Assessing Policies and Strategies to Reduce the Impact of Health Worker Shortages in Primary Health Care Facilities in Ghana

by

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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

TABLES:

FIGURES:

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SUMMARY

The shortage of health workers in rural areas is a global challenge although its impact is greatest in low- and middle-income countries. In attempts to address this problem, interventions and strategies have been suggested and implemented but very little has been established or documented on the effectiveness and sustainability of these interventions in attracting health workers to stay in rural areas. In Ghana, despite policy interventions put in place to reduce the impact of rural health worker shortages and increase their retention in Primary Health Care (PHC) facilities for quality health care delivery, such facilities continue to lack adequate numbers of skilled health workers. This research was therefore designed to assess the effectiveness and level of implementation of interventions including task-shifting practice, incentive packages, and policies on recruitment, postings and finance, and to examine the push and pull factors that affect health workers' movements. The study in the Upper East region of Ghana was designed to achieve the following objectives: to explore policies and strategies (incentives) put in place to retain health workers; to explore the extent to which these policies and strategies worked; to examine the extent of task-shifting in management of inadequate numbers of health workers; and to explore the push and pull factors that affect health worker retention.

The study was conducted in 10 of the 13 districts in the Upper East region of Ghana. The districts were selected purposively to obtain a mix of health centres situated in typically rural, peri-rural and urban settings to improve the study area diversity. An interpretive phenomenology research design was used to understand the meaning and importance of health workers' and managers' perceptions and experiences of task-shifting, incentives and other policies regulating health workers in the study area. Qualitative methods and a realist evaluation framework approach were used, with data collected through field interviews and review of relevant policy documents. In total, 68 in-depth interviews were conducted with health workers in PHC facilities (health centres) and four in-depth interviews with key persons involved in staff management. The data were analysed using thematic analysis with inductive and deductive approaches.

The findings revealed that task-shifting was a common practice across health facilities to help reduce the impact of insufficient numbers of health workers. Generally, health workers had comprehensive training that supported the organisation of task-shifting. However, they were sometimes engaged in tasks above their level of training and beyond their job descriptions.

Adequate training was not usually provided before additional tasks were assigned. While some staff perceived the additional tasks they performed as an opportunity to learn new skills and become multipurpose, others described this as stressful, work overload or unsafe because of the tendency to complicate the health status of patients.

Different incentive packages, fiscal and non-fiscal, had been instituted to motivate health workers working in rural health facilities in the region. Generally, awareness levels about incentives varied among different cadres of health workers, with most of them unaware of their full incentives package. Health workers had different preferences for incentives and did not regard some as attractive enough to motivate them. Different cadres of health workers involved in the study had different perceptions on recruitment and posting policies and described the processes as unfair and employment contracts unclear. Push and pull factors that affected health worker retention in rural areas included distance from spouses and other family members, fear that unmarried workers would not find suitable partners in rural areas, poor infrastructure development, inadequate equipment, lack of ambulances to aid referrals, poor/inadequate social amenities and lack of safety.

The findings suggest that the impact of health worker shortages in the Upper East region of Ghana can be improved if task-shifting is systematically organised with adequate training and supervision put in place. Health workers should be made aware of all incentives and appropriate distribution mechanisms should be put in place to ensure that all workers benefit from incentives. Some incentive packages need modification, along with reinstatement of previous incentives and introduction of new ones to achieve the intended purpose of motivating health workers to work in rural areas. Health workers should be involved in formulation of their incentive packages so that their preferences can be considered. Policies on recruitment, posting and finance need modification so that health workers build trust in the health sector. Adequate social amenities and infrastructure development are required, and this shows the need for comprehensive programs rather than stand-alone interventions in rural areas.

STUDENT DECLARATION

I certify that this thesis does not incorporate without my acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where reference is made to it in the text.

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Date 31-07-2018

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To God almighty be the Glory for with Him all things are Possible.

ABBREVIATIONS

ADHA – Additional duty hour allowance

AHP – African Health Placement

ANC – Antenatal

BMC – Budget Management Centre

CHO – Community Health Officer

CHAG – Christian Health Association of Ghana

CHPS – Community-based Health Planning Services

DCO – Disease Control Officer

DMO – District Medical Officer

DHMT – District Health Management Team

ES – Eye Specialist

HSA – Health Service Administrator

HRO – Health Records Officer

GDHS – Ghana Demographic & Health Survey

GHS – Ghana Health Service

GSS – Ghana Statistical Service

HIV/AIDS – Human Immune Virus/Acquired Immune Deficiency Syndrome

HWAI – Health Workforce Advocacy Initiative

NHIS – National Health Insurance Scheme

MoH – Ministry of Health

NYEP – National Youth Employment Program

NGO – Non-government Organisation

PA – Physician Assistant

PHC – Primary Health Care

PN – Psychiatric Nurse

OPD – Out-Patient Department

UNAIDS – Joint United Nations Programme on HIV/AIDS

WHO – World Health Organization

CHAPTER 1
INTRODUCTION

1.1 Introduction

In this chapter, the background to human resource shortages in the health sector, especially in rural areas, is presented and the various policy interventions that have been instituted to address this challenge outlined. Specifically, this chapter focuses on the institution of various incentive packages to motivate health workers, the practice of task-shifting, and the push and pull factors that affect health worker retention in rural areas. There is an explanation of how rural health worker shortages became a public health concern. The problem statement and the significance of the study, the study aim, questions and specific objectives are stated. Finally, there is an overview of the thesis structure.

1.2 Background

Human resources are an essential component of health systems because adequate health care cannot be provided and made accessible to individuals without health workers (Buchan et al. 2013; WHO 2006b). As such, human resource shortages in the health sector have been considered an utmost pressing health issues globally, with the health worker shortage estimated to be nearly 4.3 million, which includes physicians, midwives, nurses and other health personnel (Aluttis, Bishaw & Frank 2014; Crisp & Chen 2014). There are 75 countries with less than 2.5 health professionals per 1000 population, though this is the minimum number required to provide basic health care, with most of these countries located in Africa (Lehmann, Dieleman & Martineau 2008; WHO 2006). Although Africa comprises only 11% of the world's population, it accounts for 25% of the global burden of disease and has only 4% of the global health workforce to tackle this problem (Bangdiwala et al. 2010). This situation is more critical in sub-Saharan Africa, where 36 countries have critical shortages of doctors, nurses and midwives (Kinney et al. 2010). Countries such as Ghana, South Africa, Zambia and Nigeria, with already stressed health systems, also experience considerable health worker shortages (Hoyler et al. 2014). The situation has been described in a World Health Organization (2006) report as amounting to a health workforce crisis. These countries require an increase of nearly 140% in the number of health professionals to meet

internationally acceptable standards of personnel-to-population ratio (Bangdiwala et al. 2010; Kinfu et al. 2009).

This problem of inadequate workforce is undermining the capacity of health systems in poor countries to implement interventions in maternal, neonatal and child health (Kinney et al. 2010). Targeted programs for HIV/AIDS, tuberculosis and malaria are similarly affected (Bangdiwala et al. 2010; Chen et al. 2004; Naranbhai et al. 2014). The training, recruitment, and retention of health workers remain significant challenges especially in rural areas, because health workers are often unwilling to accept posting to these areas (Awofeso 2010; Dielemann et al. 2003; Dussault, Gilles & Franceschini 2006; Lehmann, Dieleman & Martineau 2008). In many less developed countries, fewer than half the health personnel required are available to provide healthcare to rural populations (Buchan et al. 2013; Dielemann et al. 2003).

Although health worker shortages can impede quality healthcare delivery, greater impact occurs if such shortages are accompanied by an imbalanced workforce distribution (Buchan et al. 2013; Dussault, Gilles & Franceschini 2006). Loss of health professionals in rural areas lead to difficulties in accessing healthcare (Salafsky, Glasser & Ha 2005) and comparatively high mortality rates in these areas (Adzei & Atinga 2012; Buykx et al. 2010a; Chen et al. 2004), while lower nurse-to-patient ratios have also led to more problems and poorer health outcomes for patients (Sun et al. 2013). Other outcomes include increased costs and overcrowding by rural inhabitants in urban healthcare facilities (Buykx et al. 2010a; Dussault 1999; Global Health Workforce Alliance 2013) with increased workload subsequently causing work-related stress (Dieleman et al. 2011).

Public health research has recently been focused on how to reduce the impact of rural health worker shortages through task-shifting and the institution of various interventions including financial and non-financial incentives to improve retention of health workers in these areas (Bärnighausen & Bloom 2009; Grobler et al. 2009; Henderson & Tulloch 2008; Lehmann, Dieleman & Martineau 2008; Wilson et al. 2009). Task-shifting involves the use of available human resources by allocating tasks needing high skills to lower qualified health professionals (Dovlo 2004; WHO 2006). Over the years it has been adopted by many countries after it was encouraged by WHO as a means of ameliorating rural health worker shortages (WHO 2006). Despite these efforts, a detailed review of literature has revealed that very little is known regarding the effectiveness of the interventions that have been proposed

and implemented by countries worldwide, although assessment of interventions would provide important information to policy makers on their effectiveness and applicability in their own context (Dolea, Stormont & Braichet 2010). This has recently led policy makers and academics to consider assessing the level of the effectiveness of incentive packages in improving rural retention as one of the most priority areas of research in the health sector (Alliance for Health Policy and Systems Research 2008; Ranson et al. 2010).

1.3 Problem Statement and the Significance of the Study

Ghana, like many countries in sub-Saharan Africa, has experienced acute shortages of health personnel over the years (Ghana Health Service 2011; Liese, Blanchet & Dussault 2003). To a large measure, the situation is an outcome of the 'brain drain' that the country has experienced over the past few decades (Dovlo 2003). From the year 1993 to 2000, the percentage of trained graduates from the medical school in Ghana, who migrated from the country, was 68%. (Anderson et al. 2007). As a consequence, a considerable number of health facilities in the country lack doctors, pharmacists, midwives, anaesthetists and other critical health staff, making human resources for health services delivery the principal challenge for quality health services (Adzei & Atinga 2012). The shortage of health workers has hindered the success of developments including the attainment of the health-related millennium goals in various countries (Nullis-Kapp 2005), with Ghana not being exempt. The country is faced with the challenge of retaining health professionals and ensuring a balanced distribution of staff in rural communities (Adzei & Atinga 2012; Kwansah et al. 2012b). At present, rural health facilities remain largely under-resourced because of the difficulty of training, recruiting, and retaining health professionals. There is an inverse correlation between the number of health workers in a given population and disease-specific outcomes, maternal mortality, and infant mortality (Khan et al. 2003).

Ghana has high rates of infant and maternal mortality and morbidity, with the majority of cases occurring in rural and remote areas. According to the Ghana Demographic & Health Survey [GDHS], 2014, maternal death ratio is estimated at 378 per 100,000 live births and infant mortality rate in the urban area is 49 per 1000 live births but in the rural areas, it is 56 per 1000 live births (Ghana Demographic & Health Survey [GDHS] 2014). For children aged under five years, the mortality rates in urban and rural Ghana are 75 and 90 deaths per 1000 live births respectively. Despite high infant mortality in rural areas, there are skilled personnel in attendance for only 43% of rural births compared with 83% of births in urban

settings (GDHS 2008). Great disparities exist in the regions and these are most notable in the northern sector, with coverage is low. For instance, while in the predominantly urban Greater Accra Region there was skilled personnel in attendance at 84% of births, regions which are largely rural such as Upper West and Upper East recorded 47% and 46% respectively (GDHS 2008; Ghana Statistical Service 2009).

Similar to other countries, the distribution of health workers in Ghana is highly skewed towards urban centres (Adzei & Atinga 2012; Dolea, Stormont & Braichet 2010). In 2011, the Ghana Health Service (GHS) highlighted the difficulty of retaining human resources and inequitable distribution of available staff as major challenges hindering service efficiency. Although there was a 19% increase in the total number of different cadres of health workers in 2009, it was still difficult to recruit and retain them in largely rural regions such as the Upper East, with auxiliary nurses comprising almost half of all personnel working in this region (Ghana Health Service 2010; Kwansah et al. 2012a).

The issue of health worker recruitment and retention, mainly in rural areas of Ghana, is still high on the national agenda, so that high quality health care delivery will be achieved in these areas. However, the basic problem is that health workers are not willing to move to or stay in rural areas of Ghana (Adzei & Atinga 2012; Kwansah et al. 2012b), thus creating severe shortages of health workers which contribute to problems of health care accessibility (Salafsky, Glasser & Ha 2005). Factors such as inadequate supervision, infrastructure and equipment together with poor incentive packages have been identified as contributory push factors for health care personnel refusing to work in rural and remote areas (Hongoro & Normand 2006; Kruk et al. 2010; Lehmann, Dieleman & Martineau 2008). Uneven distribution of the few health personnel who are available is also an essential policy issue, caused by failures of recruitment and retention by employers (Buchan et al. 2013; Colvin et al. 2013; Kwansah et al. 2012b; Mullei et al. 2010). Apart from these efforts, policy makers and managers in many less developed countries have for years been exploring various means to increase retention of health workers in rural areas. The question therefore remains: How can health workers be persuaded to serve in rural areas?

Over the years, the government of Ghana and the Ghana Health Service have tried various interventions to retain Ghanaian health workers in the country and to entice them to accept postings to rural areas. These interventions have primarily been aimed at sustaining an appreciable level of district and community-based health delivery services. They include

training and use of auxiliary personnel, staff re-distribution, payment of rural service allowances (salary supplement), preferential conditions of service, community and/or local government support for health staff, provision of special incentive packages (Ghana Health Service 2011) and the adoption of adaptive mechanisms, such as task-shifting (Buchan et al. 2013; Colvin et al. 2013; Kinney et al. 2010).

Ghana and many other countries have relied largely on interventions like these to tackle human resource shortages, especially in rural areas (Kinney et al. 2010). However, the level of their implementation and the extent to which they contribute to amelioration of the effects of rural health worker shortages has not been investigated thoroughly nor well understood in Upper East region of Ghana. There has been no study of the impact of these policies on the retention of health workers in this region, hence this study will contribute to knowledge in this regard.

The findings of the study will help in shaping existing policies and interventions aimed at addressing health worker shortages and thereby improve their retention in the Upper East region of Ghana, by assessing the effectiveness and level of implementation of existing interventions. It will also help policy makers and implementers such as the Ministry of Health and Ghana Health Service to develop interventions to improve health worker retention in the region. The findings will also be made available to the authorities of the health facilities that participate in this study so that the researcher's recommendations can be incorporated into existing strategies.

1.4 The Study Aim, Questions and Specific Objectives

This study aims to assess the strategies and policy interventions put in place by policy makers to address health worker shortages in rural areas in the Upper East region of Ghana, and to get a better understanding of the push and pull factors that influence health worker retention.

1.4.1 Research Questions

What is the impact of targeted interventions on the retention of health workers in the Upper East region of Ghana?

What is the extent of the implementation of task-shifting in the management of inadequate numbers of skilled health personnel in the rural Upper East region of Ghana?

What are the push and pull factors affecting the retention of health workers in the Upper East region of Ghana?

1.4.2 Specific Objectives

1. To explore the policies and strategies (incentives) put in place to retain health workers in the Upper East region of Ghana.

2. To explore the extent to which the policies and interventions put in place to retain health workers in the Upper East region of Ghana have been successful.

3. To examine the extent of task-shifting in managing inadequate numbers of health workers in Primary Health Care facilities in the Upper East region of Ghana.

4. To explore the push and pull factors that affect retention of health workers in the Upper East region of Ghana.

1.5 Outline of the Thesis

This thesis consists of seven chapters. Chapter 1 has provided the introduction to the study where I discussed the background of the study which highlighted the impact of rural health worker shortages, the problem statement and the significance of the study. I have also introduced the aim of the research, research questions and the objectives.

In Chapter 2 there are critical reviews, analysis and discussion of the evidence relating to factors that influence health worker retention in rural areas from theoretical perspectives and practical views. The chapter begins with a comparative analysis of different theories which relate to the main issues of this thesis, followed by discussion of identified factors that influence the movement of workers and their motivation.

The methodological approach of the study is explained in Chapter 3, which includes a description of the study setting. This provides the context for the study design, including description of the strategies for recruiting study participants, data collection methods and the thematic approach used to analyse data.

In Chapters 4, 5 and 6 there is analysis of the findings of this study including the main themes that emerged from the data. These three chapters provide the contextual interpretation of each of the main themes and sub-themes by referring to the verbatim narratives of study participants. A section highlighting the main findings is provided at the end of each chapter,

The final chapter (Chapter 7) provides a conclusion to the thesis. It presents a summary of what the study has achieved. It also highlights the key arguments and the possible policy implications and recommendations on the issues to improve health worker retention in the Upper East region of Ghana and subsequently address rural health worker shortages.

1.6 Conclusion

The issue of how to address health worker shortages in rural areas and improve their retention is necessary for adequate health care delivery. As such, in understanding the effectiveness of policy interventions put in place to motivate and retain health workers in rural areas, it is important to explore the efforts under way and document strategies adopted to address difficulties in recruitment and retention. Previous studies have indicated the existence of various interventions geared towards health worker retention but there is a lack of literature on the effectiveness of these interventions, particularly in the Upper East region of Ghana. Therefore, this study will bridge this literature gap.

In this chapter, background information has been provided for this research, which aims to assess interventions to address rural health worker shortages and improve their retention. The next chapter provides a detailed review of literature relating to the core issues of this thesis.

CHAPTER 2
LITERATURE REVIEW

2.1 Introduction

In Chapter 1, the study was presented, the research problem defined, and the aim, objectives and significance of the research were explained. There was background information on various interventions aimed at addressing rural health worker shortages and thereby improving health worker retention.

This chapter contains a review the literature on the main factors that affect health workers' decisions to accept postings to, and remain in, rural areas. It begins with a comparative analysis of different theories associated with the core issues of this thesis. From there, the analysis proceeds to a discussion of the identified factors that contribute to workers' mobility and motivations. With a focus on the competing needs of the workers and the interests of the government (policy makers and politicians), the analysis seeks to underscore, in the context of worker satisfaction and productivity, the various issues that shape health workers' mobility from various theoretical and practical experiences. Central to the main theme of the thesis – assessing the policies and strategies to reduce the impact of health worker shortages in PHC facilities in Ghana – the content of the review is structured around the competing theoretical and practical foundations of the 'meanings,' 'interventions' and 'outcomes' of policies and strategies of public health governance. The chapter starts with an explanation of the method used to search for the needed literature. The review was structured in relation to the themes that emerged from the various studies.

2.1.1 Search Methods and Terms

A detailed systematic search was used to find relevant literature for this study. This focused on factors that affect retention of health workers in rural areas. The databases used to conduct the comprehensive search included PubMed, POPLINE, CINAHL, ProQuest Central and Google Scholar. Journals that were not indexed in the main databases but were accessible through the library of the World Health Organization and government reports were searched by hand. The following terms were used to search the databases: task-shifting*, retention of staff*, health policies*, rural areas retention*, job satisfaction*, retention in low and middle income countries*, push and pull factors*, incentive packages*, human needs theories*. These search terms were explored by themselves and in combination with professional

categorisations such as doctors*, physician assistants*, nurses*, healthcare workers* and mid-level* professionals. Boolean search terms such as 'AND and OR' were also used.

Additional searches were conducted in relevant journals such as human services research, rural health and human resources for health journals. A total of 198 research articles were retrieved during this search. Out of these, 130 were used and these included qualitative and quantitative studies, specifically those that addressed issues about rural health worker retention from theoretical perspectives and practical aspects. These articles were peer-reviewed, written in English and included literature reviews. A wide range of potential literature was included in the review process, which provided the researcher with deeper understanding of the various aspects of the study. Finally, a total of 130 peer-reviewed articles and eight reports were assessed and analysed thematically. The themes and sub-themes that were identified are detailed under four broad headings hereunder.

2.2 Section One: Theoretical Review

2.2.1 Job Satisfaction: Comparative Theoretical Perspectives

Job satisfaction is a popular concept that has been looked at by various scholars. It has been well documented in empiricist studies that show variations in the contextual conditions under which people's work choices are evaluated. It is a concept that is connected to productivity and motivation (Yasrebi et al. 2014). There appear to be various arguments in the literature on the meaning of job satisfaction. It is presumed that at any specific point in time, an individual occupies a point on a continuum that ranges from a strongly positive emotional state to a strongly negative one (Brown, Hohenshil & Brown 1998). The situational response of the individual depends on both external and internal factors, factors that are sometimes beyond the control of the individual. Thus, we can assume people's emotional state (of being and belonging) is affected by the level and pattern of interaction they have, or are aspiring to have, in and towards their communities (workplace and home). Normally this aspect of aspiration affirms their affective primordial connections to one another. It is this connectedness that invariably produces belief systems that see one's work as either satisfactory or non-satisfactory.

One content-specific theory is Maslow's (1943) needs-based theory (see Section 2.2.3 below). He stated that motivational pulls, as a measurement variable of job satisfaction or

non-satisfaction, are determined by needs. This perspective shows how unmet and unsatisfied needs are a representation of deficiencies in the workplace. Maslow contended that these deficiencies produce discomfort and restiveness in the individual, who will undertake activities that will reduce this discomfort. Once the lower level needs are satisfied, they no longer serve as motivators for the individual. There is the requirement, therefore, for jobs to provide a pathway for growth and acquisition of higher level needs because this could help improve the satisfaction level of individuals. More importantly, better motivation implies that individual unfulfilled needs have been recognised, and efforts put in place to meet them. This is because once lower level needs are fulfilled, the degree to which higher level needs are fulfilled becomes very important for regulating the degree of satisfaction experienced by an individual.

