnicity were less than 10 percent.

Table 4.1: Background characteristics of respondents

Variables		Frequency	Percent
Sex	Male	81	77.9
	Female	23	22.1
Total		104	100.0
Age	20-29	24	23.1
	30-39	31	29.8
	40-49	27	26.0
	50-59	22	21.2
Total		104	100.0
Marital status	Married	51	49.0
	Cohabitation	11	10.6
	Single	33	31.7
	Divorced/Widowed	7	6.7
Total		104	100.0
Number of children	No children	44	42.3
	1-3	56	53.8
	4-6	4	3.8
	6+	0	0.0
Total		104	100.0
Ethnicity	Akans	40	38.5
	Ewe	15	14.4
	Ga-Dangbe	10	9.6
	Northerners	9	8.7
	International studies and others	30	28.8
Total		104	100.0

Source: Field data, 2019

4.1.2 Intended duration to be spent in Ghana before emigrating

The study revealed the period a student intended to stay in Ghana before emigrating. More than half (51.0%) of all students who had intention to emigrate wanted to leave Ghana within three to five years after completing medical school, while a fifth (20.%) of the students wanted to leave within two years followed by those who opted for 5 years (10.6%) absence should they emigrate. The rest of the duration to be spent was less than 10 percent. One student had this to share:

When I migrate I have to work for a while and acquire the needed specialties before I return and it likely going to allow me to stay beyond two years (**Awo Yaa a medical student, 2019**).

Table 4.2: Intended duration to be spent in Ghana before emigrating

Intended duration	Frequency	Percent
Less than a year	10	9.6
Within two years	21	20.2
Within three to five years	53	51.0
5 years	11	10.6
6 years and above	29	8.7
Total	104	100.0

Source: Field data, 2019

4.1.3 Intention to specialize after graduation

Medically, the hierarchy of medicine is well appreciated when one is able to specialize with respect to offering services (Lawrence & Ahamed, 2001). Figure 4.9.4 presents information on whether medical students intend to specialize should they migrate. Out of the responses, overwhelming majority (93.3%) responded yes while the rest said no to such specialization.

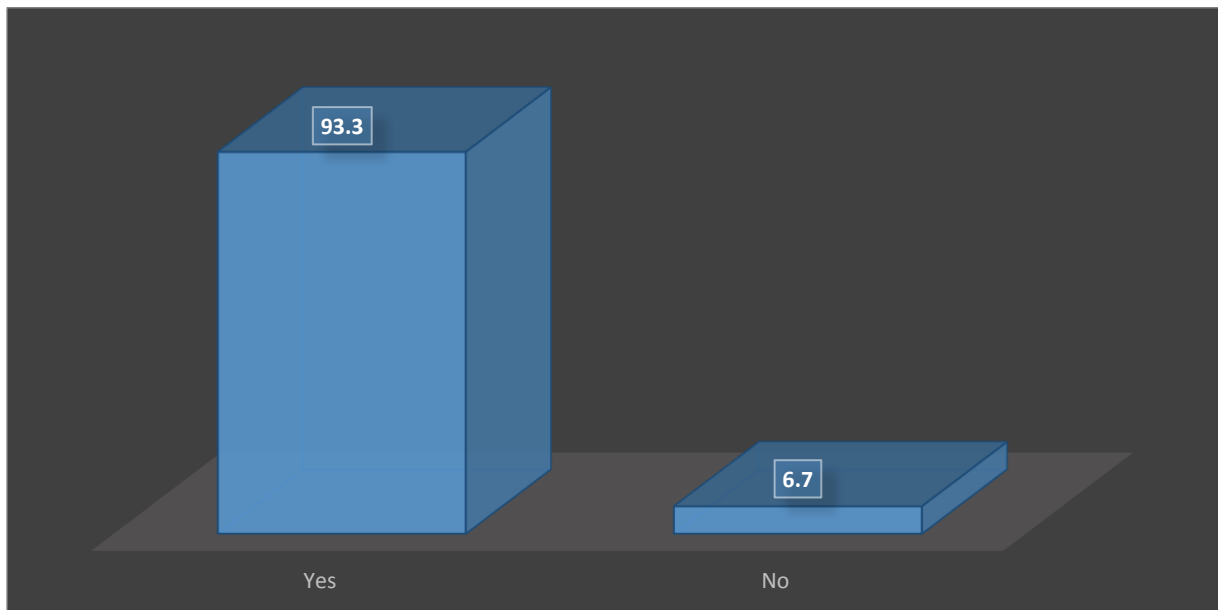
The outcome is an indication that specialty in the field of medicine is significant to potential doctors. A lecturer at the department had this to share:

