Attraction and Retention of Newly Qualified Medical Doctors to Deprived Regions in Ghana: A Qualitative Case Study

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Abstract

Healthcare delivery is labour-intensive. Therefore, the health worker's role is indispensable in maintaining and improving individual and population health. In Ghana, the doctor-patient ratio is 1:10,450, with a disproportionate tilt in favour of the relatively resource-rich southern part of the country. The Upper West Region, located in Northern Ghana, is among the poorest regions in the country. The study uncovered why medical doctors are unwilling to accept postings to the Upper West Region, where their services are needed most, despite some efforts to attract, motivate and retain them. Current initiatives by the Ministry of Health and its partners to attract and retain doctors in the Region were also examined. Qualitative methodology was employed with an in-depth interview guide to collect data. Sixteen respondents comprising medical doctors, health managers and other health-related partners purposively selected took part in the study. Data were recorded, transcribed, coded, and categorized into themes in tandem with the objectives of the study. The study found that medical doctors are unwilling to take up appointments in the Upper West Region because of limited career and continuing professional development opportunities, poor financial inducement, weak leadership, and other important contextual social and cultural factors. Critical success factors to surmount these challenges include concessions and sponsorship for medical specialization training for doctors and clear, implementable national and local policies on postings.

Key words: Attaction and Retention, Deprived Regions, Ghana, Medical Doctors, Newly Qualified

Introduction

The health status of the citizenry of any nation determines its productive capacity, economic position, and the general welfare of its populace. Thus, the standard of healthcare delivery is crucial to

the development of nations around the globe. Healthcare delivery is labour-intensive, and the most critical element of functional health systems is human resources for health. Consequently, managers of healthcare systems, in considering their local priorities and resource availability, strain to find the most effective blend of health professionals and workers necessary to accomplish their objectives (Kolié et al., 2023; Poku et al., 2023). However, the determination and achievement of the right mix and distribution of health personnel remain major challenges for most healthcare organizations and health systems (WHO, 2000). This, makes it difficult for health systems to achieve their obvious goal of making quality healthcare available to all their citizens, especiallythose in rural areas.

Attracting and retaining newly qualified medical doctors in deprived regions is a critical challenge faced by many countries across the world. According to Kolié et al. (2023), financial incentives significantly attract and retain health workers in deprived regions. Other studies suggest that offering higher salaries, financial incentives, and additional benefits such as housing allowances, educational support, and loan repayment programmes can encourage doctors to work in underserved areas, which is not the case in many low-and-middle income countries (Behera et al., 2019; Brugha, 2022; Van Dormael et al., 2008. This makes the deprived regions unattractive and reduces the retention rate.

It is important to note that professional growth and development opportunities are crucial for retaining doctors in deprived regions. Continuous medical education training programmes, mentorship, and career advancement opportunities can enhance job satisfaction and retention rates (Amiresmaeili et al., 2022; Kolié et al., 2023). Also, availability of infrastructure, medical equipment, and essential resources in deprived regions are important for doctors to provide quality healthcare services. Thus, the presence of improved healthcare facilities, well-equipped hospitals and clinics, and access to diagnostic tools and essential medicines in deprived regions can attract doctors to these regions (Behera et al., 2019), and a supportive work environment is crucial for retaining doctors them (Kerketta & A.N, 2022). Factors such as positive relationships with colleagues, effective leadership, and recognition for their work can enhance job satisfaction.

Availability of amenities and quality of life factors play a role in attracting doctors to deprived regions. Access to basic amenities like housing, schools, transportation, and recreational facilities for doctors and their families can positively impact retention rates. Involving doctors in community engagement activities can help them feel connected to the local population and develop a sense of purpose. Building relationships with the community and involving doctors in local health initiatives can increase job satisfaction and retention (Sirili et al., 2018). Government policies and initiatives on prioritizing healthcare infrastructure development, rural healthcare, and incentives for doctors working in deprived regions are pivotal (Brugha, 2022). Effective implementation of these policies, such as deploying doctors to underserved areas and supportive regulatory frameworks, can improve the attraction and retention rates worldwide (Amiresmaeili et al., 2022; Kerketta & A.N, 2022; Poku et al., 2023).

Ghana is no exception to this phenomenon. An assessment of the Ghana Health Sector Program of Work for 2013 revealed that out of the 2 615 doctors in the public sector , over 50% were in the Greater Accra Region. More than half of the remaining number were concentrated in the Ashanti Region, skewing the distribution to the detriment of the other eight regions of the country at the time (MoH, 2014). The government of Ghana is not oblivious to this problem; hence, several measures have been introduced to attract and retain health workers, particularly doctors, to deprived areas like the UWR.