Content-specific theories of job satisfaction have examined intrinsic and extrinsic pull factors, but there also exist many process theories of satisfaction that, collectively, suggest methodologies that could help us understand how reactions to environmental stimuli combine to produce the state called satisfaction or dissatisfaction. Researchers have proposed that many emotional states that can be observed in humans appear to follow a regular pattern of change (Ekman 1992; Keltner & Haidt 1999; Mauss & Robinson 2009; Solomon 1980; Solomon & Corbit 1974). In process theories, people tend to look at their values and expectancies (Gruneberg 1979). This implies that workers select their behaviours to meet their needs. Contributor to this theory is Vroom (1982) . According to Vroom, individuals recognise in their jobs inputs such as capabilities, experiences, efforts and outcomes including salary, advancement, and recognition (Vroom 1982). In understanding the concept of this theory, equity theory comes into play. This explains that people seek social equity in the rewards they expect for performance. They feel fulfilled at work when their input to a job and the resulting outcome are equal to those of their peer workers (Page 2009).

Next, I consider what is meant by job satisfaction. There are several definitions for job satisfaction in the literature, including researchers such as Hoppock (1935) and Smith et al. (1969).. Robert Hoppock (1935) believed job satisfaction was dependent on a number of physiological, psychological, and environment conditions, which lead an individual to express satisfaction with a given job.

For Vroom (1982), job satisfaction is best understood through the prism of workers' emotional orientation toward their current job roles. For their part, Smith et al. (1969)

contend that job satisfaction is emotively connected to the feeling an individual has about his or her job. Another important element in Vroom's theory is the employee's personal decision-making within the work environment. He argued that, employees' decisions to do a task or not will be based on their perceived capability to do the work and be rewarded accordingly. The variables used by Vroom to define job satisfaction were expectancy, instrumentality and valence. Expectancy is an individual's perception of how well he or she can undertake the assigned task (Vroom 1982). The next variable, instrumentality, is the individual's confidence that he/she would be rewarded or compensated accordingly for accomplishing the work, and valence constitutes the value of the reward the employee expects (Vroom 1982). All these variables have their individual probability values and when all of them are high, employees will have higher satisfaction and motivation towards work. Conversely, if any variable is low, worker motivation will fall, consequently affecting work outcome.

The theory of job satisfaction proposed by Vroom (1964) examined the interaction between workplace and personal variables, taking into consideration employees' expectations. This theory emphasises that an employee's performance deserves appropriate rewards (Konrad & Pfeffer 1990; Vroom 1964). The reward must be according to the outcome of the employee because dissatisfaction might occur if an employee is rewarded with less than she/he expected or if the person feels there has been unfair treatment. Similarly, to prevent the employee from experiencing guilt, over-reward should be avoided. Rewards or compensations can take monetary or non-monetary forms. As Gruneberg (1979) tells us, salary is a personal achievement. He sees organisational salary status and the impact it has on the recognition of workers' abilities and capabilities to be connected only loosely, apart from the fact that it is the most visible and easily modified element of outcome and one which makes it possible to acquire material goods.

In the purview of Locke, job satisfaction, within its role as a tool that fulfils the social contract of people (to the state), is a positive or pleasurable reaction that results from an individual's job appraisal, attending especially to one's job experiences and/or job achievements (Locke 1969). In another study, Locke defines job satisfaction as "a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences" (Locke 1976, p.1300). This definition brings to light the concern that participatory research on job satisfaction should also focus on work motivation. All models, at the foundation level,

should position the worker at the centre of the analysis rather than the motivation to work. Locke contends motivations are nothing more than the utilisation of consumable energies whose (un)satisfactory level is measured by either an increase or decrease of the pleasurable experiences people face from their day-to-day experiences (Locke 1976). Intuitively, therefore, social energies and their corresponding effects on notions of reception or adaptation to work and authority, are an outcome of stimulating actions and the reaction of the individual (or the collective) towards the (in)sensitivities of rules and norms regulating work. These actions, whether positive or negative, are an indication of the potential that power-over 'others' have in framing people's thought processes of acceptability or rejection on one hand; and, on the other, how that stimulating thought process of receptiveness affects individual behaviour towards work (see also Landy [1978]).

As Locke polemically put it, the challenges mostly come with some form of increased responsibility; the inconveniences this produces determine the success of the pleasurable outcome (Locke 1976). This kind of analysis can be used to show the challenges associated with work-related promotions and the corresponding benefits (such as increases in bonuses and salary scale) and challenges (for example, of having to take full responsibility for the poor performance of junior workers).

Extrinsic factors, on the other hand, are external job-related factors such as conditions at work, management capabilities and salary incentives. These extrinsic factors have effect on job satisfaction (Martin & Schinke 1998). Conversely, Schultz and Schultz (1986) see job satisfaction as the psychological affinities and the subjective and objective pulls that attract people to their work and prevent them from transposing their responsibilities onto others even if they are required to do so. Siegel and Lane (1982), while agreeing with Schultz and Schultz about the subjectivities and objectivities surrounding a person's decision to keep on working, contend further that job satisfaction is determined by the emotional responses and the degree to which people emotively respond to the positivity produced by the incentives that come with their job. What they fail to say, and for which they have been criticised by other existentialists and constructivist scholars, is whether such emotional responses are what lead people to be attracted to the job or whether they are an outcome of the job. Either way, Siegel and Lane's (1982) experience-based hypothetical reasoning is still relevant in the theorisation of the causes and effect of policies on job satisfaction.

Adopting their reasoning, Lofquist and Davis (1991) provided justifiable examples to show that whether or not emotional responses have positive implications for job satisfaction, they should be seen not just in the lifestyles of the workers but also in shaping their individual reactions to the target environment. This reaction should be measured through a carefully devised, results-oriented appraisal and thought processes that reflect calls for a balance between their personal aspirations and the needs of the community/society within which they find themselves (Lofquist & Dawis 1991). Therefore, if job satisfaction is determined by aspirations, expectations and needs, including those that should benefit society, it simply means that the push and pull factors that affect people's decision to stay on in a specified job are not wholly determined by the people themselves. Rather, there are competing causes that impact the discursive representation of notions of like and dislike for a job when they make their decisions to stay or move on.

2.2.2 Causative Interpretation of Job Satisfaction – Interventions: From Theories to Practice

Although different scholars have explained job satisfaction in different ways over the years, all agree that there should be a common denominator that situates the notion of job satisfaction as an employment-related choice that has affirmative emotional effect on workers and their workplace specifically, and society more generally.

There appears to be less uniformity regarding the sources of job satisfaction. Studies have revealed that job satisfaction is created by factors such as job characteristics and individual traits (Wexley & Yukl 1984). To give clearer understanding to this, theories have been developed based on further studies that used Wexley and Yukl's framework**.** These theories looked at the presence or absence of certain intrinsic and extrinsic factors that could affect an individual's satisfaction level. Intrinsic factors are based on individual perceptions and feelings such as recognition, progression and obligation. Intrinsic factors, it should be noted here, are not only based on responsibilities and pleasures. Rather, they also produce what Herzberg et al. (1959; see also Locke 1965) have referred to as 'challenges'. By challenges, they mean the polyphonic complications that emerge out of people's pleasurable interactions.

In another study, Herzberg (1974) proposed that the job itself could serve as a source of motivation. He looked at job satisfaction and dissatisfaction and concluded that job characteristics generating dissatisfaction were different from those generating satisfaction. Hertzberg identified the elements that contribute to each dimension as motivators and

hygiene factors. Motivators are intrinsic factors that influence satisfaction based on fulfilling higher-level needs such as accomplishment, opportunity for advancement and recognition. Hygiene factors are extrinsic factors such as salary, work situation and interpersonal relationships that must be met to prevent dissatisfaction (Herzberg 1974). While poor hygiene factors imply dissatisfaction, the absence of them does not automatically lead to satisfaction. Where individuals are satisfied with their work, motivators exist but removing the motivators does not automatically lead to less satisfaction. To a higher extent, job satisfaction depends on the extrinsic characteristics of the job such that the job can fulfil an individual's higher needs for self-actualisation, an important insight of Hertzberg's Motivator–Hygiene theory.

What is the role of motivation in job satisfaction? And what are the factors that motivate people to work—even if they are not emotionally connected or attracted to the kind of work they do? In the next section, a critical review and discussion of these questions is presented. The aim here is not merely to talk about the factors, but also to show how existing theories cannot fully be used to explain the key variable, the individual in the Third World (and Ghana, specifically) in the theorisation of the competing variables on motivation**.** It is the absence of this key variable, the individual worker, whose world views and situational circumstances have not been fully understood and theoretically positioned, that showed me the need for this study to explore and document the local realities that influence health worker retention in rural areas.

Another theory of job satisfaction is the situational theory of satisfaction. According to this, job satisfaction is based on elements such as situational characteristics and situational occurrences. Situational characteristics include salary, management abilities such as supervision, career advancement opportunities, and work policies that are considered by the worker before accepting a job offer (Quarstein, McAfee & Glassman 1992). Situational occurrences occur after a person has taken the job, and might be positive or negative, tangible or intangible. For instance, a negative occurrence could be the absence of adequate equipment for work.

Neo-Marxism is closely related to this situational theorisation of satisfaction. For neo-Marxists, job satisfaction is not only about employees in the same workplace, but also extends to other institutions that are considered similar employment places (Milkovich & Newman 1990). In other words, the satisfaction of workers in 'Workplace A' also depends on the satisfaction that workers in 'Workplace B' enjoy. This neo-Marxist thinking sees

satisfaction as something that cuts across social and economic boundaries and adopts a transnational outlook.

2.2.3 Between Politics and Governance – Outcomes: Human Needs and Interest-based Perspectives

At the epicentre of discourses on global human resource management for health is the political being; the individual, collectively understood as the initiator, implementer and (in) direct beneficiary of policies that feed into the public good. How to understand this individual, his/her motivations and needs has long been an area of epistemological inquiry. What are the pull and push factors that regulate people within their environment—the workspace and other spaces that collectively form the social polity within which others are directly affected? Despite theoretical differences embedded in theories that have been used to understand the socio-political and economic spaces, they have all situated the individual as a being that is capable of experimenting with competing ideas, and interestingly, such people-centric experimentation has shown how people are, in fact, an outcome of the experimentation of the self.

As such, the political uses of health policies have taken various forms; forms that do not exclude the use of people to achieve the desires of the collective. In the formulation and implementation of policies that regulate workers, we have seen the creation of countless perspectives at both global and national levels. Benchmarks to access, monitor and evaluate policies are constantly being developed (Daniels et al. 2000; Navarro 2008) and it is evident that policies do not exist in a vacuum. They are created for and regulated by people, who despite their collective desires to promote the welfare of the collective also have their individual, albeit competing, needs and aspirations. In trying to understand the delimiting factors that affect policy successes and failures in relation to individual workers' receptiveness to bureaucratic policies, many competing ideas have been proposed to suit different contexts.

Abraham Maslow's (1949) basic needs theory has as its central premise the hierarchical nature of people's needs. Maslow claimed that, removed from society, people are faced with multifaceted choices that compete between needs and wants. Where wants are determined by means—understood here, within its Smithsonian economic limits, as means (to an end; rather than an end in itself)—the natural initiative to put needs on a scale of preferences creates a problem of choice. In Maslow's purview, this scaling leads to the hierarchical positioning of

needs. To this, he contended that within this scale, the basic, and sometimes trivial, needs should be met first before more important needs can be achieved. Applying basic needs theory to the recruitment and retention of workers in rural areas, African Health Placement (AHP) (2014) contends that "one can assume that before reaching the top two tiers of the triangle (i.e. esteem needs and self-actualisation), a person (in our case, health policy makers) will first have to achieve reliable and sufficient income, suitable accommodation, security, stability, confidence, a well-looked-after family and good relationships at work".

In this regard, they further contend that health workers should gain satisfaction from the various types of jobs they perform. There needs to be a workplace environment wherein workers are willing to take full responsibility for what happens there—a willingness that brings with it a sense of achievement and personal growth. But this willingness, they contend, is determined by the actualisation of basic needs, identified (and discussed) as accommodation and security, social support and education (AHP 2014).

One of the vital problems affecting staff retention in rural health facilities is the availability and quality of accommodation, because in most instances health care facilities cannot provide accommodation for all health care workers (AHP 2014). In some instances, accommodation is not of good standard and nor well maintained. This leads to health workers having to tolerate lower standard accommodation or instead rent houses that can be far from the facility and necessitate reliable means of transportation. To some extent, this is because funding allocated to facilities is normally used to purchase immediate items needed to provide care, such as drugs and other supplies. Consequently, little attention is given to housing, which falls into a poor state of repair.

Personal security is affected when staff must choose between low-standard accommodation close to the facility or better accommodation further away. Housing that is not well maintained is innately less secure, while safe accommodation might not be available within a reasonable distance, meaning health workers are compelled to choose between travelling long distances to work or living in closer but less secure housing (AHP 2014). The effects of inadequate accommodation are magnified when health workers realise that their colleagues are resigning because of the poor conditions. This not only intensifies the workload but also increases awareness of loneliness (Dieleman et al. 2011). In relation to social support, loneliness is common to rural areas and can be either a pull or a push factor. While it could be attractive for some to live far from the city, rural inhabitants must travel long distances on

bad routes to purchase basic items or to see families and friends. It becomes tiring and time consuming when people need to travel several hours to accomplish simple everyday activities.

Education may act as an incentive for staff to move from rural areas. AHP state that training and career progression opportunities are critical in shaping the mobility of health workers. People with higher levels of education are less likely to want to work in rural areas, while those with less education are more likely to stay and work there. Although this is beyond the scope of this research, it is essential to observe that AHP did not discuss and possibly failed to understand the fact that staff at rural facilities generally have lower education levels and that this can affect the standard of health care that people in rural areas receive.

Management theory is one thing, but putting theories into practice is another. This is especially true in less developed countries like Ghana, where people's needs are hard to understand and quantify. This is partly because of the lack of information and technology, but also because the processes of policy development are top-down, making use of expert opinions rather than consulting health workers (Ghana Health Service 2011). Policies are made largely without the participation of the workers in the field. Their thoughts are usually neglected, and if they are considered they are interpreted as factors that compromise the successful implementation of bureaucratic policies.

From what has been said so far, it is evident that formulation of policies governing the management of human resources for health care is a complex issue, especially when the politics surrounding formulation, implementation, evaluation and associated consequences are considered. Policy formulation is not just about the needs of the people (including the workers), but also about the political purposes it serves (Navarro & Shi 2001). It is about the logic of consequences, whereby rational actions are taken by parties to maximise result-oriented outcomes (Navarro 2008; Navarro & Shi 2001). This is especially the case where the logic of appropriateness (Goldmann 2005) surrounding the creation of bureaucratic policies for the maximisation of intended outcomes is heavily mediated by standardised work ethics and sociocultural norms (Campbell 2002; Olive, Raymond & Gunasekara 2011). These norms are regulated by desires and thought processes, where, in the end, the policy takes an ideational turn (Campbell 2004; Hall 1993). As such, the need to understand the political undercurrents in human resource management for health becomes all the more relevant. Its relevance, however, also hinges on the norms and socio-political practices of the health

workers for whom and by whom these policies are developed. The predisposition of norms, social context and their corresponding influences on patterns of interaction between policy makers, politicians and ordinary health workers in the field is under-researched in the human resource management policies of the health and social services sectors in West Africa, most specifically Ghana.

Health policies are adopted for the purposes of either achieving political mandates or to intervene, on humanitarian grounds, to alleviate the sufferings of the less privileged in society. In both cases, rational choices—which are determined by the logic of appropriateness and consequences—are intuitively about the interface of subjectivities and uncodified socio-political practices (Goldmann 2005; Tsebelis 1990). In attempting to understand these subjectivities and how they interface with policy-driven human resource management to produce a pull-and-push phenomenon, I posit that there is a need to examine the views of health workers on policy strategies put in place to retain staff in rural areas.

To date, there has not been a cost–benefit analysis of whether direct involvement (or exclusion, conversely) of health workers in policy development would maximise positive outcomes or compromise policy directives. There is little knowledge about when or how to involve them, or what the nature of their input should be. Such matters can only be understood by understanding the perceptions of these health workers regarding the various policy interventions and strategies put in place for their retention. The interaction between politicians and policy experts is also determined by normative subjectivities, but it can be analysed under a number of well-defined policy-oriented bureaucratic standards that spell out their terms of reference (Scharpf 1997). This is specifically true in the case of Ghana, where views about work and ethics have traditional undertones. As such, interviewing health workers could reveal the local realities which in turn could help to give a clearer picture of what characterises their mobility in (northern) Ghana.

What then can be constructed or deconstructed from this politics–policy interplay? How can we use it in our attempts to understand human resource management for health issues? Despite the nuances that have been associated with the use of subjectivities—which we should note cannot be understood through empiricist scientific study—qualitative studies appear to be the best means through which we can understand how power and place, interest and needs have all helped to frame and regulate health policies in Africa generally, and Ghana, most specifically.

There is truism in this because, as the case of Ghana demonstrates, it is thoughts that are translated into actions, and actions are always backed by policies (Asante & Zwi 2009; Asante, Zwi & Ho 2006; Cassels & Janovsky 1992). Be they standardised principles or not, health policies carry with them social meanings (Wilkinson & Marmot 2003). These social meanings are created from a complex and sometimes specific mix of various beliefs, history and notions, which must be understood if we are to proffer a better template of the behaviour of health workers, in relation to their reaction to state health policies that regulate their recruitment, postings and retention. For instance, the variations of people's circumstances and the environment within which they live can determine policy typology.

Comparatively, the practical application of national health policies for northern Ghana and southern Ghana is different. The ways people in the north perceive these policies, in terms of purpose, use and intended outcomes, might be different from the way those in the relatively affluent south would understand them. Because of the existence of several norms, people in the north could attach subjective reasoning to everything. These attributive meanings could be understood differently by the national government in Accra, the political and administrative capital, and its international health partners. In the past, the nuances of these social meanings have had a central role in the development of health policies (Wireko & Béland 2013), especially during the 1970s when political debate started over the need to recognise and incorporate traditional healers and herbalists into the formal regulatory health systems of Ghana.

As well as differences in social meanings surrounding issues about human resources for health care, lack of region-specific policies could also affect the ways health workers react to their postings in the north and how local people interact with them. From the political perspective, we could say that the subjectivities and structures at the local level might not have been taken into consideration. For policy makers in the Ministry of Health, their interpretation of these subjectivist constructions also determines their historically strategic culture of managing the health sector in ways that do not trivialise conventional wisdom and replace it with a proliferation of competing individual perceptions.

That said, a central focus of this political understanding of public health policy development, as it relates to understanding the pull and push factors that affect recruitment and retention of health workers, is the social context in which policy processes occur. As such, my concern is what leads people to identify best practices and how that rationality becomes a driver for

deciding whether to accept authoritative dictates and stay where they have been posted to work. I will call this kind of action 'ideational rationality', in that the rational reactions to policy have a crowd psychology pull (Drury & Reicher 2000). The perceptions and desires of health policy makers and politicians also determine the behaviours of health workers towards their employment and retention in rural areas.

While it remains a matter for open debate, I am of the view that the policies of the Ghanaian government could be a representation of its character of being a rational actor (Barnes & Sheppard 1992) in the management of health polices in northern Ghana. Variations in terms of health perspectives, coupled with health workers' desires and the existentialist belief systems in communities, goes beyond the simplistic argument that governments pursue policies for the sake of having policies in place. They are determined by factors such as political survival, power, and budget savings reasons (Navarro 2008; Navarro & Shi 2001). In the end, the views of individual health workers may be of no value in the framing of government policies, even though they bear the brunt of policy decisions.

2.3 Section Two - A Global Survey of the Issues: A Situational Analysis

The purpose of this section is to review the issues surrounding unequal distribution of health workers and its associated problems across countries, and further examine trends in the rural–urban movement of health workers, to get a comprehensive understanding of the situation. Factors influencing health worker retention and the main strategies adopted worldwide to attract and retain health workers in rural and remote areas will be reviewed to comprehend and document the various efforts underway to minimise the effects of rural health worker shortages.

The effects of poor recruitment and retention of (un)qualified health personnel, particularly in rural areas, have been well documented (Awases et al. 2004; Awofeso 2010; Dussault, Gilles & Franceschini 2006; Lehmann, Dieleman & Martineau 2008). Staff vacancies are reported for all health professions with more vacancies in rural settings, suggesting that rural inhabitants, particularly in less developed countries, have less access to qualified health workers and consequently experience poorer health than those living in urban areas (Francis 2012; Francis, Bowman & Redgrave 2002). These health workers include medical doctors, nurses, indigenous health workers, pharmacists, laboratory technicians and others.

2.3.1 Uneven Distribution of Health Workers: More Developed versus Less Developed countries

Global imbalances in the distribution of health workers greatly affect the least developed countries, especially those in Sub-Saharan Africa and Asia. The situation is, however, different for middle-income countries in Asia, especially Malaysia and China; in Latin America, in the case of Brazil and Cuba; and for developed countries of the West, such as Australia and Scandinavia. Asia, with about half of the population worldwide, has about 30% of the world's health professional accessible to them, while Africa, which has the world's highest concentration of tropical communicable and non-communicable diseases, is facing a severe health worker crisis (Joint Learning Initiative 2004). In both continents, emigration of available health workers to more affluent countries and government neglect of health infrastructure are among the factors that contribute to these persistent problems of disease and inequality.