Of course, it is good to specialize as time goes by since it adds to your qualification with extra money and it also comes to help in the field of medicine with respect to the area of specialization **(A lecturer at the college of health sciences, 2019).**

Another student reiterated that:

The five year policy introduced, makes doctors wonder what was the basis for this policy, one would rationalize that it is because they want to post doctors to the districts but if countries like Germany are giving physicians opportunities to specialize why would I want to stay if the number of years I can specialize is increased unduly to increase my burden, I will leave, why would I stay, unless I do not know what I want **(Kuma a medical student, 2019)**

Figure 4.9.4: Intention to specialize after graduation



Source: Field data, 2019

4.1.4 Targeted countries for specialization after graduation

Table 4.3 illustrates the countries students targeted for specialization after their studies. The USA was the most targeted country (48.1%). A good number of students also cited the UK as their preferred choice (19.2%) followed by Australia (14.4%). The rest of the student's choice of a country for specialization was less than 10 percent. It also shows a strong deciding factor for emigration as a result of one's intention to pursue further studies. Other reasons for such countries are that they are English speaking countries in which the migrants can adjust easily in addition to having the presence of their friends and relatives offer support. This is clearly stated in the statement below by Anita:

I would like to go to the UK, precisely London because I have about three friends working there as nurses. They all left after working in Ghana for some years and have been encouraging me to join them. My uncle is also in London so I believe it will be easier for me there (**Anita a final year medical student, 2019**)

Table 4.3: Targeted countries for specialization after graduation

Targeted countries for specialization	Frequency	Percent
Australia	15	14.4
UK	20	19.2
USA	50	48.1
Germany	10	9.6
Canada	8	7.7
Others	1	1.0
Total	104	100.0

Source: Field data, 2019

4.1.5 Intended preferred countries by Gender

Table 4.4 presents information on respondent's preferred countries should they migrate. Among the male population, more than a third (37.0%) of the respondents prefer UK while those who preferred USA were 15 times (24.7% - 9.9%) more than those chose Germany. The rest of the countries preferred by the respondents were less than 10 percent within the same population. In terms of the female population, UK and USA were the most preferred choice of destination followed by Canada (17.4%) and Canada (14.3%). The overall implication is that is the presence of social networks at the destination aide respondents to choose those countries as well as common official language and the existence of colonial ties. However, there was no statistical relationship ($\chi^2 = 21.975$, $df = 12$ and $p\text{-value} = 0.750 > 0.05$) between one's sex and preferred intended country.

Table 4.4: Intended preferred countries by Gender

Preferred countries	Gender		Total
	Male	Female	
Australia	10 (12.3%)	2 (8.7%)	12 (11.5%)
UK	30 (37.0%)	9 (39.1%)	39 (37.5%)
USA	20 (24.7%)	5 (21.7%)	25 (24.0%)
Germany	8 (9.9%)	3 (13.0%)	11 (10.6%)
Canada	6 (7.4%)	4 (17.4%)	10 (9.6%)
Other	7 (8.6%)	0 (0.0%)	7 (6.7%)
Total	81 (100.0%)	23 (100.0%)	104 (100.0%)

($\chi^2 = 21.975$, $df = 12$ and $p\text{-value} = 0.750 > 0.05$)

Source: Field data, 2019

4.1.6 Bivariate analysis between gender and intention to migrate

There was no relationship between gender and the intention to migrate. Table 4.5 shows that the proportion of male medical students who wanted to migrate was 46 times more (72.8% - 27.2%) more than those who were not willing to migrate. Similar responses were obtain with regards to female population. The findings also revealed that, men were more likely to migrate than women is not surprising because in many African countries, migration flows have traditionally been dominated by men (Adepoju, 2005). In recent years, however, the numbers of women migrating independently is on the increase and many scholars have therefore argued that migration flows are being feminised (Awumbila et al, 2014). Again, there was no significant association ($\chi^2 = 28.204$, $df = 30$ and $p\text{-value} = 0.657 > 0.05$) between one's gender and intention to migrate. The general implication is that one's migration intentions depends on the availability of it cultural capital as well as the presence of a network and likelihood opportunities at the destination. One female student had this to say:

Intention to migrate goes beyond one's gender. For me it has to do with information available in terms of opportunities as well as networks that have in those countries (Asana a medical student, 2019).