Despite these interventions, anecdotal evidence shows that wide disparities exist between the deprived and underserved regions in the country and their relatively urban and resourceful counterparts in health worker distribution, particularly medical doctors (MoH, 2014). This study, therefore, sought to uncover, using qualitative methods, the initiatives taken by the Ministry of Health and other health-related partner organizations aimed at motivating, attracting, and retaining medical doctors in deprived regions and the factors militating against these initiatives with the Upper West Region as the case

Theoretical and Conceptual Framework

Human Resources has long been recognized as the catalyst for putting other factors of production to effective use because it provides the know-how or the skill, ideas, and manpower (Torrington et al., 2020). This study is underpinned by Adams' Equity Theory (Adams, 1963; Adams, 1965).

The equity theory proposed by John Stacy Adams in 1963 in his work on "Wage inequities, productivity, and work quality" centred on exchange relationships where individuals gave something (inputs) and, in return, expected something (outcome) (Adams, 1965). The adoption of the 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 a mutually beneficial exchange of inputs and outcomes. This theory is again, appropriate in this study's context where newly graduated medical doctors often opt to work in urban areas of the country because of the disparities in the working conditions between the urban and rural communities. Anecdotal evidence indicate that these conditions significantly influence the choice of place of work of these doctors.

The Conceptual Framework posits that effective attraction and retention of medical doctors in deprived areas may involve an exchange relationship that may be affected by several equity variables. However, success in attracting and retaining newly qualified medical doctors in deprived regions would be dependent on the proper identification of the stakeholders in the attraction and retention exchange relationship, the correct definition of the inputs of the stakeholders in the attraction and retention relationship, the identification of available outcomes by stakeholders, the determination of equitable outcomes in deprived areas of work, and the determination of inequitable outcomes in deprived areas of work. These when appropriately aligned and fed into national and local policies aimed at attracting and retaining medical doctors in deprived regions may see desirable results.

(see Figure 1).

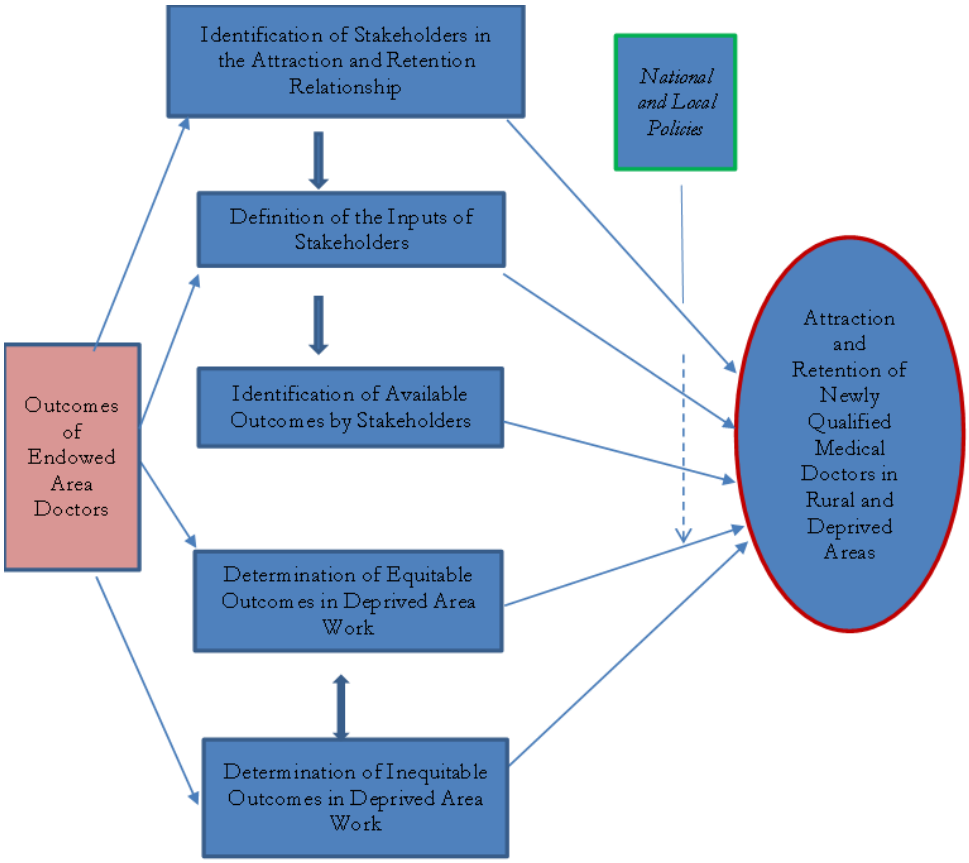

Figure 1: Conceptual Framework of Attraction and Retention of Newly Qualified Medical Doctors to Deprived Area