The situation is worst in sub-Saharan Africa. There are serious shortages and unequal distribution of doctors and nurses, high levels of illiteracy, sexual and gender based violence, economic poverty (leading to the inability to buy medications) and urban–rural inequalities, all of which have led to deplorable health care outcomes (Chen et al. 2004). The HIV/AIDS epidemic is exacerbating the situation. It has contributed to higher workloads for the limited number of health personnel, some of whom, though rare, have contracted the virus while caring for patients (Anyangwe & Mtonga 2007; Chen et al. 2004; Tawfik & Kinoti 2006). The fragmentation of health systems in low-income countries has also reinforced global inequalities and increased the unequal distribution of health workers, making it hard to meet the needs of rural populations (Joint Learning Initiative 2004; Lehmann, Dieleman & Martineau 2008).

International migration, especially emigration of trained and experienced staff, is also largely to blame for the present crises, with substantial numbers of health personnel moving to affluent nations (Hongoro & Normand 2006; Martineau, Decker & Bundred 2002; Willis-Shattuck et al. 2008). There are many reasons for both internal and external migration of health workers. These include organisational issues as well as social and political factors (Anand & Bärnighausen 2007; Denham & Shaddock 2004).

For example, better quality of life, professional development, improved pay and working conditions and personal safety have been shown to contribute to nurses' migration (Kingma 2007). Research conducted in six African countries revealed that majority health professionals intended to move to other countries for higher remunerations (Hongoro & Normand 2006). It is estimated that approximately $500 million is disbursed yearly in Africa on medical training of health workers leave for other countries (Chen et al., 2005). The training of a single medical doctor in Kenya from basic education to completion requires US$65,997 and as such when a doctor migrates, it represents a loss of investment of US$517,931 (Kirigia et al. 2006). The World Health Organization (2006) reported that about 30,000 of health professionals trained in sub-Saharan Africa are currently employed in various Organization for Economic Cooperation and Development (OECD) countries.

The trends discussed above are very similar to those observed in Ghana. For example, of the 489 doctors trained between 1985 and 1995, only 191 were still employed in the country (Dovlo & Nyonator 1999). A 1999 study also discovered that 70% of medical doctors who graduated in 1995 had migrated to OECD countries by the end of the fiscal year 1999 (Awases et al. 2004). This has been the trend in the country since the 1980s.

Undoubtedly, the shortage of health workers in Africa has created life-threatening conditions for rural and remote communities, where professional health workers might just vacate their post through internal or external migration (Aluttis, Bishaw & Frank 2014; Buchan et al. 2013).

Studies by policy makers and health managers into the management of health worker movements have led to health policies and interventions in developed countries, such as Australia, Canada and United States, and the WHO is seeking to replicate some of the best practices in less developed countries (Lehmann, Dieleman & Martineau 2008). There have been studies into the influences on health workers in rural practice, while other studies devised, implemented and assessed interventions aimed at recruiting and retaining health care workers in rural areas. The factors that influenced the choice of location to practice by physicians have also been investigated to some extent in less developed countries, showing that medical students with rural backgrounds can easily opt for rural practice (Rabinowitz et al. 2001). However, there have been few studies conducted in low- and middle-income countries, and most of these focused on the reasons why physicians are normally not willing practice in rural areas. Findings from a review established that factors affecting the

movement of health workers could be more complex in less developed countries, and as such researchers have suggested a combination of different strategies in enticing and retaining health professionals especially in rural areas (Lehmann, Dieleman & Martineau 2008).

2.4 Push and Pull Factors: Factors Influencing Retention of Health Workers in Rural and Remote Areas

The factors affecting choice of employment in rural and remote areas have been investigated (Dieleman & Harnmeijer 2006; Lehmann, Dieleman & Martineau 2008). The terms push and pull factors are often used in this context, mostly in relation to national and international migration of health workers (Awases et al. 2004; Bach 2004; Zurn et al. 2004). Pull factors attract people to a new place of work and may include, higher salary, improved living conditions or the availability of good schools. Push factors are those that deter an individual from living in a locality, and might include low salaries and allowances, poor living environments, and poor schools within the locality (Boyle, Halfacree & Robinson 1998; Lehmann, Dieleman & Martineau 2008). Although grouping these factors generates some problems, they can be categorised into a) familial factors: individual and family considerations; b) organisational factors: working conditions and structural challenges; c) political consideration: government policies and ideological projections; and d) environmental factors: the prevailing conditions within the community. It should also be noted that these competing factors do not work in isolation. Rather, they interact to influence an individual health worker to make decisions about job movements in various ways. Familial and organisational factors will now be discussed in more detail.

2.4.1 Familial Factors: Individual and Family Consideration

Familial factors include age, gender, marital status, class, and beliefs. These factors differ based on an individual's lifecycle and the stage in his/her career and this should be considered when developing retention strategies**.** For instance, although health professionals who lived in rural communities are more likely to accept jobs in these areas (Dussault, Gilles & Franceschini 2006), women are generally less likely to accept postings to rural areas, especially if that may result in family separation (Doescher, Ellsbury & Hart 2000). Compared with older workers, younger staff are more willing to move to rural areas because they normally have fewer responsibilities. An individual's expectations and career plans may also influence the choice of place to practise.

Health workers have said that family support is necessary to reduce isolation in rural communities. This increases the possibility of an individual health worker accepting work in a rural or remote area where they have family members (Dussault, Gilles & Franceschini 2006). Where there is little or no family support, women often make decisions that may constrain their professional abilities so they can balance their professional and personal lives. This means they may select employment specialties that enable them to have a family life (Elston 1993). In addition, the presence of a spouse and/or children influences career decisions, more so for women than for men. While the movements of men are mainly linked to financial considerations (Songsore & Denkabe 1995), the movements of women are strictly associated to family considerations (Boakye-Yiadom & McKay 2007; Quartey 2007). For instance, studies have revealed that while women in the field of medicine leave work or opt for part-time work because of family responsibilities their male counterparts do so because of higher wages in other places (Foster et al. 2000; Fox, Schwartz & Hart 2006; Mayorova et al. 2005). Other factors concerning rural retention ranked highly by young graduate health workers were opportunities for social interaction, schools for children and employment for spouses (World Health Organization 2010).

The difficulties females face in balancing the double work burden of their occupational and family roles put them in a critical position especially when it comes to decisions about work and movement. In a study conducted in Bangladesh, married female doctors recorded higher overall absentee rates and among the reasons they cited was their preference to stay where their husbands' jobs were located (Chaudhury & Hammer 2004). Also women comprise a greater proportion of the health workforce in most countries, and demands from patients, especially female patients, may compromise their gender-specific needs, security, and personal/domestic roles and responsibilities (Sen & Östlin 2010). For this reason, the views and needs of female health workers need to be understood and incorporated into policies regulating their work to better tackle recruitment requirements in rural communities, where women, out of cultural considerations, are less likely to be placed in units where they will be working with male patients (Chaudhury & Hammer 2004; Dussault, Gilles & Franceschini 2006).

2.4.2 Organisational Factors: Work Conditions and Structural Challenges

Work conditions such as compulsory service and rural internships are strategies that have been adopted by many countries to increase health workers numbers in rural areas. In South Africa, compulsory service has been successful in increasing the number of health professionals, especially medical doctors, in remote areas (Reid et al. 1999). In Ghana, experience in rural areas extended the time workers were willing to spend in rural practice (Wibulpolprasert 1999). While compulsory service has contributed to retention of an appreciable number of health workers in rural communities, policy makers have acknowledged the difficulties involved in its management and enforcement. As such, the provision of incentives in monetary form such as rural service allowances (Sempowski 2004; Wibulpolprasert & Pengpaibon 2003) and non-monetary forms have become popular.

Education and pre-service training as prerequisites for employment (and conditions for post-employment promotion) have been identified as factors influencing selection of a practice location after graduation. Health workers' training experiences can influence their distribution. Generally, students choose to live and work in locations similar to those where they studied, and for those still in school, in locations close to their educational institutions (Dussault, Gilles & Franceschini 2006). Because many medical schools are based in urban areas, students mostly feel happy living in urban areas to practise rather than in rural communities (Rosenblatt et al. 1992). Medical and nursing institutions in rural communities are more able to provide experiences of rural practice, which subsequently, prepare and motivate students to accept rural practice after completion of their studies (Dussault, Gilles & Franceschini 2006; Lehmann, Dieleman & Martineau 2008). For instance, rural training centres in Thailand have played an important role in enhancing access to healthcare in rural areas in the whole country (Wibulpolprasert & Pengpaibon 2003). In the United States of America, rural recruitment and rural education have helped to improve the number of health professionals in rural areas (Salafsky, Glasser & Ha 2005).

The establishment of medical health institutions in rural areas is another strategy that has been tried in both developed and less developed countries with different levels of success. Similarly, strategies to tackle factors that influence rural practice such as increasing medical institutions enrolments from rural areas and integrating rural practice into medical training have been tried with mixed results (Smith et al. 2005).

One key consequence of the challenges discussed above is the shortage of workers in places where they are most needed but where many do not want to work. Consequently, management teams in these staff-starved facilities are left with no option but to promote the idea of task-shifting. As the name implies, task-shifting comes with its own promises and perils. In the next section, these issues are critically discussed.

2.5 Section Three - Task-shifting: Characteristics and Perspective

Various studies have highlighted the importance of teamwork and supervision if there is to be successful implementation of task-shifting, which includes quality healthcare across the spectrum of health services (Bärnighausen & Bloom 2009; Lehmann & Sanders; Lewin et al. 2007; Nemcek & Sabatier 2003; Swider 2002). Although much emphasis has been attached to task-shifting in Ghana, there is a dearth of literature on understanding the practicalities and challenges of this practice from people who are directly affected by it. This emphasis is due, in part, to the recent emphasis that WHO has placed on this practice.

That said, the purpose of this section is to give the reader an understanding of the meaning and contextual applications of task-shifting. A critical examination of the pros and cons associated with the practice of task-shifting *per se* will be discussed in relation to several study sites in Ghana in Chapter 4 of this thesis.

2.5.1 Task-shifting

The challenges associated with the growing shortages of health workers and the fast-increasing needs in terms of care created by the HIV/AIDS epidemic in many African countries have created some positive changes in recent times, as pointed out by Lehmann et al. (2009). This is seen mostly in the impact on the evolution of theoretical approaches or concepts related to task-shifting. Health services have had to adapt to these changes, including practical changes to management structures and the associated ethical issues regulating them. It should be emphasised here that the idea of task-shifting, as prominent and urgently relevant as it is, was put forward as a way of reducing health disparities within as well as between various countries and to address the decline of public health systems. The Joint Learning Initiative (2004) emphasised the need for sub-Saharan countries to triple their current health workforce to achieve health Millennium Development Goals.

What is task-shifting then? It involves delegating tasks from one type of health worker to

another, otherwise known as substitution (Dovlo 2004). Implicitly, “substitution is the name now given to a process of delegation whereby tasks are moved, where appropriate, to less specialised health workers”. Dovlo (2004) used the term “substitute health workers” to describe health workers who were assigned roles and functions usually allocated to internationally recognised health workers. Normally, these “substitutes” are given shorter pre-service training and perform parts of tasks that the more highly trained workers usually perform. Substitution is a mechanism that is connected to alternative health care provision to enhance access to quality healthcare services on a cost-recovery basis, or is state-sponsored to reduce costs. Many less developed countries rely on task-shifting to tackle the endemic technical and financial problems in health services (Samb et al. 2007).

Why is task-shifting relevant? The Health Workforce Advocacy Initiative (HWAI) (Baker et al. 2007), explains that task-shifting was intended to achieve four important goals. These goals were to:

(1) “Share and assign tasks among health workers in the most efficient manner in order to take advantage of the different competencies of the existing mix of health workers.

(2) Take advantage of simplified health promotion and treatment protocols that permit task-shifting to less intensively trained and specialized cadres of health workers,

(3) Shift more health promotion and treatment and care delivery to the community level by introducing new or strengthening existing cadres of community health workers and,

(4) Increase access to health care and advice in under-served communities, particularly rural communities” (p. 1).

However, they further explain that, for a successful operation of task-shifting, it is necessary to pay attention to the systems that support the goals, which should be arranged in ways that make the outcomes feasible, and that will also enhance the performance of human resources in the health sector.

My review of literature revealed that task-shifting needs to be organised carefully taking into consideration the structure and resources within health sector. Samb et al. (2007, p. 2513) explained that task-shifting must be integrated into the broader strengthening of the

healthcare system for sustainability. They further argued that governmental organisations should assist in the preparation of adequate healthcare systems for successful implementation of task-shifting by making sure that adequate supervision and appropriate training institutions are established (Samb et al. 2007). Due to the inadequate initiatives for the establishment of health systems and improving capacity in many countries in African, the question of what this may mean comes to mind. In my evaluations, it calls for the integration of concepts and roles of new cadres. Taking this further, Samb and colleagues noted that this integration is best served by changes to the scopes of practice and regulatory frameworks, because it aids the incorporation of best practices which in turn reduces bottlenecks in the recruitment of professional staff into the mainstream health system. However, this study did not show how such enhancement can curb the associated negative consequences of how professionals relate to their 'unprofessional' counterparts who are recruited to perform tasks they previously undertook.

The shortage of human resources for health has been identified as a major constraint to the achievement of universal access to health care including HIV care and treatment in many countries (Van Damme, Kober & Laga 2006). Inevitably, this constraint has led to various arguments about the impact of task-shifting. The main focus of debate has been on questions of practicality, effectiveness and mode of operation. This debate, it should be noted, took form following the WHO's recognition of this unconventional practice in their 2006 World Health Report. The World Health Organization, in attempting to address the shortage of workers, has recommended task-shifting. From a historical perspective, WHO recognition was an idea first conceived by the Health Workforce Advocacy Initiative. They were the first to urge WHO, OGAU and UNAIDS, among others, to adopt their suggested approach to task-shifting (Baker et al. 2007). In practice, this also means recognising the auxiliary systems that are vital to the successful implementation of task-shifting. According to HWAI (Baker et al. 2007), the system has four important elements, planning and regulatory training, supervisory and evaluation systems. Planning involves coordination at both international and national levels to institute appropriate policies, while training includes processes in recruitment, in-service and pre-service training and certification. The supervisory system comprises supervisors and mentors, with the means to address challenges and provide psychosocial support and appropriate referral guidelines. Evaluation includes appraisal of job performance and monitoring of task-shifting practice. Collectively, these four structures should be in place for successful implementation of task-shifting practice.

As highlighted by Lehmann et al. (2009), the main aims of task-shifting include to increase the number of healthcare services delivered at a particular cost and quality and to decrease the needed time for scaling up the health workforce, due to the fact that the workers engaging in task-shifting need less training. Although task-shifting has been taking place for decades, great urgency has now been attached to it because of health worker shortages (WHO 2008).

In an investigation into the role of primary health care in achieving equitable care, De Maeseneer et al. (2007) asked whether task-shifting could ever be a "more than a short-term solution" to tackle communicable diseases such as the HIV/AIDS crisis, and whether it could contribute to reviving the primary health care initiative to mitigate the crisis in health systems affecting developing countries. Potential benefits of task-shifting include improving the skills sets of teams (Goldman et al. 2004), lowering costs for training and remuneration (Mullan & Frehywot 2008), shifting health care to cadres with better retention rates (Pereira et al. 2007) and supporting retention of existing teams of health workers by minimising breakdown from incompetent care procedures (Zachariah et al. 2009). Reports have proven that lay health professionals who were given particular skill accompanied with well-defined tasks could complement and assist in providing services given by highly skilled health professionals (Buchan 2002; Mullan & Frehywot 2008).

Task-shifting can be explored in several ways. One way is through the health team approach. This may include introducing new cadres of health workers or tasks delegation that help solve the problem of fragmentation, especially in situations where fragmented and unsustainable add-on workers were relied upon to provide services. Their presence or absence in centres inevitably determined the services that were accessible across the board. The delegation of counselling and testing voluntarily to lay health workers, may need not only their recruitment and training, but the duties and workloads of workers who would be involved in the coordination and supervision need to be changed (Marchal, Brouwere & Kegels 2005).

Ultimately, successful task-shifting, which remains largely unexplored in relation to African countries (and which this thesis seeks to address) should necessitate a comprehensive and integrated aspect of various health partners especially at the levels within the primary and community healthcare. Whether the integration of new categories of health workers into the provision of healthcare would necessitate the availability of reliable funding for a specified time period, is yet to be tested in relation to Africa—hence the relevance of the study.

2.6 Section Four - Motivating Rural Health Workers: Health Policies and Intervention

Motivation is considered as an essential factor for individuals' and organisations' performance (Martínez & Martineau 1998), and it contributes significantly to the intention to leave a place of work (Tzeng 2002). It can be defined as "an individual's degree of willingness to exert and maintain effort towards organizational goals" (Franco, Bennett & Kanfer 2002, p.1255). Motivation, as a form of recognition, is also important because the morale, status and desire of health workers are improved greatly when the services they render to communities are publicly recognised (World Health Organization 2010). Low motivation is associated with a negative job performance of health professionals. It further influences health workers' movement and their willingness to accept postings to rural areas (Awases et al. 2004; Joint Learning Initiative 2004). It is therefore essential for management to motivate health professionals, from the leaders of health institutions to supporting staff.

However, most research into increasing motivation of health workers was carried out in high income countries where, as already stated, funds and scientific innovations that can be spent in such activities are readily accessible (Franco et al. 2004). The state of health systems in less developed countries is different and the context in which health system policy interventions are designed and implemented varies between countries, from region to region within countries and between different time periods. Therefore, policies developed from the developed world may not necessarily target issues experienced in less developed countries (Dolea & Adams 2005). More specifically, in resource scarce countries such as Ghana, salaries are low, and where instruments and equipment are missing or broken, staff must innovate to deliver treatment. They cannot replace these instruments, so they are forced to be resourceful and employ primitive methods or non-clinical instruments. Faced with the problem of scarce or no funds for staff development, workers' proactivity and motivation suffers. Because of negligence and other forces (within and beyond the control of governments), scholars like Dolea and Adams (2005) have suggested the need for thorough assessment of theories developed in Western countries before adopting them in the context of less developed countries. The quality of working environment, such as access to adequate supplies and overall working conditions, influence retention. For instance, Zimbabwean health professionals reported that lack of basic equipment which includes thermometers and injection kits in public health institutions affected the morale of workers and hindered them from providing quality health care for clients (Crush & Tevera 2010). Poor working

conditions have been identified as being responsible for emigration of health workers in six African countries (Awases et al. 2004), while Stillwell et al. (2004) noted that doctors in Nigeria migrated in search of better opportunities for professional development in areas with better medical infrastructure.

2.6.1 Health Policies and Interventions

Health policy—which is an outcome of epistemological and scientific development—plays a role in regulating the health system. It refers to "decisions, plans, and actions that are undertaken to achieve specific health care goals within a society" (WHO 2014). It is therefore defined as "a formal statement of procedures within institutions, particularly government, that defines priorities and the parameters for action in response to health needs, available resources and other political pressures" (Zurn et al. 2004). Health policy is normally formed through legislation which provides rules for the creation of rules that regulate and create incentives for health services and programs. Sometimes, non-health policies that do not directly tackle issues concerning health have an indirect effect on health issues. These include public interventions regarding education, regional or national development and employment that may help to regulate the health workforce (WHO 2014).

The interest of policy makers in identifying and implementing efficient and effective policies and interventions to tackle the health worker shortages in rural and deprived communities has increased recently (Grobler et al. 2009; Lehmann, Dieleman & Martineau 2008). For health policies and interventions to succeed in achieving the goals of the health sector, there is the need for the policies to address various aspects of the problem, implying, for instance, the need for programs to concentrate on recruitment, retention as well as health workers motivation. Therefore, studies have recommended the need for financial incentives targeted at health workers to be used in conjunction with interventions that tackle some of the organisational barriers to location in rural communities, such as regulating resource distribution systems to improve resources availability within the health system in communities in the rural areas, as well as health policies that explicitly tackles career enhancement for health professionals in these areas (Buykx et al. 2010b). The different means through which the problem could be tackled are evident in current inventions such as advancements in information technology like telemedicine programs. Such initiatives have been used in paediatrics to increase patients' referrals to specialists in Australia (Smith et al. 2005) and could also be used to improve the supervision and assistance given to health

professionals in rural communities (Gruen et al. 2004). While proven to be effective in providing support to rural health workers in developed countries, the use of interventions like these might not necessarily produce similar outcomes in less developed countries because of contextual differences between them. Nevertheless, to build a foundation for future learning and innovation it is important to explore and understand existing interventions, including incentive packages that have been used globally to aid the recruitment and retention of health care workers in rural areas.

2.7 Incentive Packages for Retention of Rural Health Workers

One of the most common means of addressing the problem of retaining and motivating health staff is the use of incentives, both financial and non-financial, and several of these have been recommended in different countries. Incentives could be defined as "all the rewards and punishments that providers face as a consequence of the organisations in which they work, the institutions under which they operate, and the specific interventions they provide" (WHO 2000). Policy makers have several options for incentives other than income, and may use different indicators to assess the cost and the effectiveness of each to select the most appropriate (van Lerberghe et al. 2002). Studies conducted on different types of incentives have revealed different success levels, with a common consensus that when both financial and non-financial incentives are implemented appropriately, employers are able to attract and retain health workers in rural and remote areas (Bennett & Franco 2000; Martineau 2003).