Table 4.5: Bivariate analysis between gender and intention to migrate

Gender	Migration intentions		Total
	Intended to migrate	Not intended to migrate	
Male	59 (72.8%)	22 (27.2%)	81 (100.0%)
Female	20 (87.0%)	3 (13.0%)	23 (100.0%)
Total	79 (76.0%)	25 (24.0%)	104 (100.0%)

($\chi^2 = 28.204$, $df = 30$ and $p\text{-value} = 0.657 > 0.05$)

Source: Field data, 2019

4.1.7 Percent distribution of age by intention to migrate

The data gathered also shows that age is another very important determinant of intention to migrate among health professionals (Dovlo, 2005). As shown in Table 4.6, the proportion of medical students who were willing to migrate constituted 91.7 percent for the age cohort (20-29) years followed by those within the age group of (30-39) years. One's willingness to migrate decreases as the ages increases. Similar responses were obtained from those who were not in a hasty to migrate but in the opposite way since the aged were more likely not to migrate as compared with the younger ones in terms of the percentages. This finding is consistent with other empirical findings which show that incidence of migration is always higher among the youth than the aged population (Elbadawy, 2010). However, there was no significant association ($\chi^2 = 13.312$, $df = 10$ and $p\text{-value} = 0.207 > 0.05$) between one's age and their intention to migrate but other factors like marriage can impede one's migration intentions making them have lower propensity to migrate while the younger ones with fewer responsibilities were susceptible to migration. This is captured in the statement below by a young medical student:

For my current age, it makes sense to migrate because if I do I will be able to work for many years before I retire. Currently I don't have any responsibilities to take care of and therefore migrating will come with cost since it involves only me (**Kweku a medical student, 2019**).

Table 4.6: Percent distribution of age by intention to migrate

Age	Migration intentions		Total
	Willing to migrate	Not willing to migrate	
20-29	22 (91.7%)	2 (8.3%)	24 (100.0%)
30-39	26 (83.9%)	5 (16.1%)	31 (100.0%)
40-49	19 (70.4%)	8 (29.6%)	27 (100.0%)
50-59	12 (54.5%)	10 (45.5%)	22 (100.0%)
Total	79 (76.0%)	25 (24.1%)	104 (100.0%)

($\chi^2 = 13.312$, $df = 10$ and $p\text{-value} = 0.207 > 0.05$)

Source: Field data, 2019

4.1.8 Cross tabulation between marital status and migration intentions

In terms of the relationship between marital status and intention to migrate, Table 4.7 shows that married medical students were less likely to have the intention to migrate from Ghana than their unmarried counterparts. In fact, more than half (68.6%) of married students had planned to migrate as against those within the marriage cohort with no migration plans. Majority of the students intending to migrate constitute singles (87.9%) as well as divorced or the widowed (85.7%). The reason is that this category of students is of less burden as compared with their married counterparts. However, there was significant association ($\chi^2 = 13.312$, $df = 10$ and $p\text{-value} = 0.002 < 0.05$) between respondent's marital status and their migration intentions. During the in-depth interviews, some female students explained that they would not want to leave their husbands behinds for fears that other women may take their husbands if they are away.

This is clearly captured in the statement below by 29 year old female student:

I would have liked to migrate to the UK to practice for some years but my main problem is my husband. I will lose him if I leave him here because many women are chasing him even when I am around (**Yayra a female medical student, 2019**)

Table 4.7: Cross tabulation between marital status and migration intentions

Marital status	Migration intentions		Total
	Willing to migrate	Not willing to migrate	
Married	35 (68.6%)	16 (31.4%)	51 (100.0%)
Cohabitation	9 (81.8%)	2 (18.2%)	11 (100.0%)
Single	29 (87.9%)	4 (12.1%)	33 (100.0%)
Divorced/separated	8 (85.7%)	1 (14.3%)	9 (100.0%)
Total	81 (79.3%)	23 (22.5%)	104 (100.0%)

($\chi^2 = 13.312$, $df = 10$ and $p\text{-value} = 0.002 < 0.05$)

Source: Field data, 2019

4.1.9 Push factors influencing emigration intentions

Out of the sampled population (104), the most essential push factors likely to motivate migration intentions in ranked order are poor working conditions (40.4%), lack of opportunities for career advancement (29.8%) and low salaries (14.4%). The rest of the push factors were less than 10 percent of the total responses obtained. These factors continue to fuel migration intentions in developing countries like Ghana when such challenges can be eliminated by attractive factors at a particular destination (Minize-Solari et al., 2010). This assertion was reiterated by one medical student:

Whenever I think of migration, the factors that influence my thoughts are lack of jobs and educational opportunities for higher learning in terms of scholarship within our country (**Fiifi, a final year medical student, 2019**).