Source: Authors' Construct

Methodology

The study was a phenomenological single case study in design. The study area is the Upper West Region of Ghana. This Region was created in 1983 with Wa as its capital. The Region shares borders to the north with Burkina Faso, east with the Upper East Region, south with the Northern Region and Côte d'Ivoire to the west.

The study population was all present health workers in the Region, staff of the Upper West Regional Coordinating Council, staff of all District Assemblies (DAs) in the Region, and the Ministry of Health (MoH) and Ghana Health Service Headquarters staff.

The sampling technique used for the study was purposive; this technique was used to select twenty participants from among practicing doctors in the Upper

West Region, former medical doctors of

the UWR, Regional Directors of Health Services, Representatives of the UWR Coordinating Council, and District Coordinating Directors (DCDs). These individuals were purposefully selected because they were directly involved the subject matter of the research, and could offer rich inputs in attaining the aims of the study. Data saturation was reached with sixteen (16) eligible participants comprising eight (8) practising doctors, three (3) former doctor employees of the UWR, one (1) Regional Director of Health Services, one (1) representative of the Upper West Regional Coordinating Council, and three (3) District Coordinating Directors (DCDs).

Data were collected with a semi-structured interview guide from participants through in-depth interviews. Thus, 16 in-depth interviews were conducted, and they covered multiple participants at the levels of policy formulation and implementation, community leadership, and doctors who had practised or worked in the Region previously, doctors who were newly posted to Region from school, and had worked there for a minimum of one year and managers who have the mandate and authority to implement policy. Secondary data from journal articles, internet sources, policy documents, and reports were also used.

Before the start of the study, approval with the research protocol was sought from the Ghana Health Service Ethics Review Committee (ERC). Informed Consent of all participants was granted before their inclusion in the study. Confidentiality of data collected was ensured by using identifiers rather than names and titles of participants, and data obtained were safely guarded on a personal computer with a password. Participants were made to understand that participation in the study was voluntary, and thus, they reserved the right to either be part of the study or not, as well as having the freedom to withdraw from the study at any time without any untoward consequence. Permission was also sought from the participants to publish the findings of the study with anonymous quotes from them.

The digitally taped-recorded primary data obtained through interviews from the field were transcribed verbatim into a 91 paged document, and to draw inferences adequately, data were dismantled, split, and reconstructed (Boeijie, 2010). Using the data analysis approach of Miles and Hubberman (Miles & Huberman, 1994), the data were then coded and categorized into themes that reflected the respondents' views and were in tandem with the study's objectives. There was continuous coding and categorization throughout the process of data analysis to refine the major ideas. The study objectives and the theoretical framework informed the pattern of the analysis and discussion. As a guard against data loss, all recorded materials were backed up on other electronic devices, and the transcribed document was printed. Quotes were then generated to demonstrate the themes.

Findings

Ministry of Health Initiatives to Attract Doctors to Deprived Regions

The study identified specific initiatives the Ministry of Health and other health-related partners took to attract and retain doctors in the Upper West Region as Financial Incentive Packages and non-financial packages. The Financial Incentive Packages were financial

inducement policies meant to attract and retain medical doctors and other health workers in deprived areas of the country.

The Ghana Health Service issued directives for facilities to pay monthly allowances to their critical staff, known as Additional Duty Hours Allowance (ADHA) in 1999, to recognize the additional workload on the limited health staff, particularly doctors in the rural areas at the time. The Regional Coordinating Council (RCC) in 2007 gave a directive to all District Assemblies to pay a monthly salary to every Ghanaian doctor in the Upper West Region (Johnson et al., 2011; Ghana Ministry of Health, 2007).
The study also found that there had been a national directive by the Ghana Health Service since September 2014 aimed at offering educational support to doctors in their postgraduate education in the three northern regions and. There was also a policy that required the Ghana Health Service to specifically declare vacancies in rural areas, and the appointment of medical doctors was going to be dependent on the doctors accepting postings and reporting to work in rural areas to merit the educational support (Ghana Health Service, 2015).