2.7.1 Financial Incentives

There is considerable literature from different perspectives on the influence of financial incentives on an individual's decision to choose a workplace. In developed countries, direct financial incentives are thought to encourage health workers to accept jobs in rural areas, and reports from other countries such as Mali, Zambia and South Africa support this contention (Reid et al. 1999; WHO 2009). The introduction of a "health worker rural retention scheme" in Zambia in 2003, which aimed to improve recruitment and retention of doctors in rural communities through the provision of financial incentives such as "hardship allowance, school fees and loans", succeeded in enticing doctors to these areas (Koot & Martineau 2005). In Thailand, increased salary level of nurses increased their retention in the rural areas (Kunaviktikul et al. 2001).

In some countries, however, financial incentives would not attract health workers, especially medical doctors, to remote and rural areas. To some extent, this is due to the issue of comparison and choice. Where health workers are faced with multiple choices, their individual judgements come into play. This was evident in a systematic review of literature on financial incentives which revealed that although incentives that target the debt of medical students were to some extent successful in attracting physicians to rural and remote areas, their effectiveness were less than expected when a "buy out" option was available (Sempowski 2004). A study conducted on reasons for staff mobility in countries within Africa (Ghana, South Africa, Zimbabwe, Senegal and Uganda) revealed that only 24% of the study participants cited better pay as their reason for quitting their jobs (Black et al. 2006). Similarly, a study conducted on the influence of salaries in the movement of health workers showed that increased salaries played little role in influencing their movements (Vujicic et al. 2004). In Burkina Faso, the introduction of a financial allowance relating to accommodation, extra duty, night shift and risk, ranging from US$46 to US$245 depending on the category of health worker and circumstances, did not reduce movements from rural to urban settings. Workers did not consider the salary increase was competitive when compared with pay levels in the private sector, and complained that allowances for risk, night duty and accommodation were inadequate (Bocoum 2008). In South Africa, a rural allowance that included salary increment/top-up, rural inconvenience allowance, and allowance for children's education also had limited impact on retention and motivation (Reid et al. 1999).

2.7.1.1 Salary and income

General health systems and healthcare are affected by the salaries and incomes of health workers. Herzberg (1974) labelled these hygiene factors that influence the morale, motivation, and performance of workers and the capabilities of employers to attract and retain workers. Health workers receiving low salaries may search for ways to supplement their income by engaging in private healthcare services or other secondary employment, or attending workshops and seminars to receive *per diem* allowances (Roenen et al. 1997). Such activities could compromise the quality of health care given to patients, especially in rural areas.

The context in which staff work affects their ability to increase their earning power, with greater opportunities for private practice in urban areas. This is an important factor because relative differences in salary and income have been acknowledged as affecting the retention

of health professionals in rural and remote areas and between countries by contributing to dissatisfaction, low morale and low motivation (McCoy et al. 2008). This is intensified when the magnitude of difference in salaries between different cadres of health professionals, for instance doctors and midwives, is wide. While it is important to increase salaries and income of health workers, this should be done in a way that does not compromise other health activities. In Ghana in 2006, salaries and remuneration of health workers accounted for 76% of the government expenditure on healthcare, going 35% over the original budget and leaving 6% of the budget for non-wage regular disbursement after capital expenditure was disbursed (Agyepong et al. 2012).

2.7.1.2 Salary top-up/allowances

Allowances or salary top-up can play an important role in motivating health workers, especially those working in rural areas. The income of health workers is normally made up of different components, with the basic pay sometimes forming only a small proportion of total salary. Depending on the type of health staff, allowances such as additional duty allowances form the major portion of total salary. In Zambia, allowances comprised almost 40% of doctors' income (McCoy et al. 2008). Although allowances expand the salary scale across the workforce, there are sometimes considerable differences in allowances between different cadres of health workers. Another study in Zambia found that allowances increased income four times more for doctors than for nurses (McCoy et al. 2008). In such situations, affected health workers may engage in private practice to generate additional income. A survey conducted in Nigeria revealed that 45% of health workers earned additional money through private practice (Gupta, Gauri & Khemani 2003). Generating income from private practice and other activities was more common among those working in urban areas. For example, in Zambia 32% of health staff in urban areas earned income through other activities compared with 9% of staff in rural areas (McCoy et al. 2008). There are similar trends across the continent, from South Africa to West Africa. For example, in Ghana, allowances meant that doctors' salaries were three times higher than those of community health nurses and their total income was four times higher (Witter, Kusi & Aikins 2007). In Ghana in 2005, doctors' basic salary comprised 26% of their monthly income, while for mid-level staff such as senior nurses or medical assistants their basic salary was 43% of their monthly income (WHO 2006b; Witter, Kusi & Aikins 2007).

Decisions by health workers to engage in private practice depend to some extent on the level of financial incentives given to them. Incentives that are not regarded as sufficiently attractive cannot serve their intended purpose. In Thailand, the introduction of non-private practice allowances in 1995 failed to achieve desired results because even with the addition of allowances for remote locations and non-private practice, total salaries were still less than physicians earned in private practice (Wibulpolprasert & Pengpaibon 2003). Some countries have offered doctors the option of working privately in public institutions to minimise the movement of qualified staff from the public sector. This strategy has been successful in Bahrain and other countries, but in Ghana and Nepal such incentives were seen to influence health workers to choose private practice independently, while also diverting resources from public services (Zurn et al. 2002). Again, the overall effect of this incentive was the migration of health professionals from rural to urban areas, especially in countries where private practice is permitted as a means of complementing low salaries, such as Indonesia (Wibulpolprasert 1999).

Context-specific interventions have been suggested as effective in encouraging health services to develop the capability to pool existing workforce funding to focus on retention using various means that are suitable to their contexts (Buchan et al. 2013; Buykx et al. 2010a). At the same time, monitoring and evaluation should be integrated into the human resource activities of health services, incorporating regular gathering of relevant data (Diallo et al. 2003). Data normally gathered on human resource issues have been shown to be inadequate or of unsatisfactory quality to enable monitoring of retention patterns over periods of time, or for assessing the effectiveness of incentives (Humphreys et al. 2009). Collection of quality data would enable health services to identify and use appropriate benchmarks for allocating incentives packages (Cutchin 1997; Han & Humphreys 2005). The issue of human resources for health therefore includes various aspects of managing staff which include staff recruitment to attraction and retention interventions and the monitoring and evaluation of incentive packages. Buchan (2002) further observed that the successful implementation of any approach within any healthcare sector is based on varied socioeconomic, institutional and political contexts as well as health labour markets generally. According to Buchan, issues that contribute to the successful implementation or failure of strategies are availability of resources, political will and management skills (Buchan 2002).

2.7.2 Non-financial Incentives

The importance of financial incentives cannot be ignored, and as such, the problems associated with low remunerations should be tackled especially in instances where health workers' salary is not enough to take care of the basic necessities for workers and the all of their dependents. While findings are equivocal, studies have established that increase in remunerations are not enough to address the problem of low motivation, implying that provision of more money to workers does not automatically increase their motivation (Dussault, Gilles & Franceschini 2006; WHO 2010). Hence there is the need to consider non-financial incentives.

Studies conducted on health workers motivation in less developed countries has revealed that financial incentives are limited in motivating staff and shown the significance associated with non-financial incentives (Bennett & Franco 2000; Dielemann et al. 2003; Francis, Bowman & Redgrave 2002; Mutizwa-Mangiza 1998; Schmidt-Ehry & Seidel 2003). Non-financial incentive packages such as providing housing and changing the status of the employment of physicians' "from civil servants to contracted public employees" contributed to attracting and retaining health workers to rural areas in Thailand (Kunaviktikul et al. 2001). In a study of the role of salaries in the movement of health workers, Vujicic et al. (2004) concluded that what were termed 'non-wage instruments' could be very effective in minimising movements, as described in a WHO report (Awases et al. 2004). Even so, the South African rural allowance discussed above had limited effect on retention and motivation (Reid 2004). Kingma (2003) believed that while financial incentives offered an important template to regulate workers' motivation, their influence became secondary where other forms of motivation such as good leadership and supportive management were proven to be efficient. It is against this backdrop that others have suggested that even under adverse conditions of insufficient pay, a quality working environment provides opportunities for professional advancement (Stilwell et al. 2003).

It is not likely that a particular incentive package will be suitable for all cadres of health professionals. In South Africa, compulsory service and financial incentives including rural and scarce skills allowances, introduced to tackle the unequal distribution of health workers, failed to solve the problem of retaining staff in rural areas, leaving most hospitals in rural areas without health personnel (Reid 2004). As such, an important aspect of health workforce retention strategies is their adaptability to meet the explicit needs of health workers in diverse

settings, because a particular incentive package, such as providing appropriate accommodation or opportunity for career advancement, might not work everywhere. This highlights the need for context-specific interventions across and within countries, which requires an operational health system.

Successful implementation of context-specific interventions in the form of task-shifting or provision of incentive packages to motivate health workers requires a well-organised and operational health system. This is necessary because a health system that is operational responds in a well-balanced manner to the needs of a population and their expectations by enhancing the health status of individuals and communities at large and providing equitable access to healthcare among people through an improved health workforce (WHO 2010). The next section provides a detailed description of the health system in Ghana, which is important to understand because provision of human resources for health issues, the core topic of this thesis, is embedded in the health system.

2.8 Health System in Ghana

The Ghana health system is structured into four key groups for service delivery. These are "public, private-for-profit, private-not-for-profit and traditional". The first three systems are principally engaged with healthcare delivery in Ghana, and since 1995 efforts have been made to incorporate traditional medicine into the orthodox healthcare system (Barimah & Akotia 2015). In Ghana, the body responsible for policy, governance and oversight of the health sector is the Ministry of Health (MOH). This is comprised of nine agencies including the Ghana Health Service (GHS), which is accountable for public sector health services delivery and supervises the services of the private sector.

Functions of the Ghana Health Service include the planning and implementation to manage health delivery. It has 170 District Health Management Teams (DHMTs) to provide health services and organise planning and coordination of affairs at the district level. Theoretically, DHMTs are supposed to monitor and implement interventions, but they are unable to carry out their tasks effectively because of financial limitations and human resource constraints.

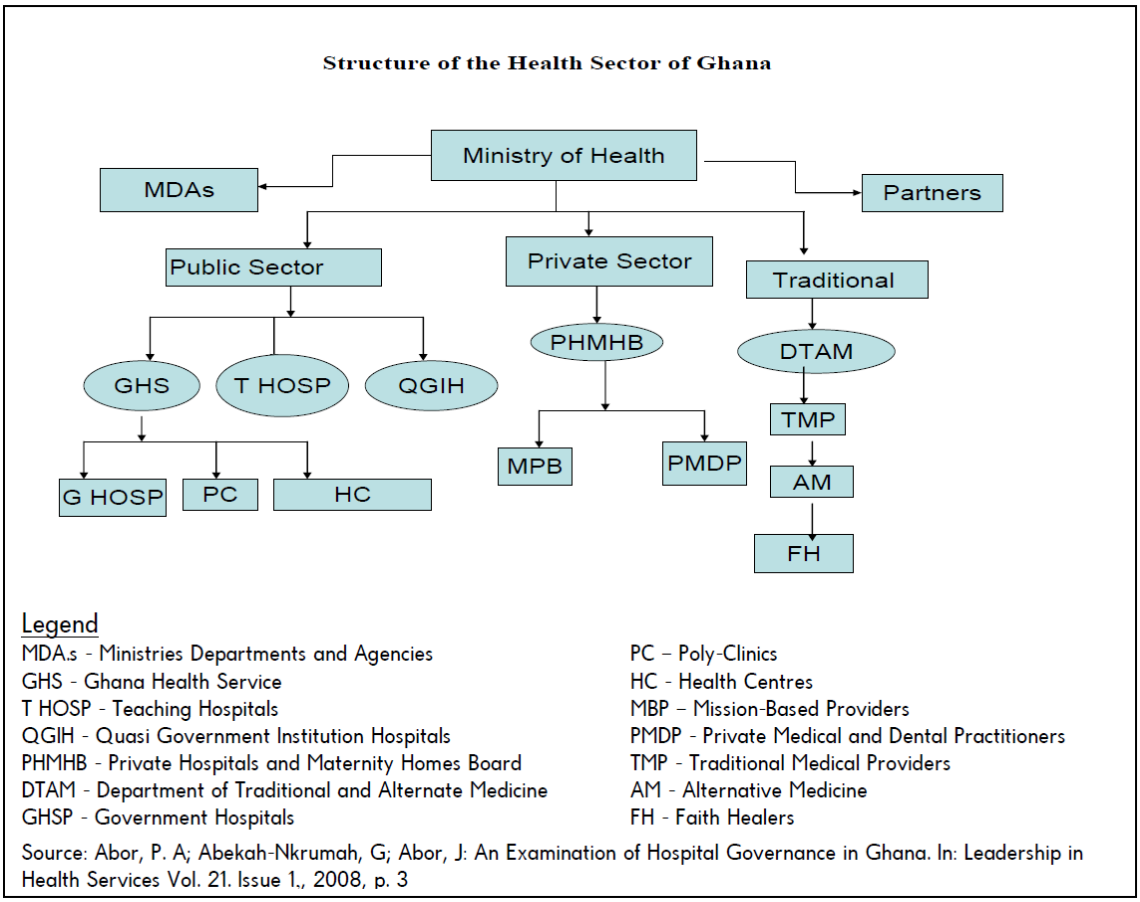

Figure 2-1: Structure of the Health Sector of Ghana

The structure of the health sector in Ghana is shown in Figure 2.1 above. While the services appear comprehensive and better than those in most other West African countries, there is still a wide gap between Ghana and more developed countries situated in the African sub-region (WHO 2011). As highlighted previously, issues such as insufficient numbers of health workers and health worker migration have meant that high doctor-to-patient ratios, inadequate health infrastructure and worker dissatisfaction are just some of challenges the health sector faces (Agyepong et al. 2012; Ghana Health Service 2011).

In addition to the shortage of health care workers hindering access to quality health delivery in Ghana, the "cash and carry" system also limits people from accessing healthcare, especially in emergency situations. This system was introduced in 1985 as a cost recovery delivery measure whereby patients who attend health facilities are supposed to pay immediately for the health services rendered to them. A National Health Insurance Scheme (NHIS) was introduced to address the challenges associated with these out-of-pocket

payments, but its implementation has not been very effective because of the limited funds allocated to health services. These issues, coupled with the insufficient number of health professionals especially in rural areas and the misallocation of the available funds (as will be shown in Chapters 4 and 6), have generated problems of inaccessibility and inequity in the health care system.

The problems of inaccessibility and inequity in the health care system were considered critical by the Ghana government and the Ministry of Health. Deterioration in health-related indicators and especially increased maternal and infant mortality led the government and its global health collaborators to take steps to improve maternal health. In 1987, WHO and other United Nations agencies had instituted the Safe Motherhood Initiative, and this was accepted and implemented in Ghana. Free antenatal clinics for pregnant women were incorporated into the health system in 1998. The government's commitment to encouraging safe motherhood led to the introduction of a policy mandating free delivery for pregnant women in three northern regions (Upper East, Upper West, Northern and Central), the most deprived regions in the country. This was introduced in 2003 and two years later it was extended throughout the country. In 2008, this initiative was supported by the British government with a financial contribution of US$90 million.

The government has instituted other national policies to enhance health care access, including Community-based Health Planning and Services (CHPS), NHIS, and the National Youth Employment Program (NYEP) to train health workers and deploy them in rural and remote areas of Ghana. Despite these efforts, access to healthcare remains a challenge because of inadequate numbers of health care workers. The challenge of recruiting and retaining health workers in deprived areas which has affected institutional delivery (WHO 2011). Subsequently, this problem of recruiting and retaining health workers has contributed to high pregnancy-related maternal mortality deaths in the country, with observed disparities between regions (see Figure 2.2, below). The figure shows that recorded maternal mortality rates in the regions of Greater Accra, Ashanti, Brong Ahafo, Western and Upper West were well below the national average of 485 maternal deaths per 100,000 live births, while in the Volta and Upper East regions maternal mortality ratios were far above the national average (705 and 802 per 100,000 live births respectively).

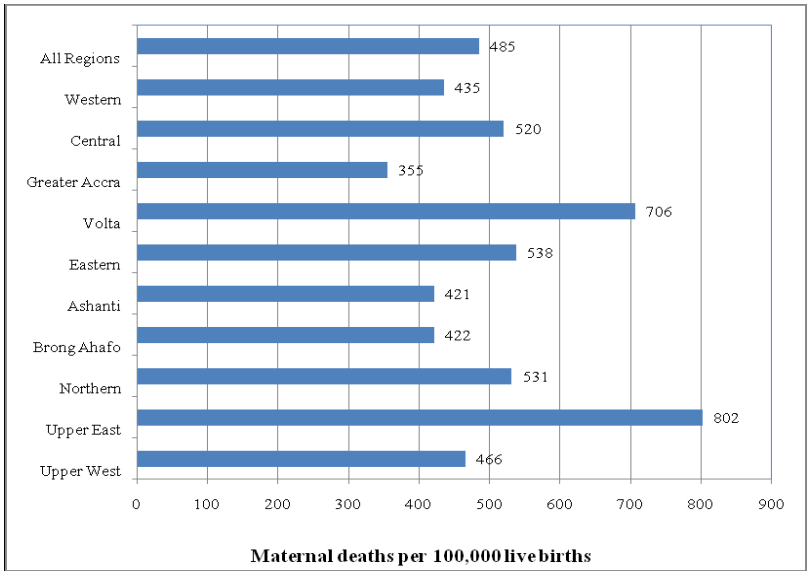

Figure 2-2: Pregnancy-related maternal mortality ratio (Ghana Statistical Service 2012)

2.8.1 Core health indicators

As outlined in Chapter 1, while there has been gradual improvement in some health indicators, great differences exist between rural and urban areas regions in Ghana, with significantly greater burden of diseases and mortality among rural populations. Core health indicators are shown in Table 2.1.

As can be seen from the table, there has been improvement in health outcomes with infant mortality falling from 50 to 41 per 1,000 births. There has also been a reduction in under five mortality (Ghana Statistical Service 2009). However, more efforts are needed to further improve health outcomes in the population, particularly for mothers and infants. Although there has been a reduction in maternal mortality rate (740 per 100,000 live births in 1990 to 451 in 2008), it is still high and is attributed to the absence of skilled birth attendants. Fewer than 60% of pregnant woman are delivered by skilled birth attendants and the situation is worse for women who live in rural areas. Child mortality remains high despite Ghana's economic development in the past decade, with neonatal mortality accounting for more than half of infant deaths. Each year in Ghana, more than 100,000 of children die under the age of five years, which accounts for more than half of all mortalities. The main causes of death apart from neonatal causes are diarrhoea, malaria, malnutrition and respiratory infection (Ghana Statistical Service 2014).

Table 2.1: Core Health Indicators in Ghana from Ghana Demographic and Health Survey 2008 and 2014

Health Indicators	Residential Area	GDHS 2008	GDHS 2014
Infant mortality		50/1000	41/1000
Under five mortality		31/1000	19/1000
Antenatal care coverage	Overall	95%	97%
	Urban	97.8%	98.8%
	Rural	93.9%	96.0%
Facility based delivery	Overall	59%	73.1%
	Urban	82.4%	90.9%
	Rural	41.7%	57.7%
Postnatal coverage	Overall	68%	78.2%
	Urban	81.6%	87.1%
	Rural	59.3%%	70.1%
Stunting in children under five years	Overall	28%	18.8%
	Urban	21.1%	14.0%
	Rural	32.3%	22.3%
Wasting in children under five years	Overall	9%	4.7%
	Urban	7.6%	3.7%
	Rural	9.1%	5.6%
Underweight in children under five years	Overall	14%	11.0%
	Urban	10.6%	9.3%
	Rural	16.0%	12.6%

Source: GSS/GDHS 2008, 2014

Core health indicators are worse in rural areas than in urban areas, and are especially poor in the Upper East region of Ghana where this study was conducted. The causes of death mentioned above are preventable, which implies that providing skilled health professionals in the rural areas would contribute greatly to reducing mortality. Attempts to tackle the issues of human resources in the health sector by increasing staff retention in rural areas have led to the introduction of interventions such as provision of incentives packages to motivate health workers in rural areas of Ghana. In addition to incentives packages instituted by the government of Ghana through the Ministry of Health, some health care facilities in the study

area have also put in place certain incentives to motivate their workers. Thus, based on the resources available in a health care facility, authorities could put in place additional incentives to motivate workers. For instance, some facilities run by the Christian Health Association of Ghana (CHAG) have instituted the *7½ allowance* where 7.5% of workers' basic salaries are given to them as an incentive.

Incentives officially put in place to motivate health workers in rural areas are shown in Table 2.2 below. The *posting allowance* is paid to health workers who are posted permanently from one station to another. It covers the cost of transporting workers' belongings. Staff who request a posting are not entitled to this allowance. The *acting allowance* is paid to workers who are assigned additional tasks in a different job position apart from their official tasks. The *leave without pay* incentive is granted to allow workers after one year of satisfactory service to stay away from work for educational or personal purposes. Such workers are not paid their salaries during that period, but their names are not taken off the payment voucher. However, if the one-year service was spent on training, it is regarded as a service period. The *in-service certificate training* incentive allows workers to participate in learning experiences designed to upgrade and improve their competencies. The *vehicle maintenance allowance* is paid to staff who receive approval to use private cars, motorbikes or bicycles for official duties.

The incentive packages listed above has been put in place to motivate health workers in Ghana, which includes those in the study area. The next section provides detailed description of the study area and the study setting.