Another student also alluded that:

As for me I will definitely migrate after school because friends of mine who completed earlier at this university and have migrated have improved in terms of their socio-economic status anytime they visit Ghana and are either advancing in their field of work or attaining higher education with specialities which is easily outside than my own country Ghana (**Kofo a student of school of medicine, 2019**)

Table 4.8: Push factors influencing emigration intentions

Push factors	Frequency	Percent
Poor working conditions	42	40.4
Inadequate medicines and equipment	10	9.6
Heavy workloads	6	5.8
Lack of opportunities for career advancement	31	29.8
Low salaries	15	14.4
Total	104	100.0

Source: Field data, 2019

4.2.1 Percent distribution of push factors motivating migration by gender

Push factors with respect to gender were explored. Among the male population, more than a quarter (28.4%) cited poor working conditions while 24.7 percent mentioned the lack of opportunities for career advancement followed by low salaries (21.0%). The same assertions were made by the female population but with lack of career advancement constituting the larger percentage (47.8%), overall, it was higher among females than males. With regard to both sexes, males were 23 times (24.7% - 47.8%) less than their female counterparts with lack of opportunities for career advancement as a push factor. However, there was no significant association ($\chi^2 = 19.276$, $df = 20$ and $p\text{-value} = 0.712 > 0.05$) between the push factors fuelling migration intentions and one's gender.

Table 4.9: Percent distribution of push factors motivating migration by gender

Push factors	Gender		Total
	Male	Female	
Poor working conditions	23 (28.4%)	6 (26.1%)	29 (27.9%)
Inadequate medicines and equipment	9 (11.1%)	1 (4.3%)	10 (9.6%)
Heavy work loads	12 (14.8%)	2 (8.7%)	14 (13.5%)
Lack of opportunities for career advancement	20 (24.7%)	11 (47.8%)	31 (29.8%)
Low salaries	17 (21.0%)	3 (13.0%)	20 (19.2%)
Total	81 (100.0%)	23 (100.0%)	104 (100.0)

Source: Field data, 2019

4.2.2 Pull factors influencing migration intentions

The results in Table 4.9.1 indicate that the essential pull factors likely to influence migration intentions are quality and variety of specialization training being offered (28.8%), higher wages in destination countries (24.0%), availability of good job abroad (19.2%) and prospects for professional advancement (13.5%). The rest of the pull factors were not more than 10 percent of the total response attained. The implication of this finding is that respondents perceived migration as the channel in order to enjoy the perceived economic fortunes at the destinations. The assertion by the respondents is consistent with Munize-Solari et al. (2010) who stated that migration only surfaces when reasons to leave elsewhere (push) can be eliminated by immediate pull factors at a particular destination. One lecturer had this to say as the reason propelling migration of students:

Nowadays education is not a guarantee to success anymore, so everybody is leaving Ghana after school to chase the perceived realities in Europe and elsewhere. When you look around, all those who have made it has top surgeons and others with specialities, a fraction of them spent some years outside before coming which motivate these students to migrate after school (**A lecturer at the medical school, University of Ghana**)

Table 4.9.1: Pull factors influencing intentions to emigrate

Pull factors	Frequency	Percent
Higher wages in destination countries	25	24.0
Prospects for professional advancement	14	13.5
Better opportunities for family abroad	7	6.7
Economic situation of the destination countries	5	4.8
Standard of living abroad	3	2.9
Availability of good jobs abroad	20	19.2
Quality and variety of specialization training being offered	30	28.8
Total	104	100.0

Source: Field data, 2019

4.2.3 Percent distribution of pull factors influencing migration intention by gender

In spite of the positives that surround migration, it has also been detrimental to origin areas due to factors that attract migrants and potential migrants to the destination. It is in this vein that respondent's view of the pull factors influencing migration intentions was explored in terms of gender. Out of the male population (81), a little over one-fifth (22.2%) cited higher wages in destination countries while prospects for professional advancement (19.8%) and quality and variety of specialization training being offered (18.5%) were the next immediate factors influencing one's migration intentions. The female population portrayed similar characteristics with regard to pull factors. More than a third of the female respondents (39.1%) cited higher wages in destination countries as the most essential pull factor. Again females citing better opportunities for families abroad were 7 times (16.0%- 8.7%) more than that of their male counterparts. The general implication is that both the male and female have similar pull factors

attracting them to the destination. Muniz-solari (2015) opined that pull factors that are strong to eliminate push factor influence potential migrant in their decision-making to migrate.