The Regional Coordinating Council (RCC) had issued directives to all assemblies and health institutions since 2007 for all public sector doctors in the UWR to be offered free accommodation and utilities for as long as they stayed in the Region (Daniels et al., 2007).

The Ministry of Health, in collaboration with the Medical and Dental Council, requires 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 (GCPS, 2015)

Reasons for the Unwillingness to Accept Postings to the UWR

The study found that newly qualified doctors were unwilling to accept postings to the UWR for various reasons:

Training of doctors: The training of doctors does not equip them for rural work, so they were not adequately prepared to perform their duties in a rural setting. Rural hospitals lack most of the equipment and human resources needed to deliver quality healthcare, hence, the doctors found it difficult and sometimes almost impossible to work in a rural setting. This is how a participant put it:

> *"I think most of the younger ones are not well equipped for work in a rural setting, where you must be able to treat every kind of condition. Imagine that you are taken to a district hospital, you are the only person. You must be the obstetrician-gynaecologist, paediatrician, the surgeon and so on, if you are not very talented, and your skills are not up there, it's going to be a huge problem for you"* (A doctor)

The doctors who find themselves in the rural areas take up managerial duties which they find difficult because medical education does not include managerial training. One participant complained:

> *"You become the Medical Director in these hospitals while you are not prepared for it. Our training does not include management. We find it very difficult to combine managerial duties with medical practice."*. (A Doctor)

Time for private activities: Respondents complained that unlike their counterparts in the urban areas, who have some time

for private activities, doctors in the Upper West Region do not have that privilege. Indeed, some respondents were of the opinion that this factor was the single most important reason doctors tend to stay in the relatively endowed cities. One of such respondents stated;

> *"Most people will want to hang around the Teaching Hospitals and the bigger facilities where their absence will not be felt when they escape to do their private business, because of the large numbers of professionals there.* (A Doctor).

Career development: Doctors in the rural areas are disadvantaged to the extent that, they do not have the opportunity for career development. One of the respondents complained about this issue as follows:

> "*In the UWR here, there are no opportunities for career development. All the specialist, consultants and professors who will mentor us are concentrated in the urban areas.* (A Doctor)

Access to complementary skills and services: Unlike their rural counterparts, doctors in urban areas had access to complementary skills and services from senior colleagues and the private sector, who offer them the needed mentoring and support. The availability of complimentary services such as medical laboratory, radiological studies and pharmaceuticals help them achieve the needed results, thus, boosting their morale and motivation. These make it difficult to work effectively and achieve results in a rural setting. A respondent presented this as follows;

> *"Sometimes you are saddened when you write a prescription for a patient and you know that the patient cannot get the medicine. The person has to roam, one week, two weeks go to Kumasi, Tamale, Accra to look for a drug. By the time they get the medication the patient may have died.* (A Doctor)

Ineffectiveness of the interventions by MoH and partners: The study revealed that efforts by the Ministry of Health and partners to attract and retain medical Doctors to the Upper West Region did not bear fruits as expected, because doctors were still not willing to accept postings to the region, and the region is still deprived of physician services. The interventions' ineffectiveness was attributed to financial constraints impacting greatly on the facilities' efforts at sponsorship for career development or salary top up for doctors because their main source of income, the District Assembly Common Fund (DACF), had been erratic. A participant expressed:

> *"Our District Assembly Common fund is erratic, and owing to competing demands for other developmental needs, the sponsorship of doctors may deplete our coffers and render us incapable of meeting the needs of other sectors like education, transport etc.".* (A District Assembly Leader)

Lack of knowledge among leaders: There was also lack of knowledge exhibited by some leaders of the implementing institutions i.e., (the Regional Coordinating Council and District Assemblies) on the Assembly using some of their common fund to help retain doctors in the Region. This was identified when respondents were asked about the policies. One participant said:

> *"I was not here so I cannot remember" and this one I have not heard that we have to use some of the common fund for doctors. I'm hearing it for the first time, but I don't think*

we do it" (A District Assembly Leader)

Lack of coordinated efforts: A major managerial weakness was lack of coordinated efforts in the drive to attract doctors to the UWR. There was no proper reception and orientation offered to new doctors. One respondent intimated the following about the phenomenon:

"I think there is a challenge with leadership in general in the Region. By this I mean no one cares about taking steps to attract medical doctors to the Region or taking steps to motivate them and keep them when they come" (A Regional Coordinating Council Member)