2.9 Study Area

The Upper East region of Ghana was purposively selected as the site of fieldwork. It is one of 10 regions and is situated in the north-eastern corridor of Ghana, with Bolgatanga as its regional capital. It is demarcated into 13 districts as shown in Figure 3.2. It shares boundaries with the Republic of Togo to the east and the Republic of Burkina Faso to the north. These neighbouring countries have similar demographic characteristics which include language, sociocultural and belief systems and as such there is considerable movement of persons, goods and services across the borders which present several challenges to disease surveillance and control, mainly at the points of entry. The national government, through the

GHS, is the main healthcare provider in the region with 88% of health facilities, followed by private providers (7.7%), mission providers (4.4%) and quasi-government providers (0.4%).

Table 2.2: Incentive Packages for Motivating Health Workers in Ghana

Financial Incentives	**Non-financial Incentives**
• 10% increment in salaries • 10% of money paid on deliveries of pregnant women given to midwives • Flexible access to bicycle, motor cycle and car loans from banks in Ghana • Posting allowance • Transport/travelling allowance • Vehicle maintenance allowance • Responsibility allowance, paid monthly to staff in senior management positions • Overtime allowance paid to workers who work beyond 40 hours a week • Acting allowance	• Study leave with pay for health workers after three continuous years of work • Leave without pay • Provision of bicycle/motor cycle/car for work • Fuel for motor cycle for work • Work uniform given to health workers • Quarterly midwife review: midwives' performance assessed and prizes awarded • Free accommodation close to the health facility • Workshop and in-service training certificate

Source: Employee policy handbook 2006, GHS 2011, MOH 2007

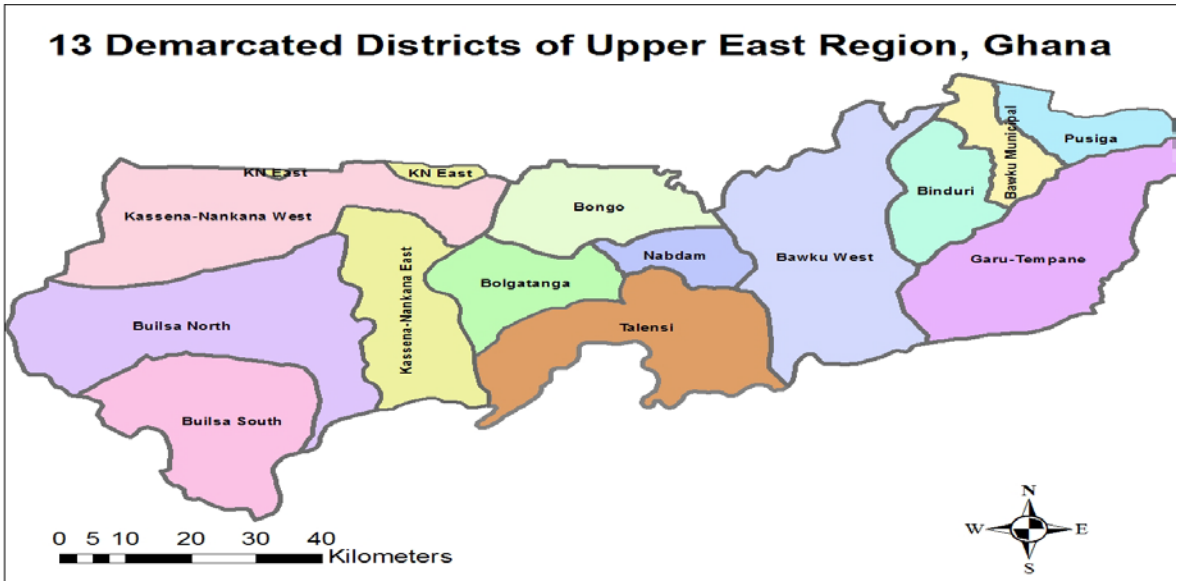

Figure 2-3: Map of demarcated districts of Upper East Region, Ghana

Source: Ghana Statistical Service, 2014

Within the catchment of the region, there are 74 health districts and 272 health facilities (Ghana Health Service 2011). Malaria, acute respiratory infections and diarrhea are the leading causes of preventable diseases.

The population of the region is estimated to be slightly above one million with a growth rate of 1.2% (Ghana Statistical Service 2013). Most of the people live in rural surroundings and families are gathered into compounds which are situated distant from each other, but individuals rely mainly on their accustomed communal way of living (Oduro et al. 2012). The people of the region are the first to experience the dry *harmattan* winds in the country each year with the temperature of the area rising as high as 43°C. From August to September which is the peak of the rainy season, most communities in the region are not accessible. The local economy is largely dependent on subsistence farming and the region experiences routine food shortages.

This region was chosen for study from the 10 regions of Ghana because its population is largely rural and it is recognised as one of the deprived regions in the country, being the northernmost part of the country and a place to where health workers least wish to be posted (GDHS 2008). It is also one of the regions with the lowest level of supervised deliveries and the highest levels of poverty and maternal mortality (GDHS 2008; Ghana Statistical Service

2012). Ghana is endowed with many natural resources such as gold, diamonds and bauxite, and fertile soil for agricultural activities. However, these resources are not evenly distributed across the country. They are concentrated in the southern belt, leaving the northern belt with almost nothing (Witter, Kusi & Aikins 2007).

As earlier mentioned, the region comprises of thirteen (13) districts. Ten districts were selected for the study: Pusiga, Binduri, West, Bolgatanga, Kassena Nankana Builsa South, Bawku East, Bawku, East, Kassena Nankana West and Builsa North, Garu Tempane. Details of the districts and health centres involved in the study can be found in Appendix 11. To obtain a mix of health centres situated in typically rural, peri-rural and urban settings, the 10 selected districts were sampled, using a non-probability technique. In Figure 3.3, population by type of locality across the 10 regions in Ghana is shown.

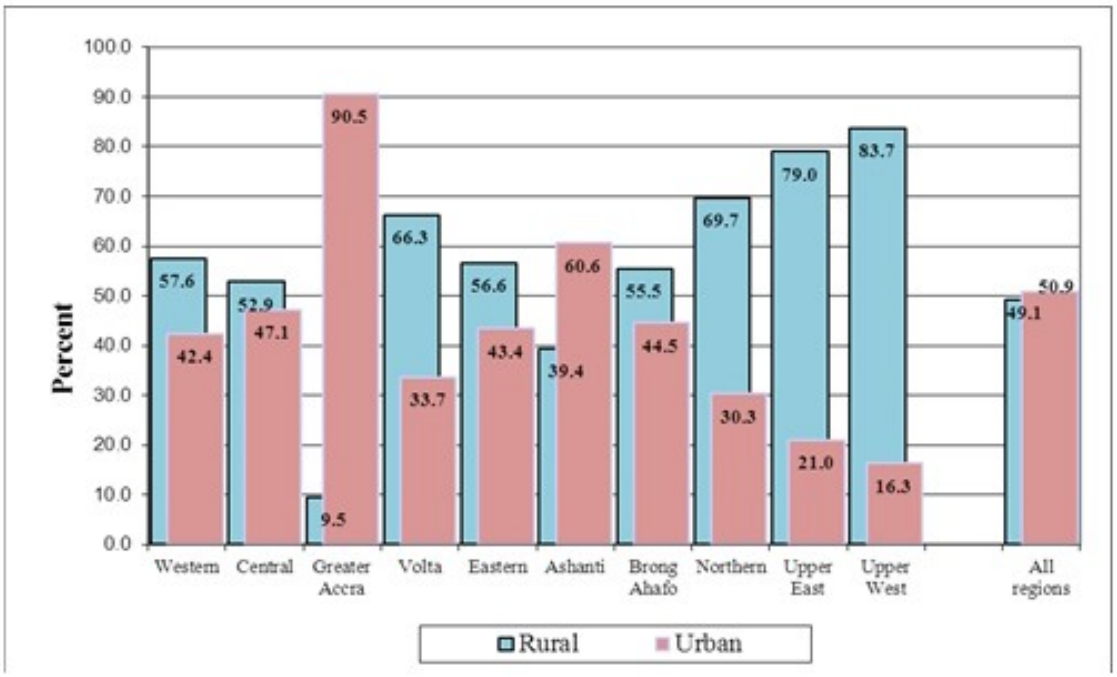

Figure 2-4: Population by type of locality (urban and rural)

Source: Ghana Statistical Service 2012.

2.9.1 Study Setting: Health Centre

The study was conducted in the Primary Health Care facilities (health centres) in the study area. In Ghana, health centres are the first tier of institutional care. They are the functional units out of which primary health care is expected to be delivered at facility and community

levels. Health workers work under the direct supervision of district health management teams and have district hospitals as the immediate level of referral. Health centres are typically expected to offer outpatient, curative and preventive services (Ghana Health Service 2011). They may have the capacity to detain moderately ill patients for a few hours while administering definitive therapy and to admit expectant mothers in uncomplicated labour. The preventive work of health centres is delivered through outreach services conducted by community health workers. These services include immunisation, distribution of impregnated bed nets, preventive presumptive therapy, health education and school health programs

2.10 Conclusion

In this chapter I have discussed existing research on factors that affect health workers' movements, more specifically those who work in rural areas, from theoretical perspectives to practical aspects. Issues of worker satisfaction and their competing needs and the interest of policy makers and politicians in relation to instituting interventions to improve retention and address rural health worker shortages were discussed. Research evidence reveals that the impact of interventions such as incentive packages in motivating health workers and use of task-shifting to improve access to healthcare have not been systematically explored. Specifically, in the Upper East region of Ghana, no study exists on the impact of these interventions and this is the gap in the literature that this study addresses. In the next chapter, the methodology used to carry out the study is presented.

CHAPTER 3
METHODOLOGY

3.1 Introduction

This study is designed to assess policy interventions put in place to address shortages of rural healthcare workers in the Upper East region of Ghana. In Chapter 2, a critical comparative analysis of the various theoretical and practical experiences that affect health workers' movements essential to the core issues of this thesis was presented. In this chapter, the methodology including the processes that were adopted in addressing the research objectives is described. It comprises the research paradigm, research approach, methodological approach, sampling and recruitment of study participants, collection of data and analysis. The study limitations and methodological rigour are also presented before the chapter is concluded.

3.2 Research Paradigm

The paradigm of a research study is directed by how the individual conducting the research views the world (LoBiondo-Wood & Haber 2010) and as such this researcher selected a qualitative paradigm for this study. Qualitative paradigms offer a deeper analysis and allow for a much richer and in-depth understanding of how people explain their situations and interpret occurrences (Denzin & Lincoln 1994; Marriam 1998) thereby allowing these individuals to contribute to knowledge. The flexibility of qualitative methods makes them appropriate to explore and understand the subjective experiences and meanings of individuals (Liamputtong 2007), and more importantly enables participants to express and understand their feelings and experiences using their own words, not only answering the "what" but also including the "how" and "why" (Hesse-Biber & Leavy 2010). The combination of the "what, how and why", gives a researcher a broader understanding of the experiences of participants and leads to obtaining rich and detailed data (Liamputtong 2007).

Qualitative designs are used to facilitate human understanding on issues that require further study and they are essential to uncover and understand information (Strauss & Corbin 1990). As such, they were used in this study to understand health workers' and managers' experiences regarding policy interventions. This research method further recognises the fact

that the experiences of individuals are not constant but change from time to time and from one setting to another (Lewis & Ritchie 2003) and, as such, it is inappropriate to generalise the study findings. Since the researcher does not intend to generalise the findings of this study, qualitative design was most suitable. Quantitative methods are built on casual inference and the use of standardised procedures to produce standardised data that can be analysed statistically. However, qualitative methods are needed to generate and explore detailed, thick, descriptive data that could be transferrable and comparable to other settings and situations (Patton 2002). This design was suitable for this study because the level of effectiveness of the implementation of policy interventions could vary in different settings.

Furthermore, whereas quantitative study aims to uncover a single reality, qualitative research recognises the fact that there are numerous truths or realities to discover (Erlingsson & Brysiewicz 2013). Because health workers and managers have varied ways of understanding and interpreting their experiences regarding policy interventions, the researcher could not rely only on a single truth, hence justifying the selection of the qualitative paradigm for this study.

3.3 Theoretical Framework

3.3.1 Realist Evaluation Framework

The researcher used a theoretical framework to find a starting point for the research problem and define the focus of the research. Based on this, a conceptual framework was also developed. These frameworks stimulate, make research findings useful and establish relationships between issues (Carter & Little 2007). To understand the influences of policy interventions on health worker movements, this researcher adopted the realist evaluation framework approach proposed by Pawson and Tilley (1997). The main explanatory focus embraced by realist evaluation is “what works for whom in what circumstances” (Pawson & Manzano-Santaella 2012, p. 177). In formative, summative and research synthesis evaluations, this method could be used prospectively, concurrently and retrospectively, respectively (Pawson et al. 2005). It gives insight into how social programs work and evaluates further their functional successes and failures for various interest groups functioning in a particular context. This clearly is concerned about the relationship existing between individuals and society and how their interactions could cause or hamper change in a social context of interest (de Souza 2013), thereby appreciating the fact that the program is active and works around active recipients.

A realist framework can be used in all forms of evaluation ranging from developmental to impact assessment by measuring either or both the processes and impact of interventions by using qualitative or quantitative methods or both (Pawson et al. 2005). The fundamental evaluative question, what works? becomes "what is it about this program that works for whom in what circumstances?" It implies that the inner workings and operations of a program and their connectivity are as equally important as the effect of the program, although normally the former is hidden from those observing the outcome procedures (Kazi 2003). These workings and operations are known as the *Context Mechanism Outcome* (CMO) configuration.

The *mechanism* is the process through which interventions are executed (Ogrinc & Batalden 2009). It forms the central point in realist evaluation, emphasising the fact that it is not the intervention or program that works *per se* but rather the target audience reactions, provision of adequate resources and the capabilities that the program offers (Pawson & Tilley 1997). The program mechanism captures the manner in which the program's resources affect stakeholders' reasoning.

The *context*, on the other hand, describes the prior existing structures of a locality and other elements such as the systems, relationships, technology and economic status that might be important to the mechanisms (Dieleman et al. 2011; Ogrinc & Batalden 2009). These factors are external to the intervention, present or occurring, and may have an influence on the outcome even if the intervention does not lead to an outcome. In addition, contextual thinking is used to address the issues of 'for whom' and 'in what circumstances' a program will work (Pawson & Tilley 1997). As such, the combination of the mechanism and the context will bring out the possible relationship to the *outcome* and be used to explain the outcome patterns. The CMO configuration revolves around the possible outcomes and outputs that are activated by the program in a certain context. This configuration is used as an imaging tool in analysing the link in the CMO to figure out how a change came about (de Souza 2013). A realist approach looks for mechanisms at individual, group, organisational and societal levels. In this study, the mechanism is the action or change produced or experienced by the health workers following implementation of retention strategies or interventions.

The application of this evaluation framework in the study was aimed at ascertaining "What intervention or strategy works for which categories of health workers, in what circumstances and in what respects?". Thus, in the study I used the realist evaluation framework approach to

understand "how" and "why" some rural retention strategies are more effective in some settings and fail in other contexts and to further understand the level of effectiveness of various interventions (Dieleman et al. 2011) put in place by policy makers in Ghana to motivate and retain health workers in rural areas. To explore existing information, structure ideas and make theoretical distinctions surrounding rural health workers retention, I developed a conceptual framework.

3.3.2 Conceptual Framework

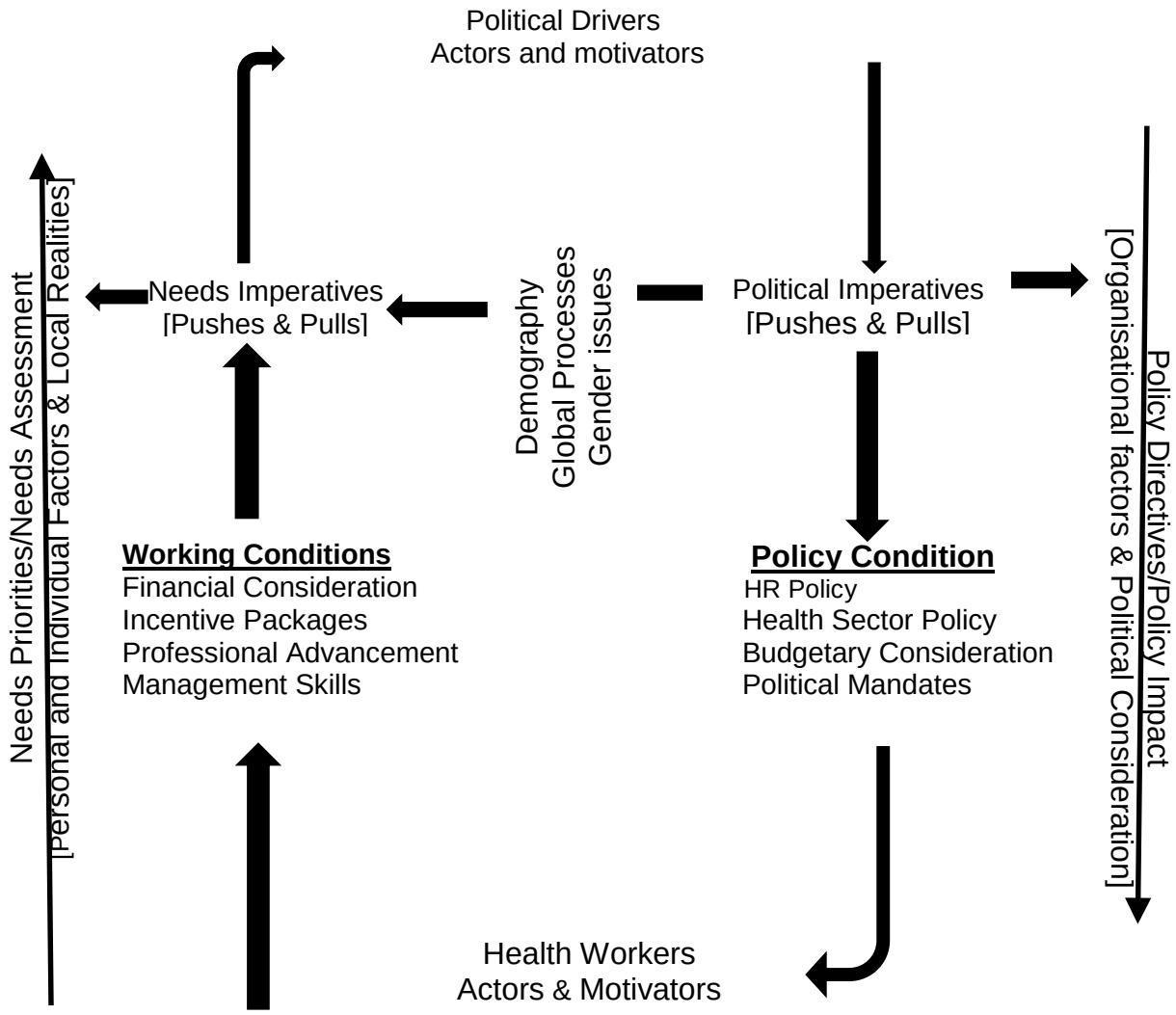

Figure 3-1: Conceptual framework

***Source**: Author's construction based on the thematic review of factors affecting rural health worker retention*

Maxwell (2012) explains that qualitative research begins with an understanding of how the study can be built on existing knowledge, conceptual frameworks or tentative theory. However, a researcher must have an open mind towards emerging concepts so as to accept and understand the qualitative process as a constant emergent process (Ritchie et al. 2013). This is shown in Figure 3.1 above. The conceptual framework constructed by the researcher and used initially to summarise the literature review also guided data collection and analysis. It was constructed from the thematic analysis of factors that affect health worker retention in rural areas and as such builds on various ideas about rural health worker retention. This simple and practical framework highlights key factors that incorporate the realist evaluation framework. As such the 'context', which describes the existing structures and other elements as illustrated in the framework, incudes demography, global processes, gender issues and policy conditions (human resource policy, health sector policy, budgetary consideration and political mandates).

In this framework, 'mechanisms' such as financial considerations, incentive packages, professional advancement and management skills can be identified, which together with the contextual factors listed above influence the outcome of policy interventions. Thus, these factors play a role in determining whether retention interventions are put in place to motivate and retain health workers in the Upper East region of Ghana work. It is not retention strategies that work *per se* but factors such as the target audience reactions, provision of adequate resources and the capabilities that the intervention offers are also important (Pawson & Tilley 1997). In the framework, further mechanisms are identified at individual, group, organisational and societal levels and these broad factors operate directly or indirectly to determine the outcome of policy interventions. Because the main focus of the study was to describe the lived experience of a phenomenon, in this case participants' experiences regarding policy interventions, an interpretive phenomenological research approach was used.

3.3.3 Interpretive Phenomenology

An interpretive approach was used in this study following the interpretive phenomenology lens because it was established to facilitate the understanding of an entire phenomenon. The perceptions of those who actually live it and make sense of it are the main focus of the data (Flood 2010; Liamputtong 2013). The foundation of the interpretive approach is that, since human beings are complex by nature, each person carries unique interpretations and

perceptions to a given condition based on their own personal realities (Schneider et al. 2007). Therefore, in accordance with the aim of the study, an interpretive research approach was used to describe the meaning and importance of individual health workers' and managers' experiences and perceptions regarding various policy interventions (Groenewald 2004; Polit & Beck 2012a).

The interpretive approach further recognises that certain factors could affect the understanding and interpretation of the phenomenon. This includes but is not limited to the researcher's past experiences (Tuohy et al. 2013), which influence his/her beliefs and notions. As explained by Flood (2010), it is impossible for the researcher to clear his/her memory of what he/she is knowledgeable of, which makes the researcher's reflexivity in the research very important.