Table 4.9.2: Percent distribution of pull factors influencing migration intention by gender

Pull factors	Gender		Total
	Male	Female	
Higher wage in destination countries	18 (22.2%)	9 (39.1%)	27 (26.0%)
Prospects for professional advancement	16 (19.8%)	5 (21.7%)	21 (20.2%)
Better opportunities for family abroad	13 (19.8%)	2 (8.7%)	15 (14.4%)
Economic situation of destination country	6 (7.4%)	0 (0.0%)	6 (5.8%)
Standard of living	3 (3.7%)	1 (4.3%)	4 (3.8%)
Availability of good jobs abroad	10 (12.3%)	2 (8.7%)	12 (11.5%)
Quality and variety of specialization training being offered	15 (18.5%)	4 (17.4%)	19 (18.3%)
Total	81 (100.0%)	23 (100.0%)	104 (100.0%)

($\chi^2 = 18.906$, $df = 20$ and $p\text{-value} = 0.2306 > 0.05$)

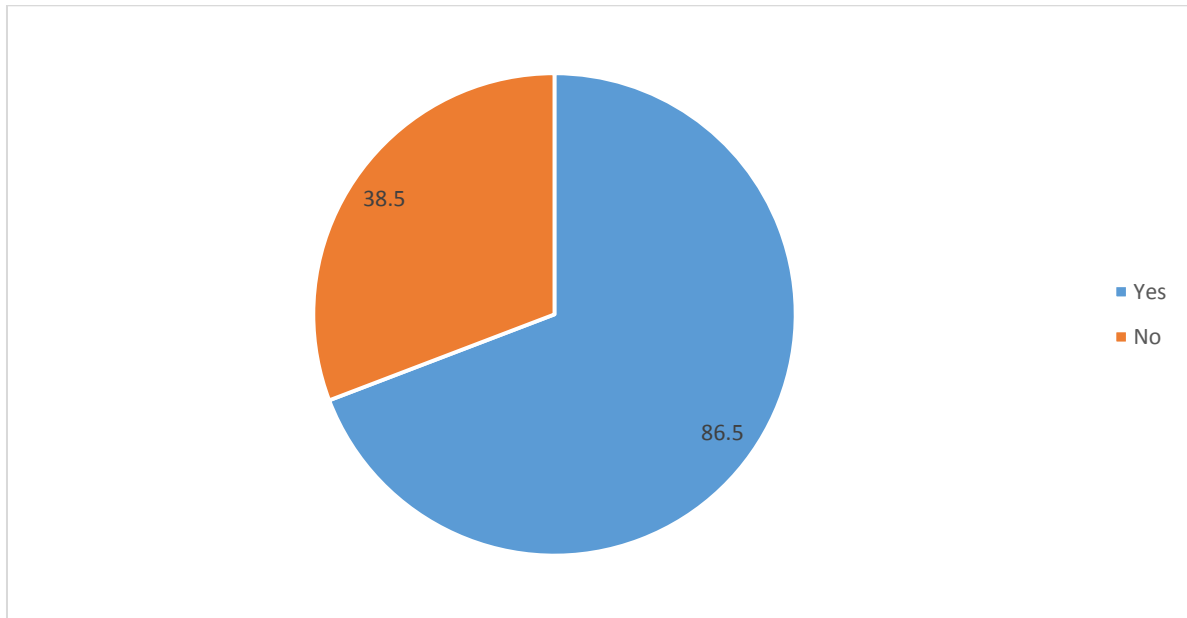
Source: Field data, 2019

4.2.4 Return intentions among medical students

Information presented in Figure 4.9.5 indicate that majority (86.5%) have the intention to return should they travel whereas more than a third (38.5%) responded no to return. The reason is that concept of return migration and its importance is beginning to have an impact on both potential and return migrants. One student had this to share in that regard:

I will definitely come back after some few years and pay my quota to the nation that developed me educationally through what has come to stay as brain gain concept in terms of bringing the knowledge acquire to the health sector and also training others
(**Enock a medical student, 2019**)

Figure 4.9.5: Return intentions among medical students



Source: Field data, 2019

4.2.5 Number of years to return to Ghana after migrating

Most students had plans of returning to Ghana after some period. In Table 4.9.3 large proportion (38.5%) of the students planned to return to Ghana after 5 years while those planning to stay for 10 years constituted 22.1 percent followed by the longer-term or permanent resident (19.2%). However, between 3-5 years was the next significant years students planned to stay in case they migrate. According to some of the respondents, most had intentions to return after 5 to 10 years of stay abroad. Within this period students are likely to have pursued their specialty programs and worked for some time to save money towards private practice. The patriotic spirit of students was also reflected in this section. A respondent had this to share in that regard:

I would like to come home after studying medicine in order to save lives because I feel satisfied in saving the lives of my own people (**Kwame a medical student, 2019**)

Another colleague also reiterated that:

I have the desire to contribute to the improvement of the health system in Ghana by coming back with the knowledge and skills acquired abroad. Finally, the prestige attached to the doctor's work in Ghana compared to abroad will play part in my return decision to return (**Papa Yaw a medical student, 2019**)

Table 4.9.3: Number of years to return to Ghana after migrating

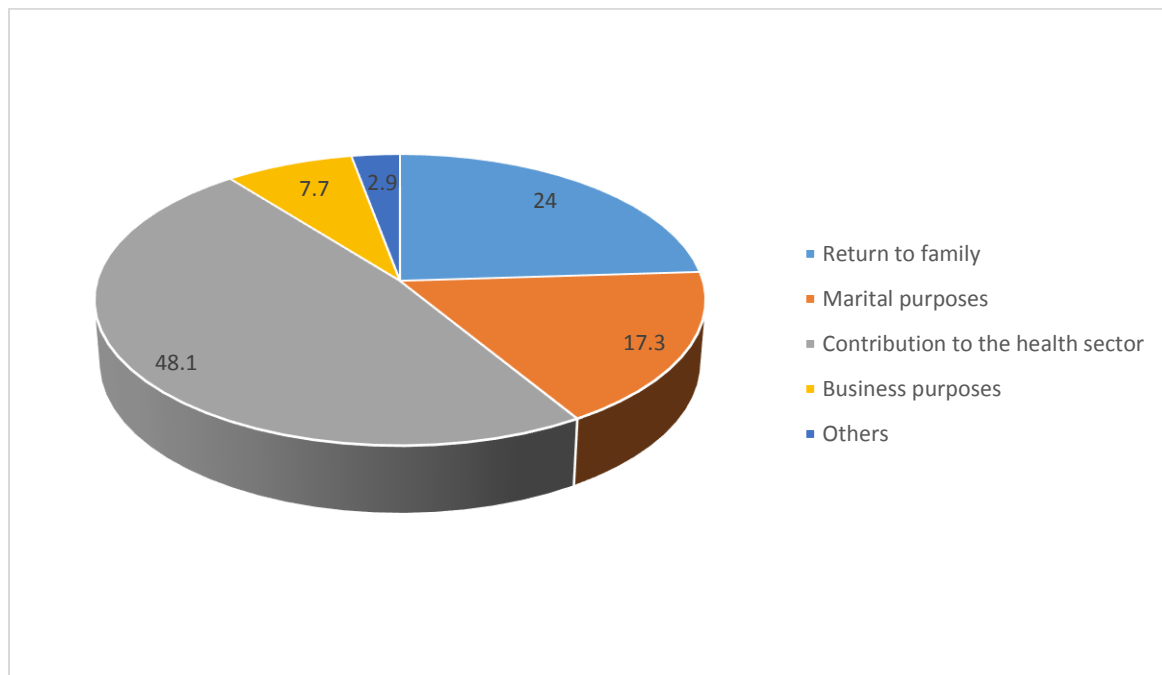
Number of years to return to Ghana	Frequent	Percent
Long term or permanent	20	19.2
After 10 years	23	22.1
After 5 years	40	38.5
Between 3-5 years	16	15.4
Less than 2 years	6	4.8
Total	104	100.0

Source: Field data, 2019

4.2.6 Reasons for future return

With regards to reasons intend to trigger the return of respondents, the findings indicate that close to half (48.1%) will be based on contribution to the health sector followed by family ties at the origin (24.0%). Marital purposes constituted 17.3 percent of the total responses obtained. The implication is that many of the respondent's decision to return is more of social than economical. This is consistent with work done by Wahba (2015) who posited that factors considered by return largely depends on social bonding and one's ability to work in the field he or she has been trained.

Figure 4.9.6: Reasons for future return



Source: Field data, 2019

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter concludes the study. It presents the summary of the key finds, conclusion and ends with recommendations.

5.1 Summary of findings

The first chapter presented the background on the migration of health professionals and the challenges of the health systems of most developing countries. A lot of resources are put into the training of doctors hence migration of doctors after their training is an issue of concern, especially for purposes of sustaining the necessary human capital to keep the health system going. The study sought to find the migration of medical students, the factors that influence intention to emigrate and the relationship between some demographic variables and migration intentions. The objectives were addressed through the study of the particular case of the University of Ghana Medical School, using a mixed-method approach. The results showed that majority of the medical students had intentions to emigrate. This decision was highly related to positive feedback from their networks in receiving countries. The respondents who had intention to emigrate were mainly in their youth (20-39) years. The most preferred destination countries were the USA, UK, and Germany. Intention to pursue further studies was a significant deciding factor to emigrate. Particularly students preferred to study abroad to escape the stress in medical school and also gain exposure to advance ways of practicing medicine.