Dependency of friends and relations on doctors: Dependency of relations and friends on the doctors was another issue identified by the study. This dependency comes in three forms: demand for preferential treatment, free services, and assistance with resources like money. This is because in the rural environment there are relatives and friends, and everyone knows the doctor. Many of these rural dwellers think that they are entitled to preferential treatment and free services and medications, or the doctor must support them financially. One respondent painted a vivid picture:

"Sometimes some relatives, when they come and they see you working, they think that you are the head of the place so the facility must be yours, and their treatment should be free [i.e., free services]. If you tell them that they have to go and buy medications, some will even be expecting you to dip into your packet and give them the money, this is resource dependency". (A Doctor)

Finding suitable life partners: One unique finding of this study is difficulty in finding suitable life partners. Finding suitable life partners was the reason for female doctors in particular, not accepting postings to the Region and particularly the districts. About 25% of respondents raised this issue and averred that, considering the social status of doctors, it will be difficult for female doctors to find husbands of their calibre or even above them in the rural communities. A serving doctor respondent shared this view:

"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 to be your husband, perhaps the chief or the chief's son … there are no marriage opportunities"

Quality of education for wards: Among the older doctors who had worked in the region before, one of their concerns was finding good schools for their school-going age children in the Region. In the rural areas, schools are of poor quality and they preferred moving to the cities where they could find schools of high quality so they can give their children better education. Thus:

"The main reason for my leaving the Region was to give my children better education, for most of the schools in the Upper West Region are of poor quality" (A Doctor)

Superstition and cultural beliefs: This study has found that one of the reasons that kept particularly indigenous medical doctors from accepting postings 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 socio-cultural and economic factors such as tradition, culture, superstition, financial, and amenities, and one doctor indicated:

"I think the issue has 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 in this area actually witchcraft and all the activities related to spiritualism are very high, and so they start working you all angles, fighting you from every angle, spiritually, physically and what have you". (A Doctor)

Though some practicing indigenous medical doctors in the study did not agree entirely with this 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?"* (A Doctor)

Discussion

Universal Health Coverage (UHC), as the World Health Organization recommended for all countries across the globe, requires that healthcare services be made available to all communities, whether rural or urban (Jashni et al., 2023; Kodali, 2023). The attainment of UHC is difficult for low-to-middle-income countries, including Ghana (Soors et al., 2015). The difficulty dwells mostly on establishing healthcare facilities and distributing healthcare professionals equitably to people from all walks of life. The most disadvantaged groups are found in rural communities. Governments of affected countries have had some measures to tackle this problem by putting in place the right calibre of healthcare personnel in rural areas.

This study identified the financial packages to draw doctors to rural areas like the Upper West Region: monthly incentives, Additional Duty Hours Allowance (ADHA) and Salary Top-up. To implement the attraction policies, the facilities were to use some of their internally generated funds to make the payments. Some facilities could not implement these policies due to lack of funds resulting from inconsistencies in the release of the District Assembly common fund (DACF). For many years now, the release of the DACF has not been regular, making it almost impossible to carry out business at the local level. This has rendered the healthcare partners at the local level unable to allocate funds to implement the policies meant to attract doctors to the Region. This is not different in Guinea where facilities are not able to support doctors and other health workers with agreed financial incentives packages (Witter et al., 2021).

The non-financial incentives included sponsorship for Postgraduate Training, declaration of vacancies in deprived areas for appointments of doctors, free accommodation and utilities, extended house-manship and post-house-manship to qualify for specialist training. These policies appear to be bold steps toward the distribution of doctors in the country. However, they were not successful because more doctors were attracted to more endowed facilities leaving the less endowed facilities still deprived. This incentive is akin to the profit-sharing

scheme found in Vietnam (Witter et al., 2015), where more endowed facilities could end up pulling more doctors than the less endowed ones. It is, therefore, imperative that in deciding on what will help motivate and retain doctors in deprived areas, factors perceived and felt to be inequitable are clearly identified and appropriately and dealt with in policy formulation and implementation mechanisms.