3.4 Researcher's Reflexivity

Reflexivity is an important feature of qualitative research, with scholars accepting the researcher as a central figure who is actively involved in the construction of the data collection, selection and interpretation (Carolan 2003; Pillow 2003). It is an essential principle that defines the influence of the research procedure on the quality of research outcomes. By definition, reflexivity is a process of "critical self-reflection of the ways in which researchers' social background, assumptions, positioning and behaviour impact on the research process" (Finlay & Gough 2008). This concept recognises research as a combined product of the research participants, the researcher and the relationship that exist between them, which serves as a means for a critical analysis of the entire processes involved in the research (Arendell 1997). Therefore, the researcher's reflexivity signifies a systematic process of the researcher learning about him/her self which subsequently leads to in-depth and richer meanings about personal, ethical and theoretical features of the research questions (Carolan 2003).

The concept of reflexivity also acknowledges that meanings are conveyed within particular contexts, settings and phenomena and as a result, the researcher's personal reflection, understanding and thinking are used as primary evidence (Finlay & Gough 2008). The means through which I sustained reflexivity were the reflexive notes I took during each in-depth interview and the development of a reflexive fieldwork journal.

The role I played in facilitating the in-depth interviews helped participants to share their views, perceptions, expectations, challenges and experiences regarding the policy interventions put in place to address rural health workers' shortage. Apart from the discussions I had with the participants, I also observed processes and events in health facilities especially regarding the practice of task-shifting, which I documented in the reflexive journal I developed. The documentation of events at health facilities and in-depth interviews with participants gave me a deeper understanding of the level of implementation of the policy interventions which enabled me to improve the richness of the data, thereby enhancing the data quality. Thus, the reflexivity process employed during this study helped in the collection of detailed data and further added value to the data during analysis and interpretation of the findings which included details of the study area,

3.5 Study Populations and Recruitment of Study Participants

3.5.1 Study Populations

The study population included healthcare workers in health centres, those rendering community-based services, and health service managers at the regional and districts levels. The different cadres of healthcare workers comprised Medical Assistants (MA), Enrolled Nurses (EN), Psychiatric Nurses (PN), Community Health Officers (CHO), midwives, optometrists, General Registered Nurses (GRN), Disease Control Officers (DCO), and health nurse aides.

The essence and effectiveness of comparison in qualitative research is connected to better understanding rather than measuring differences (Lincoln & Guba 2017). As a result, health workers were selected to reflect diversity in terms of age, designation, ethnicity, education levels, marital status and number of children. Health service managers were recruited to explore issues around the implementation of policies, sustainability of effective policies and the potential for replacing policies that failed.

3.5.2 Recruitment of Study Participants

A purposive sampling technique was used to select the different cadres of health workers and health service managers for this study because it has been shown to be instrumental in providing more insight and in-depth understanding of the topic of interest (Braun & Clarke 2013). Because the aim of this study is to discover the opinions of health workers and managers, the study informants purposively selected were considered experts and regarded as

good sources of information acquired through their experiences. Inclusion criteria were used to identify participants who were able to give in-depth information about their experiences (Polit & Beck 2012b). The inclusion criteria were:

1. Health workers working in primary health care facilities or health centres (including those rendering community-based interventions) who had worked for a year or more and expressed willingness to take part in the study.

2. Heads of the health centres (referred to as the in-charges) who had worked for a year or more in the health centre and expressed willingness to take part in the study.

3. Human resource managers, health administrators and key persons involved in the management of healthcare workers at the district and regional levels who expressed willingness to take part in the study.

Applying these criteria, a total of 68 participants was selected. They included heads of health centres (in-charges) and four key personnel involved in human resource management in the region. The researcher interviewed all study participants with interviews being conducted in 26 health centres in the selected 10 districts in the region. The heads of health centres were included to allow detailed exploration of the strategies and mechanisms employed in the management of task-shifting and to canvass their opinions on the interventions put in place to motivate health workers at their respective health facilities.

3.6 Recruitment Process

The initial phase of recruitment involved an introductory meeting at the regional level with the health management team to convey the purpose of the study and to seek their permission to visit the study sites. The researcher provided the team with ethics approvals from Flinders University and Navrongo Health Research Ethics Committee, including the introductory letter from her supervisors. Afterwards, a list of health workers working in health centres and other relevant informants in the selected districts was obtained from the regional directorate, together with an introductory letter that facilitated entry into the various districts and communities.

At the community level where health centres were situated, the researcher met with the heads of facilities, the “in-charges”, and provided the introductory letter from the regional directorate. The researcher then verified the list of health workers obtained from the regional

level to identify potential participants for interviews. Potential participants were then contacted directly by the researcher to minimise perceptions of obligation or pressure to participate in the study. They were provided with information about the study and the researcher sought their interest to participate through verbal communication. They were made aware of the purpose of the study, including its voluntary and confidential nature. The participant information documents (information sheet, letter of introduction, consent form) were handed over to potential participants to enable them to decide whether to participate in the study. The information sheet had the researcher's mobile telephone number so those who were willing to participate in the study could send a text message or call. A follow-up visit was later made to meet those who had agreed to take part, where they confirmed their agreement by signing the informed consent form and made appointments for in-depth interviews.

The researcher distributed 79 introductory letters and information sheets and received text messages and calls from 72 potential participants. Interview appointments were booked with participants at times and dates suitable to them to avoid interruption of their work. In total 72 interviews were conducted.

3.7 Ethical Considerations of the Study

The importance of ethical considerations in all research has been established and must be incorporated from the research design through to the conclusion (Fossey et al. 2002). Researchers involved in qualitative studies normally do not rely only on the approval procedure granted before starting the research but rather take a continuous approach by keeping participants informed throughout the research, thereby ensuring that participants receive the necessary respect, openness and transparency (Guillemin & Gillam 2004; Krefting 1991). The ethics approval procedure for this study centred on ensuring that the participants were fully protected from harm. It also took into consideration issues of voluntary participation, informed consent, confidentiality and anonymity.

This study observed the full process of ethical approval by following the guidelines provided by the Australian National Health and Medical Research Council. The researcher received ethics approval to conduct this study from Flinders University of South Australia Social and Behavioural Research Ethics Committee and the Navrongo Health Research Centre Institutional Review Board of the Ghana Health Service. Information documents including an

introductory letter and information sheets explaining the research procedures were handed to potential participants to enable them to decide whether to take part. Before conducting each interview, the researcher gave a detailed explanation of the contents of the documents, emphasised that participation in the research was voluntary, and stated that participants could withdraw from the study at any point in time or decide not to answer any of the questions. Each participant was then asked to sign a written informed consent form accepting to take part in the study.

Interviews were conducted in places chosen by participants to ensure confidentiality. Participants were also assured that the information they provided would remain anonymous. A unique identification code was assigned to each participant and these identification codes were disconnected from personal identifiers to prevent the possibility of linking data to participants after the study was completed. Further, the storage places of the data including the Flinders University database and the researcher's computer were protected by passwords. The ethics forms, introductory letters, information sheets, and consent forms can be found in Appendices 1, 2, 3, 4 and 6 respectively.

3.8 Data Collection Methods

The primary source of data used in this study was in-depth face-to-face interviews. Secondary data included policy documents, researcher's field notes and reflexive dairy, informal discussions and observation of general events.

3.8.1 In-depth Interviews

Face-to-face in-depth interviews were conducted with participants because in phenomenological research these enable the researcher to discover and comprehend the experiences of participants (Flood 2010; Minichiello, Aroni & Hays 2008). In-depth interviews also lead to a better understanding of the topic under investigation by facilitating understanding of the very detailed subjective coverage including issues of power conflict (Ritchie et al. 2013), making them the best means to investigate health workers' and managers' perceptions regarding policy interventions.

A semi-structured in-depth interview technique was used that provided deep understanding of the phenomenon under study by allowing participants to talk openly and freely during the discussions (Gill et al. 2008). This is an appropriate means to encourage open-ended

responses, by integrating the experiences of interviewees, their perceptions and meanings of the phenomenon and for promoting discussion of issues considered complex, confidential or sensitive (Creswell 2013). As such, each interview took a form of two-way conversation (Rice & Ezzy 1999) guided by a semi-structured interview guide. This enabled participants to express their opinions and experiences openly regarding existing policies and interventions. Further, conducting in-depth interviews using a semi-structured interview guide supports the idea that there is no study conducted without assumptions, and hence there is need for the researcher to think of broader questions before starting the interview. Subsequently, this created an enabling environment for participants to give deeper reflections on the topics that were presented and enabled them to come out with their own thoughts on the areas under discussion (Broom 2005). Interview guides for health workers and managers can be found in Appendices 9 and 10 respectively.

3.8.1.1 Interview Procedure

Before data collection, the semi-structured interview guide was pilot tested among health managers and healthcare workers outside the study area to be sure that its structure and length were appropriate. Data gathered during the pilot interviews were used to revise the interview questions and procedure. This continued during data collection when after each interview the researcher used a reflective approach and thereby information gathered enhanced subsequent interviews. The interviews were conducted between August 2015 and January 2016.

The semi-structured guide used for conducting the interviews, comprised of open-ended questions but to improve the flow of the discussion the researcher did not adhere strictly to the order of the guide. The interview took the form of a two-way conversation where the researcher started with broad questions on rural practice and policy interventions and then narrowed the focus to address the issues on the interview guide. Although the interview proceeded with broad questions, probes were used for clarification and to uncover essential issues so as to deeply understand the topic of interest (Qu & Dumay 2011). Despite the use of probes by the researcher to obtain detailed data, respondents were made aware that they were not obliged to answer questions.

Interviews were recorded on a digital recorder to obtain the exact words spoken by participants. Recording allowed free conversation without disruptions and subsequently led to accurate transcribed data. During recording the researcher wrote brief notes about non-verbal

expressions such as body language and mannerism of respondents along with general observations to enrich the verbal data (Oltmann 2016). Interviews were only recorded after participants granted permission. Where permission was not granted, notes were taken during interviews and detailed conversations written as soon as the interview had ended.

The duration of qualitative interviews can vary in a study and could range from 20 to 60 minutes depending on the issues being discussed and the interviewees (Gill et al. 2008). In this study, interviews lasted from 30 to 60 minutes. The interview was conducted in English and the transcription was done by the researcher. Some respondents were very open and readily gave detailed information without much probing, while others were less forthcoming and more probing was needed.

Data collection and analysis were carried out simultaneously because this enabled the researcher to create understanding that emerged from the research questions which in turn informed the sampling and how the questions were asked during subsequent interviews (DiCicco-Bloom & Crabtree 2006). Throughout the interviews, the researcher maintained good relationships with participants and this helped to build trust and further contributed to the acquisition of valuable and relevant information from study participants.

3.8.2 Document Review

Information from available documents in the study area was included because documentary evidence can be combined with interviews and observation data as means of triangulation, to minimise bias and increase credibility (Bowen 2009). Analytical procedures for documents involve finding, selecting, appraising, and synthesising data found therein to identify salient extracts, quotes or complete passages of data that are further organised into main themes (Labuschagne 2003) for interpretation. Therefore, available key strategic and policy documents of the Ghana government that related to policy interventions put in place to address the challenge of health worker shortages in rural areas were reviewed, enabling the researcher to identify, analyse and obtain relevant information systematically from the documents (Bowen 2009). This contributed to the researcher gaining a deeper understanding of policy interventions in the study area.

3.8.3 Observation and Field Notes

The researcher lived in the study area and this enabled her to record events and occurrences that contributed to understanding the context of the study. The general settings of interviews

and the environment were observed. Field notes were made in the researcher's reflexive dairy throughout the observations, focusing on what was seen and experienced. The notes recorded by the researcher helped to determine the meaning of observed events which then assisted her to respond to the research questions during the processes of data analysis (Bogdan & Biklen 2007; Pitney & Parker 2009). Taking reflexive notes was also useful because it helped the researcher to identify when it was appropriate to revisit participants to acquire additional deep understanding of their experiences regarding policy interventions.

3.9 Processing of Information and Data Analysis

As explained by Polit and Beck (2012), the aim of data analysis is to draw meaning and make sense of the data collected. After careful consideration of various methods for analysing data, the researcher chose the thematic analysis approach proposed by Braun and Clarke (2006). This method was used because it was appropriate for studies that aimed to explore and comprehend the perceptions and experiences of individuals (Clarke & Braun 2013), which was in accordance with the aim of this study, namely to understand health workers' and managers' experiences and perceptions about policy interventions for addressing rural health worker shortages. Thematic analysis was also consistent with the interpretive phenomenological approach used in this study and it forms the basic method of analysing qualitative data. Hence it is an appropriate means of extracting rich and comprehensive data in different contexts (Braun & Clarke 2006; Polit & Beck 2012b; Vaismoradi, Turunen & Bondas 2013).

Braun and Clarke (2006) explained thematic analysis as a process used to categorise, analyse and report on various themes extracted from data. Additionally, it gives interpretations on the different aspects of the research topic (Boyatzis 1998). According to these scholars, theory-driven interventions have various assumptions which are connected to the type of data in terms of truth and this can be made more transparent using appropriate thematic analysis. At the beginning of thematic analysis, themes may be derived from the data or could be predetermined beforehand, referred to as 'inductive' (data driven) and 'deductive' (theory led) respectively (Braun & Clarke 2006; Patton 2002). In this study I used the inductive method whereby the themes identified or categorised in the process of analysing the data were strongly related to the original data. To improve the richness and quality of the findings, I also took into consideration theoretical recommendations (Braun & Clarke 2014; Nicholls 2017; Pope, Ziebland & Mays 2000).

As clarified by Boyatzis (1998), themes can be identified on two levels, semantic and latent. A semantic method of analysis identifies themes within the explicit or surface meaning of the data collected. It does not go beyond the information obtained from research participants. On the other hand, the latent level of thematic analysis goes further by recognising the fundamental concepts, assumptions and ideologies that theoretically inform the original data. The development of themes for latent thematic analysis includes interpretive work and the analysis that is generated is not just description but is already theorised. From an interpretative phenomenological approach, I concentrated on latent thematic analysis which enabled me to explore health managers' and workers' experiences regarding the practice of task-shifting and the interventions put in place for the retention of health workers in rural areas.

Although the qualitative research approach is known to offer a deeper analysis of how people explain their situations and interpret occurrences, limited tools exist to aid in the process of analysis (Denzin & Lincoln 1994; Marriam 1998). However, Braun and Clarke (2006) have provided a template with six step-by-step stages for carrying out thematic analysis and this is what I used to analyse the data in this study. In the subsequent paragraphs, details of this method of analysis are presented.

Step 1: Familiarising myself with my data

The first step involved in data analysis is for the researcher to familiarise him/herself with the data collected. According to Braun and Clarke (2006), this is essential because it enables the researcher to be immersed in the data in such a way as to become familiar with the depth and breadth of the data content. A suggested means of immersion is multiple reading of the data in an active manner in search of meanings and patterns. In this study, data transcription began concurrently with data collection in the field. Shortly after conducting each interview, I listened to the recording and made a full verbatim transcription ensuring that this accurately reflected the true words of the respondents. The transcripts were read repeatedly and the recordings replayed to ensure the data had been fully captured during transcription. The non-verbal expressions and utterances of participants that were recorded were also read often to understand the context of the interview. After transcription was finished, I read through the transcripts multiple times until I was certain that I had adequately familiarised myself with the data before proceeding to the next stage of the analysis.

Step 2: Generating initial codes

After multiple readings of the data to ensure adequate familiarisation, and having produced initial lists of ideas regarding the contents of the data and some of the interesting aspects of it, I began the next stage which was the formation of initial codes. I identified codes within the data that seemed interesting in a meaningful manner concerning the phenomenon (Boyatzis 1998; Braun & Clarke 2006). I used the data-driven approach of thematic analysis, which is geared towards coding the content of the whole dataset, and this was done manually. I started the coding in a systematic manner and in the process paid attention to each item in the data, thereby identifying essential aspects of the items in the data that could possibly form the foundation for repeated patterns or themes through the data set. I used different coloured pens during the coding process and then used similar coloured pens to indicate codes that were repeated in the data set. To confirm that all actual data excerpts were coded and organised into each code as recommended by Braun and Clarke (2006), I pulled out the sections of the data segments that were coloured and collated similar coloured sections under each code. An example of the process of code extraction from the data is shown in Table 3.1.

Step 3: Searching for themes

This step started when I had finished coding all the data and collated them. At this point, instead of codes I redirected the analysis into identifying themes at the broader level. I organised the different codes into possible themes and collated all the essential coded data extracts within each identified theme. Then I began to analyse my codes and considered the links between various codes, themes and the different levels of themes. As Braun and Clarke (2006) recommend, I began listing possible themes from the patterns that recurred in the data, based on my reflection on mind-maps of the possible themes after analysing the coded data. Shown below in Figure 3.2 is an example of the thematic map at this stage of the analysis. It shows how the themes were selected from the whole dataset.

Table 3.1: Data extract with initial codes

Data Extract	Coded for
You know here we have only one disease control officer. Because she is not around at the moment, I have added her work to mine and if midwife is not around, I will be forced to conduct deliveries but I don't have any training in that so it can worsen the health condition of patients. We don't have enough staff so we have do something to save the lives of the people. I do other tasks but I don't receive more money or anything to motivate me. The only motivation is that I am learning new skills. (CHO 4)	Engaged in other tasks Forced to conduct delivery Staff not enough Trying to save lives Not trained for additional work No incentive for additional work Worsen patient's health conditions Learning new skills

The process of analysis involved constructing many charts through which I identified possible themes that emerged from the dataset. After identifying the possible themes, I proceeded to the next phase of the analysis which involved reviewing the themes.

Step 4: Reviewing the themes

In this stage, themes identified earlier were reviewed and refined. I did this by first reviewing all possible themes by reading the collected extracts for the different themes to ascertain whether the themes formed a clear pattern or an important piece of the whole data set. According to Braun and Clarke (2006), the essence of carrying out this exercise was to ensure that the themes truly reflected the data set and then to search and code other data within themes that were unnoticed. During this analysis, I altered the positions of some of the main themes and sub-themes to give the data deeper understanding. Thus, at this level of analysis, I had a good idea of the various themes, the relationship between them, their consistency in the data and the general story they conveyed around the data. For instance, during the review of the initial themes indicated above, I developed the thematic map shown below (Figure 3.2).

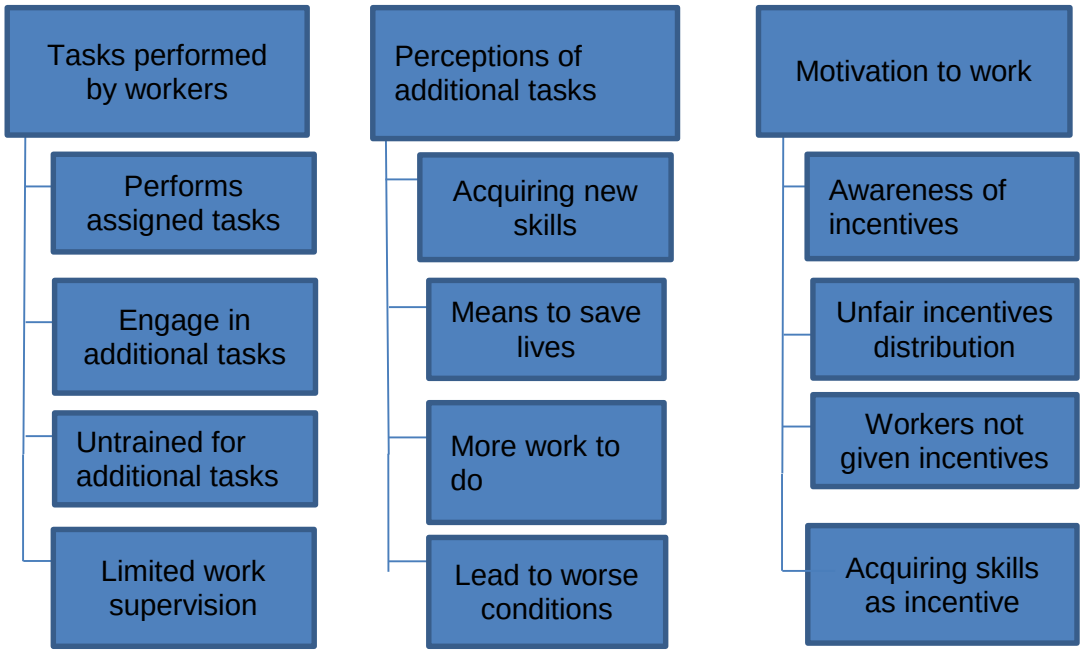

Figure 3-2: Example of thematic mapping

Before completing this phase of analysis, I constructed a thematic map of each theme. I ensured that the consistency and connection of each sub-theme with extracted data from the complete data set was sustained. This exercise was carried out to ensure that the various themes extracted were the true words of the study participants and a reflection of what they had experienced (Braun & Clarke 2006; Clarke & Braun 2013). Finally, after constructing the thematic map of the various key themes, I continued to the fifth stage of the analysis which was to define and name the themes.

Step 5: Defining and Naming the Themes

According to Braun and Clarke (2006), this phase of analysis involves defining and refining the themes that would be used for the analysis and analysing the data within them, to recognise the essence of each different theme, namely what each theme is about. It also helps to determine the various aspects of the data that are captured by each theme. In the process of doing this analysis, the content of the data extracts illustrated was paraphrased. I recognised what was interesting about these extracts and why. Additionally, I identified the story around each theme and the connection of these individual themes to other themes. I moved back and forth between themes and re-examined the dataset to assign suitable names to individual

themes. I further defined individual themes in connection to the meaning they carried in the data and produced sub-themes under the key themes to define their links in the data.