Certain push, pull and intervening factors influenced intentions to emigrate. These factors include poor economic conditions, wage differentials, and poor working conditions. Wage differentials of doctors comparing developing and developed countries served as a demotivating factor and increased intention to emigrate. Most students desired high quality of life abroad compared to the poor quality of life in their recipient countries. Conditions of service further served as a push factor as it made the work of the doctor difficult.

There was a relationship between marital status and intention to migrate. This shows that medical students who were not married were more likely to have the intention of migrating abroad as compared to those who currently married. Medical students who were married have to consider the social, emotional, moral and financial implications on their migration on the nuclear family. Younger medical students were also more likely to have the intention to migrate than older ones and this is consistent with other empirical findings that show that incidence of migration is always higher among the youth than the aged population (Elbadawy, 2010). Furthermore, the findings revealed that there was no relationship between gender and intention to migrate since migration decisions go beyond one's sex.

5.2 Conclusion

The study makes the following conclusions based on broad issues on the study's theoretical framework, methodological approach and some key findings:

First, in the view of push-pull and network propositions, potential migrants constituting medical students make cost and benefit analyses of the push and pull factors at home and destination countries as well as the presence of social networks in such destination. However, the study has shown that their analyses are mainly economic and social which is likely to trigger migration intentions. This finding provides evidence that suggest that sometimes migrants intend to move to places with economic and social benefit such as better opportunities for career advancement, specialization areas as well as better education for their families. This is in line with work done by Awumbila et al. (2008) and Black et al. (2006).

Second, the demographic characteristics reveals a youthful population within the ages of 20 to 39 years which suggests that majority are near completion of school and are likely to migrate due to push factors (difficulties in getting job and poor working conditions) at home and pull

factors (employment and educational opportunities) at the destination. This finding supports scholarly studies by Kwankye et al., (2007) and Muniz-Solaris et al., (2010) and the push-pull approach that migration and its intentions surface when reasons to leave the origin (push) can be eliminated by specific pull factors at a particular destination. Therefore, it can be concluded that migration intentions emanate from such factors where potential migrants see migration as a means to improve upon their socio-economic status.

Challenges associated with migration of doctors have emerged as a result of globalization and efforts need to be put in place to derive more positives than the negatives. According to IOM (2009), the question is no longer whether to have migration, but rather how to manage migration effectively so as to enhance its positive effects and reduce its negative impacts. For managers of health issues, there is the need to be empowered to take steps to reduce uncontrolled turnover, and in particular turnover due to emigration.

5.3 Recommendation

As explicated by the students, the stress in medical school, the financial burden on students in terms of the high cost of living as a student and huge school fees all constitute a fraction of the numerous factors that contribute to the formation of their migration intentions. A complete restructuring of the training modules of medical students with emphasis on retention in mind will facilitate retention of a greater number of students. It is appropriate to learn from the experiences of developed countries by devising a mechanism where students can work part-time to subsidize their cost of living on campus and their school fees to reduce the financial burden on students and their sponsors. The study demonstrated statistically that a significant portion of the students has an intention to migrate after their study and the most preferred destination was the USA, UK, Australia, and Germany. Ghana can liaise with developed worlds especially countries where trained physicians

from Ghana currently work to source sponsorship to develop modern technology at the medical school to make teaching and learning easier, thereby giving students some exposure to advanced technologies in the medical field. In addition, exchange programs can be encouraged in conjunction with rural volunteering programs that will give students international exposure at the same time instill in students the spirit of patriotism.

Finally, more efforts may be directed towards stabilizing the economy to make the incentive of increased salaries effective. Disparities in salaries of health professionals may be given attention so as to prevent demotivation of other workers in the health sector. Additionally, due to inadequate resources Ghana can consider training of more physician assistants or prescribers whose certification is not internationally recognized thus limiting their propensity to migrate and who would also accept posting to deprived areas where services of doctors are needed most.

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APPENDICES

APPENDIX A

MIGRATION INTENTIONS OF HEALTH PROFESSIONALS: THE CASE OF FINAL YEAR MEDICAL STUDENTS, UNIVERSITY OF GHANA

QUESTIONNAIRE

I am a post-graduate (MA) Student of the Centre for Migration Studies, University of Ghana Legon. I am undertaking this research work as part of my course requirement. The study aims to investigate the “**Migration intentions of health professionals: The case of final year Medical students, University of Ghana**”.

I would like to assure you that all information collected is strictly for academic purposes and would be treated with utmost confidentiality. It would be appreciated if you could take some time to complete this questionnaire.