The findings of the study indicated that newly qualified doctors were unwilling to accept posting in rural regions. Some of the reasons the respondents gave were the difficulty of doctors to work in the rural setting because they were mostly trained in schools in urban areas, lack of managerial training, lack of extra time for private activity, limited opportunities for professional development, lack of access to complementary skills and services, and lack of mentors like senior colleagues. The training received by Ghanaian doctors is urban-oriented because the curricula made doctors function only satisfactorily in the urban setting, where there are specialists and consultants and the necessary gadgets. Thus, when these doctors find themselves in a rural setting where there are no specialists and consultants to mentor them and have no relevant equipment to work with, they feel lost and are unable to function. This situation is not exceptional as career development is one major priority that are keeping doctors in urban centers (Snow et al., 2011).

In the same rural areas, doctors became managers while receiving no managerial training according to the findings. They, therefore, have difficulty combining managerial and clinical activities. This calls for a rethink of the institutional, managerial arrangements and more value placed on professional managerial training for doctors during their training.

Doctors in the rural areas further argued that the excess time available to doctors in the urban areas allowed them to do private practice to supplement their income and combine work with career development because most higher learning centres were in the bigger cities. These privileges were unavailable to their counterparts in the Region. Previous studies back this study's finding that being in a rural area provides limited opportunities for continuous professional development; for example, a study found that professionals who take up jobs in rural and remote areas risk slowed or no career development and growth (Hatcher et al., 2014; Kemei & Etowa, 2021). This is also a deprivation input 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 (Mohammed, 2013).

The study also indicated that, despite the efforts made through the interventions stated in the previous section by the stakeholders to attract doctors and sustain them in the Upper West Region, their efforts were ineffective because doctors were still unwilling to accept posting to the Region. The ineffectiveness of the interventions was attributed to financial constraints, lack of knowledge about intervention policies by some important officeholders in powerful positions, and general weakness in leadership at the regional level.

Financial constraints impacted greatly the facilities' efforts at sponsorship for career development or salary top-up for doctors

because their main source of income, the District Assembly Common Fund, from the government had not been regular. Financial constraint is also loss input which is a deprivation input as explained by Witter (Witter et al., 2015), as things that a party loses in seeking to find solutions to a problem, such as sacrificing health infrastructure adjustments for salary by health authorities or an assembly sacrificing the sponsorship of teachers to sponsoring only doctors for training. In this case, the District Assemblies had to sacrifice other developmental needs to sponsor doctors or top up their salaries. Also, lack of knowledge about this among some sensitive office holders in the Region, as found in our study, could account for poor patronage of such schemes as in the sponsorship by assembles, just as earlier studies in Zambia also found (Agyepong et al. 2004). This may be a manifestation of weak leadership, both at the policy formulation and implementation levels (Ahmat et al., 2021; Collin et al., 2022). Hence, the need to develop a comprehensive policy document that will synthesize all the initiatives to be used for any recruitment drive. The essence of good leadership support by regional health departments and local government authorities in attracting and retaining health professionals in deprived areas has not been hidden by previous studies (Goma et al., 2014; Rao et al., 2013).

Another unique finding of this study is the resource dependence on doctors posted to deprived regions in the country. Though being a native of rural origin has been found to positively impact the choice of rural practice (Amalba et al., 2018), this dependency finding appears to be contrary to previous conclusions about rural indigenes.

The difficulty finding appropriate suitors agrees with earlier studies where females were less likely to take up postings to deprived areas for the same reason (Hatcher et al., 2014; Ramani et al., 2013). It must be stated here that at the time of collecting data for the research, there was not a single female Ghanaian doctor in the Region, thus giving further credence to this finding. Therefore, any attempts to get female doctors to rural areas will likely fail.

Though it was found that superstition affected indigenous doctors, some respondents argued that using such reasons could also scare away non-indigenes. They added that some doctors could be overly exploiting this view as an excuse not to take on appointment to the Region, adding that traditional leaders could make such beliefs' friendly'. It should, however, be pointed out 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 as some people in the Region are not discounting it completely.

This study is a case study of the Upper West Region of Ghana, and thus, findings may not be generalizeable to the entire country or around the globe, however, in areas within Ghana and elsewhere where contextual issues are similar to those of the study area, the findings and recommendations of the study may be very useful.

Conclusion

Sponsorship and bonding, salary top-ups, and vacancy declaration as some of the initiatives taken by various stakeholders in Ghana to attract and retain doctors to

deprived areas are insufficient. Thus, in closing the gap in the huge doctor/population ratio in deprived regions, a holistic policy on medical training and administration reforms, concessions in postgraduate medical specialization and aggressive sponsorship schemes, amidst other personal and socio-cultural factors would have to be considered to effectively attract and retain doctors in deprived regions of the country.

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