At this point, I collated extracted data pieces under individual themes and sub-themes, which formed the basis for organising the report. After compiling the extracted data segments, I systematically structured individual themes into a comprehensible and consistent version with supporting narratives from study participants. I then gave in-depth explanations of the individual themes and sub-themes with the confirming data connected to the general story around the data and the exact narratives of each theme. I concluded this phase of the analysis by describing the final themes and sub-themes supported with the narratives that were extracted from the whole dataset. The key themes and sub-themes that emerged from analysing the data were used to produce the report.

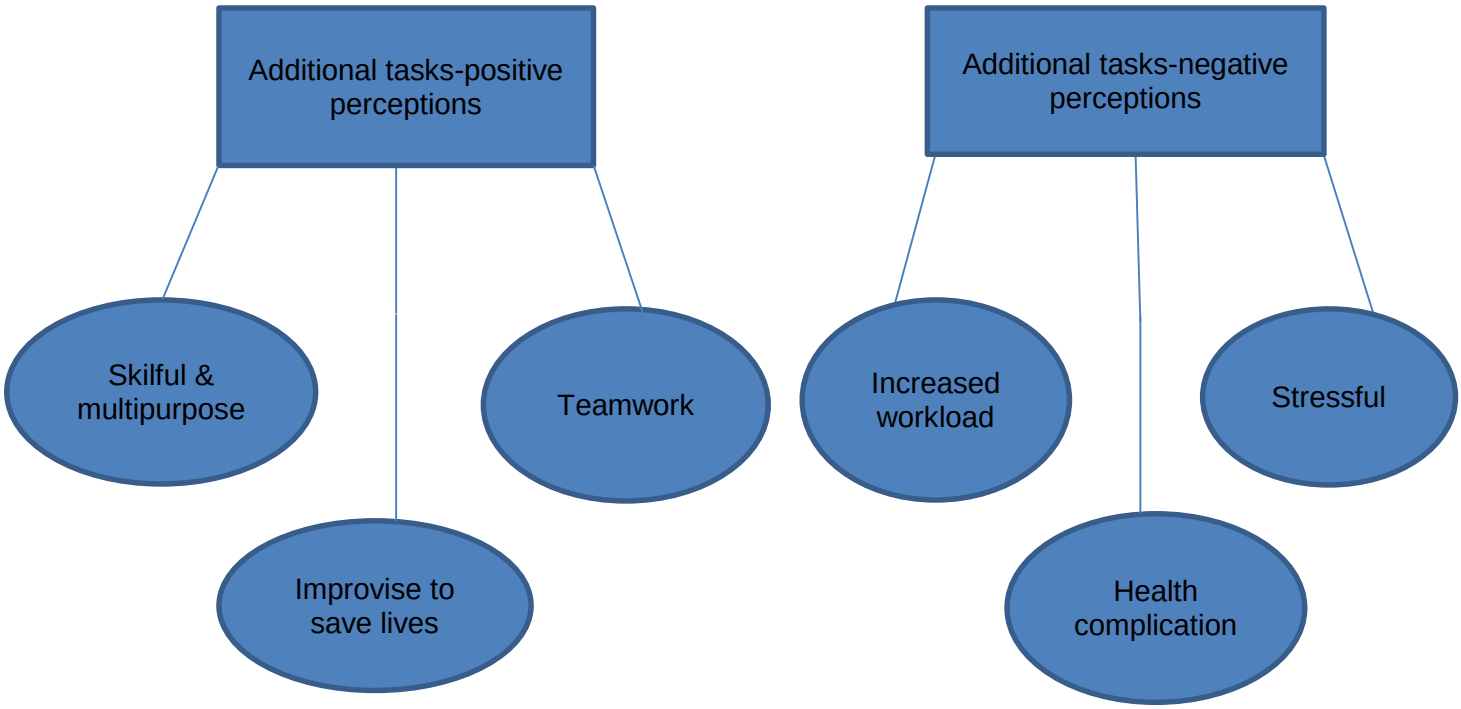

Figure 3-3: Example of reviewed thematic map

Step 6: Producing the report

I started this phase of analysis after I had gathered themes that were complete from the final analysis for producing the report. The report from the thematic analysis is expected to convey the complex story of the data in a manner that convinces the reader about the quality and validity of the analysis (Braun & Clarke 2006). It is also necessary to ensure that the data

analysis including the report and the data extracts gives a coherent, rational, non-repetitive and interesting interpretation of the story the data conveys across the themes (Braun & Clarke 2006; Fereday & Muir-Cochrane 2006). Taking these recommendations into consideration, I developed different chapters based on the themes constructed in the fifth phase of the analysis. In so doing, I constantly moved back and forth through the whole dataset to be sure that I had not lost essential data in writing the report. The individual extracts from the dataset were rooted within an analytic interpretation that demonstrated the opinions I was interested to uncover in this study. I completed the analysis by producing a write-up of the data and this is detailed in the subsequent three chapters (4, 5 and 6). Sections of Chapter 6 contain an analysis of policy documents and details of the processes involved in the analysis are outlined below.

3.9.1 Document Analysis Process

According to Bowen, document analysis is a systematic process for reviewing and assessing materials which are either printed or in electronic form. Similar to other analytical approaches in qualitative study, the analysis of documents entails examination and interpretation of data to produce meaning, gain understanding and build knowledge empirically (Bowen 2009). Bowen described document analysis as including scanning, thorough scrutiny and then interpretation of the documents, while Scott (1990) explained the need for documents to be examined and interrogated in the context of other data sources, such as semi-structured interviews and observations in the case of this study. Taking these recommendations into consideration, the process of document analysis in this study involved five systematic steps which are explained below.

Step 1: Setting inclusion criteria for documents

This phase of analysis involved outlining certain measures to guide selection of documents. To do this, I took into consideration the organisations that would be involved, the different types of documents to be reviewed, the sources of documents and the times of publication and release. The criteria for choosing which organisations should be included were that the organisation was presently involved with human resources for health management in Ghana, including development partners. They should also be organisations where suitable human resources for health policies, strategies or procedures was available publicly. The types of documents to be included in the analysis comprised organisational policies, strategies and procedures or related documents on human resources for health management. Because this

study was designed to assess policies and interventions to address health worker shortages in rural areas, I decided to analyse documents that were currently or previously in use, and this included evaluation and annual reports on human resources management in the health sector. Dates of publication were considered to allow me to understand and track the changes and progress in policies and interventions over specified periods. I focused on relevant documents that were published from 1990 to 2016. After identifying criteria for selecting the documents, I proceeded to the next step, gathering the documents.

Step 2: Gathering the documents

Some documents were accessible publicly online and these included appraisal, annual and progress reports. However, practical documents specifically describing existing strategies and interventions for motivating health workers in practice were not available online and I requested and obtained these documents from the Ghana Health Service and Ministry of Health. For documents obtained online, I searched the Internet using key terms such as human resource*, health sector*, Ghana Health Service*, postings*, recruitment* and appointment*. These key terms were explored in various combinations using the search terms 'OR' and 'AND' which were further searched in combinations with "Policy OR "Strategies" OR "Actions". I also searched the websites of the Ghana Health Service and Ministry of Health. In total, five appraisal and annual reports were retrieved online and ten documents were collected from the organisations. After gathering these documents, I proceeded to the next phase of the analysis which involved screening and selecting the documents.

Step 3: Screening and selection of documents

The inclusion criteria outlined above (step 1) were applied in screening and selecting the documents for the analysis. During the screening process, documents selected were those officially approved by the national government of Ghana, written in English, publicly available and related directly or indirectly to human resources for health. There was no language barrier because policies were documented in English. Documents that did not meet the inclusion criteria were excluded from the analysis. All government documents that included national objectives and guidelines for action in the area of human resource management in the health sector were considered. This included but was not limited to documents specifically referring to health workers' postings and/or recruitment and/or finance. Out of the 15 documents retrieved, nine were finally selected for the analysis after the screening process.

Step 4: Evaluating the evidence

As recommended by Bowen (2009), despite the possibility of documents serving as a source of rich data, it is necessary for researchers to examine documents critically before including them in their studies. Accordingly, I scrutinised the documents to determine how they contributed to the core issues of this study. I considered the importance of each document in relation to the research problem and aim, and determined whether it was consistent with the study's conceptual framework. Scott (1990) recommends that researchers should assess the authenticity, credibility, representativeness and meaning of documents to be used in research. In checking the authenticity of documents, the soundness and authorship were assessed by determining the originality of the document. Where I received copies instead of original documents, I conducted a verification exercise with the appropriate departments to ascertain whether additional material had been incorporated, changed or removed. Apart from the soundness, I checked the authors of the various documents. Because I was dealing with official policy documents which were based on various administrative processes, the authors were not cited as individuals but the knowledge I acquired from these processes was critical in reading between the lines of the various documents.

Additional useful information I assessed included the dates documents were written, contextual issues such as political, social, economic or historical motives that might have influenced the author and the document's contents, the coverage or topic of the document, various terms that were used and the main findings or statements. I also found out if there were other sources that I could compare the documents to and whether the documents were reliable. I further assessed how comprehensive each document was, whether it covered the topic broadly or selectively, and the target audience. The information outlined above is necessary when evaluating the data (Bowen 2009; Scott 1990).

Step 5: Analysing the selected documents

As explained in the initial steps, document analysis as a qualitative research process involves identifying underlying themes in documents, then analysing and interpreting these themes in a way that supplements a theoretical argument. The analysis of the documents in this study was carried out manually using Bowen's (2009) process for document analysis, which combines elements of content and thematic analysis. For the content analysis, I organised the information into categories in relation to the main research questions. At this point, meaningful and pertinent passages of text were identified. I tried to identify relevant

information and separate it from irrelevant material. After identifying relevant information, thematic analysis was used where I recognised patterns within the data and the themes that emerged became the categories for analysing the data (Fereday & Muir-Cochrane 2006).

The process of identifying themes involved careful re-reading and review of the data. I examined the selected data critically, performed coding and constructed categories based on the characteristics of the data. Themes that were relevant to the phenomenon were identified. Bowen (2009) discussed the possibility of using predetermined codes in situations where the document analysis supplements other research methods used in the study. As such, apart from the identified themes, predetermined codes were also used because the policy document analysis supplemented data from the other sources which included semi-structured interviews and observations. Therefore, some codes used in the analysis of the in-depth interviews were applied to the contents of the policy documents. Various codes and themes that were produced served as a means of integrating the data collected through interviews and observations, details of which are presented in Chapter 6 of this thesis. Fereday and Muir-Cochrane (2006) explain that issues of objectivity and sensitivity are considered important in document analysis. In this research, I demonstrated objectivity in the selection and analysis of the document data through fair representation of the research material, and sensitivity by responding to even subtle cues to meaning. Details of the documents sampled and data analysed can be found in Table 3.2.

Table 3.2 Documents Sampled and Analysed Data

Documents selected	Analysed Data
Human Resource Policies and Strategies for the Health Sector, 2007-2011	Data on allocations of funds for human resource management. Funds for salaries and incentive structure for the payment of additional duty allowance incentives
Human Resource Development Directorate Policy and Guidelines on Posting, 2006	Data on the processes involved in hiring and posting of health workers
Human Resource Development and Directorate Employee Policy Handbook, 2007	Data on details of what GHS expects from health workers after being appointed and posted to workplaces. Includes incentives on in-service training, capacity development, orientations, promotion and study leave incentives
Human Resource Development Policy for Inducting Staff into Ghana Health Service, 2006	Data on health workers conditions of work. Include incentives workers are entitled to such as responsibility allowance, overtime allowances, acting allowances and postings allowance.
Policies on Human Resource Sector of the Ghana Health Service and Ministry of Health, 2002	Budgetary support for deprived area incentives and expenditures in the health sector. Data on legislative processes involved in the making of the fiscal policies
Ghana Health Service (GHS) Report, 2011	Human resources for health shortages and challenges faced in training, recruiting and management of health workers in rural areas
Ghana Health Service (GHS) Report, 2014	Data on GHS structure, governance and human resource related issues
Ghana Health Sector Facts and Figures, 2011	Statistics on human resource for health and related data
Ghana Health Service and Teaching Hospitals, Act 1996	Data on the GHS formation, objectives, functions, administration, management and annual budget estimates

3.10 Methodological Rigour and Trustworthiness

The process used to evaluate the quality of research is termed as rigour and the rigour of a study is assessed using a framework referred to as trustworthiness (Graneheim & Lundman 2004; Krefting 1991). In this research, the trustworthiness and rigour were assessed using criteria such as credibility, transferability, dependability, and confirmability.

The credibility of a study is a measure of the accuracy of the findings of that study and how the findings relate to the study participants experiences (Cutcliffe & McKenna 1999). The

credibility of this study was enhanced by recording the face-to-face in-depth interviews. This process ensured the exact capturing of participants words so as to prevent the researcher from missing essential information.

Furthermore, a member-checking exercise was carried out to improve the quality of the interviews. It involved verification of respondents' information by providing them with a sample of the transcripts to be checked and verified (Henwood 2014). Since it was not feasible to undertake this member-checking procedure among all the study respondents, a sample was selected. Another process that enhanced the credibility of this research was persistent observations during field work. I stayed in the field for a long period of time when I was collecting the data. This made it possible for me to visit the healthcare facilities in the study area to observe various activities and events which subsequently enhanced the information that was collated during the interviews. The data were revised to check for consistency in the codes and the themes that were identified, and the interpretations in the study findings were supported by the quotes from the study informants and this further made the interpretation credible (Erlingsson & Brysiewicz 2013).

Furthermore, the quality of this study was enhanced using the process of triangulation. This strategy involved the diverse sources of data, investigators, and different methods of collecting of data or using different methods of interpreting the data (Golafshani 2003). This study incorporated different methods of data triangulation through the diverse ways of collating data using reviews of documents, interviews, researcher's reflective field notes and the in-depth interviews. The process of triangulation was also improved through the in-depth interviews carried out with the different cadres of health professionals and the health managers.

The transferability criterion was used to assess the possibility of applying the findings of the study to other settings (Liamputtong 2013). To do this, it is essential that researchers make sure that detailed information on the location of the study is made available. This will enable other researchers to make a decision on the applicability of the findings of the study to other settings (Finlay 2006). In this study, the researcher has provided detailed information on the study area and the purposive sampling method used to select participants' ensures the transferability of a study (Petty, Thomson & Stew 2012). However, the researcher wishes to clarify that she does not have the intention to generalise the study findings but rather, to provide a detailed description of the phenomenon under study within the particular location.

Another strategy that measures the trustworthiness and rigour of a study is referred to as dependability. This method is used to evaluate the consistency of the findings of the study. Assessment of dependability requires the study investigator to provide detailed information on the various methods that were used in the data collection, analysis and interpretation (Krefting 1991). Based on this, the researcher has systematically described the methods used in this study to allow others to reproduce the study if they wanted to, although it would be difficult because of variations in settings and time.

Lastly, the quality of this study was evaluated using the confirmability criterion. This process is used to judge the level to which the findings of a study are influenced by the participants but not the researchers' perceptions or interest. This includes establishing quality through an auditing process (Erlingsson & Brysiewicz 2013). The audit process shows the ability of the researcher to establish that a clear decision trail has been established about the development of proceedings and the rationale of the research during the specified study time. This is essential for the confirmability and dependability of the research (Krefting 1991). In examining the audit trail, an assessor would focus on the notes taken during field work with procedural or individual information, triangulation, reflexive journal keeping and member checking processes (Finlay 2006; Petty, Thomson & Stew 2012). Therefore, the researcher took detailed notes in the field which is a confirmation of the study procedure. The rationale for choosing the research site, the study participants and the research topic has been explained clearly, together with detailed descriptions of data collections and analysis. These contribute to auditability in ensuring the quality of the research (Krefting 1991; Sandelowski 1998).

As explained by Finlay (2006) it is essential for the researcher to consider a holistic means of establishing a rigorous comprehension of data as well as proceedings in the process of conducting a qualitative study. Therefore, the researcher made an effort to sustain rigor throughout this study, from the start to choosing apposite methods to collect data, formulating appropriate methodological approach, conducting analysis that was theoretically led and recognising the ethical issues associated with the research.

3.11 Study Limitations

This study has various limitations which need to be highlighted. Firstly, purposive sampling method was used in the selection of study respondents for the interviews and as with most

qualitative studies, generalisation of this study findings to other districts and regions in Ghana is not possible. This is because opinions of individuals may differ across districts and regions. However, it has provided comprehensive and highly contextualised information and understanding regarding task-shifting practice, effectiveness of incentive packages and outcomes of policy document analysis that could inform policies.

Additionally, the interpretive methodology used depends on the verbal interpretations of study participants and this could be challenging when interviewing individuals who are unable to express themselves adequately (Boyce & Neale 2006). Furthermore, the information about incentives participants may have received was based on participants' recall and as such, some participants may not have remembered full details. However, these challenges were minimised by introducing appropriate probes that encouraged individuals to express themselves (Doody & Noonan 2013). Although data on health workers' experiences were limited to what they actually said, the interviews conducted with health managers to some extent were useful in given insight to these experiences.

3.12 Conclusion

In this chapter, the methodological approach used in this study has been described, including methodological rigor and trustworthiness. A qualitative research method was selected for this study with in-depth interviews as the primary means of collecting data which was supplemented by a review of essential documents and notes taken during field work. A thematic approach was used in analysing the data because it was suitable for studies that aim to explore and understand individuals' perceptions and experiences and was consistent with the study aim of exploring health workers' and managers' experiences and perceptions of interventions to address rural health worker shortages. Thematic analysis was also consistent with the interpretive phenomenological approach used in this study. The study adhered to thorough ethical procedures for conducting research, including obtaining informed consent, observing anonymity and confidentiality, and protecting participants from harm. The findings of the study, with the themes and sub-themes which emerged from the analysis, will be discussed in the next three chapters.

CHAPTER 4
TASK-SHIFTING ROLES AND RESPONSIBILITIES: HEALTH WORKERS' AND MANAGERS' EXPERIENCES AND PERCEPTIONS

4.1 Introduction

In Chapter 3, the methodology and steps used in conducting this study and the method used in analysing the data were explained. In this chapter, I present the findings on task-shifting and discuss these with reference to relevant literature. The main issues surrounding perceptions on task-shifting that emerged from the field are discussed, with a focus on official tasks and additional workload, and the challenges around task-shifting as explained by participants. The key findings that emerged include that health workers performed both official and additional tasks within their respective facilities; health workers and managers had positive and negative perceptions regarding task-shifting practice; there are various challenges associated with task-shifting practice and health systems and governance issues (which are discussed extensively in Chapter 6) are important. Contextually, where these complex systems are not managed properly, they will lead to problems, as the Ghana experience reveals. To better understand these issues, this chapter discusses research participants' accounts of their experiences and these are presented in three themes, as follows:

- Official (main) tasks and additional workload performed by health workers
- Management members' perceptions of task-shifting
- Health workers' perceptions of task-shifting*

* Part of this chapter has been accepted and published in the *PLoS ONE Journal, 2017, 12 (3):e0174631*

4.2 Official (main) Tasks and Additional Workload Performed by Health Workers

4.2.1 Clarity on roles and responsibilities and their impact

The health workers in the region where this study was conducted are usually required to engage in tasks for which they have been officially trained. For instance, in the healthcare system, staff in units such as maternity, cardiology or paediatrics should be able to attend to the needs of their specific client populations. One way of achieving this is the formulation of high performance tasks or roles that demand workers' willingness to accept these roles. Those working in primary healthcare facilities should be helped to comprehend these defined tasks and participate in formulating them because this enables them to have clearly defined benchmarks in the realisation of their roles.

Therefore, a well-defined task or role for different categories of health worker is important for quality and efficient delivery of healthcare and to enhance cooperation among health professionals. On the other hand, when tasks are not clearly classified or defined, it could lead to duplication and interpersonal disputes among health professionals. Consequently, the lack of precision in allocating tasks could negatively affect the effective delivery of healthcare by health workers (Delamaire & Lafortune 2010; Sangster-Gormley et al. 2011). As explained by Brault et al. (2014), apart from explicitly defining the roles of each category of health worker, additional functions are accomplished with satisfactory outcomes when professional tasks are well assigned. This involves ensuring that the tasks assigned to each cadre of health worker are adequately executed to optimise expert choice of practice for efficient management of patients.