SECTION A: SOCIO-DEMOGRHAPHIC CHARACTERISTICS OF RESPONDENTS

1. Age of respondent
2. Gender a. Male b. Female
3. Marital status a. Married b. Cohabitation c. Single d. Divorced/ widowed
4. Number of children of respondent
5. Ethnicity a. Akan b. Ewe c. Ga-adangbe d. Northern e. International students and others.

SECTION B: MIGRATION INTENTIONS AND PROCESSES

6. Do you have any intention to migrate to a country outside Ghana? a. Yes b. No
7. If yes to Q6, which country do you intend to migrate to? a. Australia b. UK c. USA
d. Germany e. Canada f. Others (Specify).....
8. Why do you prefer that particular country?
9. Do you have any contact in that country of choice? a. Yes b. No
10. If yes to Q9, what is your relationship with that contact? -----
11. How many years do you intend to stay at the destination after migration? a. Less than
a year b. Within two years c. Within three to five years d. 5years e. 6 and more
years
12. What are some of the factors influencing your decision to emigrate? a. Poor working
conditions b. Inadequate medicine and equipment c. Heavy workloads d. Lack of
opportunities for career advancement e. Low salaries f. Others (Specify)
.....
13. What are the factors that attract you to the destination country? a. Higher wages in
destination countries b. Prospects for professional advancement c. Better
opportunities for family abroad d. Economic situation of destination countries e.
Standard of living abroad f. Availability of good jobs abroad g. Quality and variety
of specialization training being offered h. Others (Specify)
14. Do you have any intention to specialize after graduation? a. Yes b. No
15. If yes to Q14, which country have you targeted for such specialization? -----

SECTION C: RETURN INTENTIONS

16. Do you intend to return to Ghana after settling in your chosen country? a. Yes b. No

17. If yes to Q16, how many years do you intend to spend at the destination before returning? a. Long term or permanent b. After 10 years c. After 5 years d. Between 3-5 years e. Less than 2 years f. Others (Specify)

18. What would be the reasons for your return?

APPENDIX B

MIGRATION INTENTIONS OF HEALTH PROFESSIONALS: THE CASE OF FINAL YEAR MEDICAL STUDENTS, UNIVERSITY OF GHANA

The interview guide is meant to create a free flowing conversation that will last between 30 minutes to 45 minutes. I seek to find out the migration intentions of health professionals, the case of medical students in University of Ghana. Therefore I would try as much to probe respondents for an in-depth understanding of some pertinent issues.

I am an MA Candidate at the Centre for Migration Studies of University of Ghana, Legon-Accra. This field research is being conducted as part of my studies. I would be grateful if you could answer the questions below. Your participation in this study is very important but it is voluntary and you can withdraw at any point. Any information provided for this study would be treated with utmost confidentiality and for academic purposes only.

Interview guide for key informant (Lecturers of college of health sciences)

BACKGROUND INFORMATION

1. Can you please tell me something brief about yourself? (Probe for age, level of education, number of years worked, courses taught etc)
2. Can you briefly tell me effect of migration of medical students during and after school?

SECTION 1: MIGRATION INTENTIONS AND PROCESSES

3. Can you please tell me the likely impact of student's migration? (Probe for the trends of migration, positive effects (brain gain), negative effect (brain drain) on the health sector etc)

4. Please in your opinion how can we manage migration of medical students? (Probe for policy guidelines, availability of employment for students, further educational opportunities, career advancement schemes etc)

APPENDIX C

I am an MA Candidate at the Centre for Migration Studies of University of Ghana, Legon-Accra. This field research is being conducted as part of my studies. I would be grateful if you could answer the questions below. Your participation in this study is very important but it is voluntary and you can withdraw at any point. Any information provided for this study would be treated with utmost confidentiality and for academic purposes only.

Interview guide for key informant (Students)

BACKGROUND INFORMATION

1. Can you please tell me about yourself (Probe for age, ethnic background, marital status, etc)

SECTION 1: MIGRATION INTENTIONS AND PROCESSES

2. Do you have any intentions to migrate after your program? (Probe for, motivation factors, country of choice, reasons for such country etc)
3. What are the steps taken toward plans to emigrate? (Probe for possibility of enrolling in intensive language course, establishing contact with other migrants, browsing employment advertisement abroad etc)
4. What are some of the reasons that will cause you to live or work outside the country? (Probe for factors likely to trigger migration etc)

SECTION 2: RETURN INTENTIONS

5. Do you intend to return to Ghana after settling at the destination? (Probe for number of years likely to be spent at destination, reasons to initiate your return).
6. What will be you be doing after returning (Probe for establishment of work, transfer of knowledge , skills to others through training program etc)