The Ghana Health Service (GHS) has employed different cadres of health professionals who received training in different health schools, allowing them to take up specific roles to provide adequate care to the population. From a theoretical point of view, the concept of efficiently delineating tasks starts from the time of training. During this time, health workers become aware of which tasks they should be doing when they start work and the tasks that they cannot perform. Therefore, situating this within the Ghana Health Service, all health personnel ranging from Medical Assistant/Physician Assistant (PA) to Health Records Officer to Health Aide (HA) generally performed tasks within their specialised areas of

training, performing duties that are defined in their official appointment letters or stated terms of reference. (As I will explain later, this does not mean that they do not perform additional tasks beyond what they were officially trained to do.) This was identified among different categories of health workers across the different health care facilities in the districts where this study was conducted. For instance, Physician Assistants (PA) engaged in consultations with patients, trained midwives assisted pregnant women in the delivery of babies, the Psychiatric Nurse (PN) took care of patients with mental illnesses, and trained Disease Control Officers (DCO) conducted disease surveillance and control. Health workers explained their official duties as follows:

> *As a trained midwife my main duty in this health centre is to assist pregnant women to deliver their babies so that is what I do here. I also take care of the women and babies after delivery to make sure they are all healthy. I do other things but the delivery is what I am trained to do and I am the only midwife here so I am most of the time busy (Midwife 6).*

> *I am a Physician Assistant (PA) who is trained to give medications to the sick in this health facility so that is what I have been doing, but you know in a village like this, it's not easy at all. Since we don't have doctors in these rural areas, we the MAs [Medical Assistant] play the role of the doctors by giving consultations to patients.*

Some of the health professionals in the study area were previously employed through the National Youth Employment Program (NYEP). This was instituted by the Ghana Health Service to help tackle the challenges associated with the chronic shortage of health workers in the country. People targeted for this program were those who had successfully completed senior high school. They were given six months' basic training in health care delivery, enabling them to assist health personnel in various health facilities across the country. Although this training was of short duration, through it some individuals developed their skills in the performance of various health related roles. Consequently, they were able to undertake tasks in rural areas, where it was initially difficult to get health workers to accept permanent posting. However, not long after the implementation of the NYEP it was suspended because of financial constraints and the lack of commitment. A Health Record Officer (HRO 2) and a Health Aide (HA 3) explained the benefits they derived from this program in relation to their career progression:

> *I was first employed by the National Youth Employment Program so I started from that level which was 2006 as an extension officer but in 2009, the program was cut off so I went for the health records course at Kintampo rural health training school. After the course I was brought back here to continue*

my work. So now I am a health records officer and what I do here is that when patients report to this facility for treatment, I remove their folders and record their information before they are seen by the MA [i.e. Medical Assistant, who are sometimes called physician assistants] or a nurse. After that I make sure the folders are filed properly though we don't have a proper place for filing the folders (HRO 2).

I was initially trained after my senior secondary school by the youth employment people and posted to this health facility to work and when the program ended, my in-charge retained me here to assist in delivery and other tasks since we don't have enough health workers in this village. Since then I have gained more skills working here (HA 3).

In the rural communities where the study was conducted, the physician/medical assistants (PAs) are officially trained to have consultations with sick people who attend the healthcare facilities. In most cases, PAs are put in place to manage the activities of their respective health facilities and this includes the Community-based Health and Planning Services (CHPS) compounds within their localities. They perform supervisory tasks, address challenges faced by other health workers and, if necessary, report to the regional directorate. Because of the management responsibilities assigned to these PAs, they are normally referred to as the *'in-charges'*, which implies that they are in charge of health care facilities. Until recently, when the Ghana Health Service introduced direct entry from senior high school into physician assistants' courses, these health workers comprised skilled nurses with many years of work experience and with some holding advanced level academic qualifications. Physician Assistants 5 and 6 explained their main tasks, thus:

My main task here is to render primary health care services. Apart from daily general OPD [outpatient department] consultations, I manage emergencies and minor procedures like seizures and assist in the Reproductive and Child Health maternity unit. As the physician Assistant [PA] sub-municipal leader in-charge of the facility, I do supervision to ensure that all staff report to work on time, and everybody is at work in their designated units. I do monitoring too by visiting the Community Health Planning Services compound on a weekly basis to check on progress of their on-going activities, and find out about their challenges so I can liaise with the municipal directorate. I am still the liaison officer between the sub-municipal office and the municipal office (PA 5).

As the PA in-charge, I am in-charge of the sub-district activities and the sub-districts are made up of the CHPS compounds and CHPS zones plus the health centre itself so I render both public health and clinical activities. In terms of the public health I make sure that the logistics and human resources are available to be able to render those services. Basically I make sure that all the activities in the sub-districts are carried out and the reports are submitted to the districts and regional office. In terms of

the clinical too I am supposed to take care of the cases that come here, I mean taking care of the sick. I do a lot here (PA 6).

In exploring the tasks of the PAs further, I discovered during my field research that in instances where there are Health Service Administrators (HSAs) in rural health facilities, the PAs are also very involved in the performance of the HSAs' duties. In interviews, study participants HSA 2, who is in charge at a Christian Health Association of Ghana (CHAG) facility, and HSA 4 had this to say concerning the main tasks they perform in their respective health facilities:

As a qualified health service administrator [HSA], I was transferred to this place to manage a managerial crisis. This facility has lots of challenges and with my expertise the authorities thought I can help manage affairs. Currently apart from the paper works I undertake here such as signing procurement for essential items to be purchased, it is my responsibility to ensure that this facility meets the needs of clients by making sure that human resource issues are addressed and that the facility has adequate staff to function properly. In short I will say that I handle all administrative duties here and report to the regional level (HSA 2).

After my training as a health administrator, I was posted to this CHAG facility to see to the day to day activities of this health centre. I make sure that everything is available for the smooth running of this health facility. This include making sure that we have adequate health personnel here. I do all the administrative work here and when I am not around, the PA takes over these duties (HSA 4).

Some of the duties described by PA6 (mentioned earlier), including making sure the appropriate human resources and logistics are available, also fall within the official roles of HSAs, as explained by HAS 2 and HAS 4 (from the narratives above). It should be noted here that HSAs are usually situated in district and regional health facilities, and are not always physically present in the rural areas where PAs work. This partly explains the emergent practice of allowing PAs to engage in high-level tasks that should be performed by HSAs. However, some non-government organisations operate under a different structure and require HSAs to perform their designated functions. For instance, facilities owned and run by CHAG have HSAs in most localities where they operate, who should be seen to be performing their duties, although CHAG also encourages some of delegation of responsibility to PAs. By way of clarification, CHAG facilities are present in places where there are also GHS facilities. Although managed by different health workers, together these health facilities are there to meet the health needs of vulnerable people and by doing so they complement the work of the Ghanaian Ministry of Health.

Community Health Officers (CHOs) are another cadre of health worker who are officially trained to carry out preventive measures in rural communities. They undertake outreach programs in schools in their sub-districts to teach about health care practices. Periodically, they hold meetings with community members to inform them about preventable diseases such as malaria and HIV/AIDS. They make home visits to pregnant and lactating mothers to advise them on the best health practices and the need to attend antenatal and postnatal care. They provide family planning services to clients in their respective health facilities and assist in running Child Welfare Clinics. Participants explained the tasks they perform:

> *I work as a CHO [Community Health Officer] and make sure that the child welfare clinics go on well in this community and the nearby communities. I go for outreach programs to give health education and give advice to people concerning their health issues. Over here we visit more than 30 schools for the health talk (CHO 6).*

> *I am supposed to provide assistance to the midwife during antenatal services, to conduct child welfare clinics, conduct defaulter tracing, I mean those who have defaulted from coming for their health care activities such as child welfare clinics and antenatal care. I also carry out daily routine home visits and community sensitisation to educate community members on health care practices and preventable diseases (CHO 4).*

Apart from the official or main tasks described by the different cadres of health personnel in the study area, they sometimes performed additional tasks to keep the facilities running when there were insufficient numbers of health workers. While their training is generally adequate for them to perform additional basic duties such as checking temperature and blood pressure of a patient, participants believed that sometimes they performed tasks that they were not trained to do. Prescribing medications to patients is one of the extra tasks performed by some health workers, who said they developed this skill through regular observations in their various health facilities and long service experience. It should be noted here that although these health professionals are aware of the possible implications of taking up tasks they have not officially been trained to do, they seem to be more concerned about saving the lives of patients by doing so, for at least it is better than doing nothing. When a General Registered Nurse (GRN 5) and an Eye Specialist (ES 1) in one of the CHAG facilities were asked during their interviews whether they engaged in tasks which they were not officially trained to perform, they answered confidently in the affirmative, but went on further to explain that despite the risks related to their additional workload, they needed to save the lives of people and as such it was important that they were involved in the performance of these tasks:

Yes we have to do that to keep the facility running. I'm an eye specialist and ideally I should be treating only eye cases but I do general consultations. I stay in this complex close to the facility so most of the nights they come to wake me up to attend to patients. Medically I treat, I can do seizure very well and I can do circumcision very well. I just observed from other health personnel and now l can do it well. I don't know how I obtain the skills to circumcise but I can do it very perfect. If I circumcise your child, you will like it. These are things we do here that we are not supposed to do but the specialists to do those tasks are not available. And at the end of the day, we do these tasks and somebody takes the credit because they don't know that there are people in the rural areas doing such tasks. We do these things and others sit in the cities and take the glory. Nobody will appreciate you for the good work you are doing (ES 1).

Oh yes I also engage in tasks which am not supposed to do because I have not been trained to do those tasks and I will say that I am not the only person who engages in other duties in this health facility. We all have to step out our boundaries to take up other roles to keep the facility going because we don't have enough health workers here. Sometimes I take up risky tasks like prescribing drugs to patients but I don't have to be doing that because am not trained in that (GRN 5).

The narrative above (ES 1) indicates the role of proximity in providing services in health facilities. As ES 1 clarified, health workers' proximity to these rural health centres serves as a compelling factor for them to engage in additional tasks to save the lives of patients. In rural areas, where road networks are bad and ambulance services unavailable, referral of patients to the regional hospital is very difficult, if not almost impossible, especially at night. The concerns of ES 1 point to the fact that authorities (their superiors) should be showing gratitude for the additional duties they perform in these rural health facilities, but it has been difficult for authorities at the district and regional level to thank health professionals for engaging in tasks that they were not officially assigned to perform. A Community Health Officer (CHO 1) and Health Record Officer (HRO 3) explain:

My tasks as a community health nurse are to go for outreach services, engage in child welfare clinics and visit people who are discharged from this health centre to check on their health to see if they are doing well. I sometimes do consultations but this is not part of my job because I have not been trained to do this. I always observe what goes on here and try to do something because you and I know that half a loaf is better than none so it's better we do something then not doing anything at all. On the other side it's dangerous because if I make a mistake of giving wrong drugs to a patient and she dies, I will be in serious trouble so am careful (CHO 1).

We all know that as a health record officer I don't have to give medications to patients because it can be dangerous if I make mistakes. I don't have official training in that but any time the medical assistant is prescribing drugs to people I observe him and now I can also prescribe. What I am trained to do in this

facility is to keep records well and take vital signs of patients when they report to this health centre for treatment but when the PA is not around, I try to also diagnose sicknesses of patients and give drugs because if I don't take care of them, there will be nobody to attend to them [HRO 3].

From the narratives above, it appears the health workers have no option but to engage in additional tasks because of the critical situations they find themselves in at their health facilities. Participants explained that their main concern when going beyond their abilities was to attend to patients and save lives, and as such the risks associated with their actions were normally ignored. They therefore deemed it necessary to assume the roles of their absent colleagues in addition to performing their official roles for the smooth running of these facilities. This was a common experience among all cadres of health workers in the study area. During interviews, participants explained how they take over their colleagues' roles in their absence:

I don't like pretending because GHS is aware that we nurses consult here but they say we shouldn't consult and they know that this health centre has only one medical assistant to attend to 100 to 200 patients a day. Can only the medical assistant do that? Of course no, so consultation, prescribing, wound dressing, seizure is sometimes carried out by people like me. I'm not supposed to refer patients but sometimes I do that. When I detain, I carry out my bedside nursing. Sometimes the midwife would call me to come and help. I'm a nurse so I'm not trained to consult but I can't leave people to die. The medical assistant is the administrator, the human resource manager and director here and how can only one person carry out all these tasks? Because I'm acting as the in-charge at the moment, I'm attending a program that is supposed to be attended by the PA if he was around. So in his absence, who do you think should consult? (GRN 3)

I am a community health officer and because there is only one midwife in this health centre, any time she is not around I add her job to mine. So I go for my outreach programs and also assist pregnant women to give birth and that is not easy because I am not a midwife but there is nothing I can do than to assist to save lives of people (CHO 4).

You know here we have only one disease control officer who has gone on leave. Because she is not around at the moment, I am doing her work. I have added her work, my work and if midwife is not around, I will be forced to conduct deliveries and do ANC [antenatal care]. The staff is not enough and we are dealing with human life so if the people report, you can't say you won't help. At least you should try and do something to save the lives of the people (CHO 2).

Apart from the additional clinical tasks health workers perform in their health facilities to reduce the impact of too few health personnel, participants complained of having to engage in non-clinical tasks which were far beyond their actual job descriptions. These non-clinical

tasks included but were not limited to the general cleaning of the health facility, filling in insurance claims forms and fetching water. Most participants described this as an ineffective approach to managing human resources and general hygiene, because getting health professionals who are expected to take care of the sick to engage in non-clinical duties increases their workload. Accordingly, participants explained:

> *As the head of the facility because I want work to go on, I have to do other things I am not supposed to do. Somethings when the taps are not flowing, I fetch water because nursing cannot go on without water and the boreholes are far from here. You will agree with me that this is poor management issues because how can a nurse who is supposed to take care of patients be doing things like this. We have complained to our superiors that we need a polytank [i.e. water storage] to store water so that when the taps are not flowing we can get water but nothing has been done about that and that is why working in rural area is difficult and frustrating. I have to sometimes fetch water from the borehole so that we can at least wash our hands and sometimes to sponge the babies with high temperatures (GRN 3).*

> *I will say that apart from engaging in consultations in this health centre which I am not trained to do, I also have to be involved in the cleaning of this place and sometimes complete the insurance claims forms. These duties make working in rural areas difficult. The cleaning is not good because there was a day when I was cleaning the floor and they brought a sick person here and because I was rushing to attend to her, I even forgot to wash my hands and that is risky (HA 1).*

The narratives above reveal the extent to which health workers engage in additional tasks in their respective health facilities. The statement made by GRN 3 *"You will agree with me that this is poor management issues"* highlights the importance of a well organised and operational health system as detailed in the WHO report (2010). Such a health system can provide quality health service to all people through well-maintained health facilities which include proper management of the available health workforce and provision of appropriate logistics. These factors are necessary to enable the health system to respond in a well-balanced manner to the needs and expectations of the population and to the smooth running of health facilities (WHO 2010). Apart from issues associated with human resource management, the provision of appropriate supplies is also important to enable health workers to carry out their tasks efficiently. Studies have established that the lack of adequate supplies and quality working conditions hinder healthcare workers in providing quality health care to their clients, subsequently affecting their morale and influencing their retention (Awases et al. 2004; Lehmann, Dieleman & Martineau 2008; Stilwell et al. 2003).

However, some health workers further explained that they willingly performed non-clinical duties as a way of motivating the workers officially assigned to perform these tasks, by making them happy and feel appreciated for the regular tasks they performed:

> *As for me the only reason I engage in cleaning this health facility is to encourage the cleaner to feel appreciated and loved which will make him happy. I sometimes take the container to the borehole to fetch water needed in this facility so we are all helping to keep the facility going (EN 4).*

Although it is encouraging for health workers to motivate non-clinical staff in the health facilities by helping them perform the tasks assigned to them as stated by EN 4, care must be taken by these health workers not to compromise the official clinical duties assigned to them, namely providing quality health care to the patients. Observably, this increased additional workload sometimes compromises the well-being of patients, such as when cleaning jobs are performed without proper sanitary procedures. Therefore, it is important to have workers' duties clearly defined within health facilities if quality health care is to be delivered. Delamaire and Lafortune (2010) stated that when managers fail to allocate tasks appropriately to health workers without adequate supervision to ensure that these tasks are carried out correctly, these health workers become ineffective in providing health care services, which subsequently affects the health status of patients.

In this section, I have explored the official tasks and additional workloads that are performed by different cadres of health workers in their respective health facilities. The findings suggest that, apart from the official tasks assigned to health workers in these primary health care facilities, they also performed additional tasks that included both clinical and non-clinical tasks to sustain the health facilities because there were too few workers. While some health workers considered the non-clinical tasks they performed were the consequence of inappropriate managerial operations, others identified them as a way of motivating the workers assigned to perform them. Although these health workers' training equipped them to undertake additional basic clinical duties such as taking patients' vital signs and keeping records, the tasks they sometimes performed went far beyond their job descriptions, including consultations and prescribing. Health workers were aware of the risks involved in prescribing medications to the sick without adequate training, but they found it necessary to do so to save the lives of patients and they considered this to be better than doing nothing. The next section explores in detail the perceptions of management regarding task-shifting.

4.3 Managers' Perceptions of Task-shifting

The preceding section provided some insight into the official and additional tasks health workers perform in their health facilities. In this section, the views of individuals involved in the management of health workers at local, district and regional levels are reported. In the Upper East region of Ghana, health managers at the regional level attend to human resource issues in the health sector. At the district level, there are district directors of health services who also manage health workers, and within each health facility, the heads of facilities, the *in-charges*, are involved in managing the health workers. At the local level, the *in-charges* report to the district directors who in turn report to the regional unit when necessary. Collectively these managers work together in managing the health workers, thereby seeing to the effective running of the health care facilities. Hence it is important to explore the perceptions of these health managers on task-shifting.

The in-depth interviews with health managers at the local, district and regional levels revealed the extent of task-shifting practice within health facilities and among different categories of health workers. According to these managers, task-shifting has become a common practice in rural health facilities because of acute shortages in a critical mix of health workers, such as physicians and nurses, who perform clinical duties. Further discussions with these health managers revealed some benefits of this emergent practice of delegating additional tasks to health workers. Shifting tasks and roles lowers the costs involved in providing health workers with additional training when compared with the traditional approach of training workers, and it also enables health professionals to identify their areas of expertise for future career progression. Key Persons 2 and 3 involved in the management of health workers explained:

> *The task-shifting is a difficult situation but we sometimes have to improvise to keep the system running. We try to give these health workers necessary capacity boost before additional tasks are handed to them especially in consultations but I am not ruling out the possibility for untrained ones to be engaging in consultations and other tasks due to inadequate skilled personnel in some of these rural communities. But you know that the additional training though could be less expensive compared to training let say a nurse for 3 years, it still involves money and therefore the need for financial commitment from the government. Sometimes too when staff take up additional tasks, it helps us to identify their special areas of interest to support them develop their careers in future. We are trying as much as we can to improve the situation (Key Person 2).*

> *In fact nobody can deny that these health workers in the rural areas are not performing additional tasks. We all know about this but there is very little we the managers can do considering the critical shortage of health workers in these rural communities. For instance I know that a health aide is not supposed to prescribe medicine to patients because they are not trained to do so but they do give prescriptions because we don't have enough of these people trained to that in all the health facilities and the sick people also need to be taken care of. So the task-shifting is what we rely on to keep these facilities going so we try to encourage the health workers to take up additional roles. It's not easy but I know things will get better later (Key Person 3).*

The narrative above (Key Person 2) shows the challenges faced by health facilities in rural areas affected by human resources shortage. The phrase "*we sometimes have to improvise to keep the system running"* highlights the alternative means employed by managers to manage health facilities through task-shifting. The WHO (2006) described task-shifting as a practice whereby alternative health professionals or lay persons are trained to perform tasks that are usually considered to be within the scope of the medical profession. From the WHO description, the element of training is essential in task-shifting practice. Therefore, allowing health workers to take up additional tasks when they have not been trained to do so, as noted by Key Person 3, "*the task-shifting is what we rely on to keep these facilities going so we try to encourage the health workers to take up additional roles"*, calls into question the type of policies put in place to manage health facilities and whether health workers and managers adhere to these policies. As noted above, although task-shifting enables health personnel in rural areas to identify their areas of expertise for future career development in ways that the traditional means of training cannot usually achieve, the possible risks associated with untrained health workers attending to the sick must also be considered, together with the ethical issues. The health managers did not seem to consider these issues of risks and ethics, because of the critical situations they found themselves. Another Key Person involved in the management of human resources explained the situation as follows:

> *What can we the managers do then to motivate and encourage the health workers to go extra mile of doing more work. They have to engage in additional duties since that's the only way out now to sustain the health centres. Shifting different tasks to different workers is important because for instance most of the health facilities have only physician assistants to give consultations and one midwife to assist in delivery and so in their absence, what happens? Definitely any health worker available will have to deliver the baby whether trained or not so we encourage and motivate them to help each other. Our superiors in regional capital are also aware of the situation but nobody is doing anything about it (Key Person 4).*

From the narrations so far it is obvious that formulation, implementation, assessment and consequences of policies for the management of human resources for health are complex issues and enmeshed in politics. This is critical to the kinds of tasks, duties and expectations that the health mangers expressed (in the quotations above). Arguing from a practical standpoint, there are many factors affecting successful implementation or failure of task-shifting practice, whether this is done to supplement the work of other health workers or to accomplish a task in the absence of a worker. It depends on the type of policies that are in place, and the ways political thinking and the medical understanding of healthcare and service provision interact to produce conditions that make health workers receptive to the idea of doing what they are not officially trained to do.

These concerns are not just about meeting the needs of the population that the workers are employed to serve. They also have a political purpose, by ensuring that the consequences do not work against the political and administrative establishment that manages the health sector (Navarro & Shi 2001). As already noted in the literature review, it is the theoretical understanding that, where rational actions are taken by workers, the aim is to maximise positive result-oriented consequences and alleviate negative consequences (Navarro 2008; Navarro & Shi 2001). Using Goldmann's (2005) logic of appropriateness to examine, for example, permitting health workers who are not trained to engage in duties that require official clinical training, the effective management of and reduction in bureaucratic regulation in the maximisation of intended outcomes are heavily mediated by standardised work ethics that do not make task-shifting a platform for obscuring policies aimed at more efficiently managing the work of health professionals.

As a result of many political and administrative factors, the nature and level of involvement of junior health workers in rural areas in the formulation, implementation and appraisal of policies is limited. As detailed in the subsequent chapters (5 and 6) of this thesis, while the level of involvement is partly determined by what is at stake, they hardly feel a sense of ownership in the procedures. As such, policies are not always developed with thought given to their advantages (or disadvantages) for the individual progression of health care personnel. This argument further begs the question: would the participation of junior health workers in policy making lead to the maximisation of positive outcomes? Depending on the players involved and the location of operation, the answer would also depend on how receptive health workers were to policies that guide their jobs, and how sensitive the policies were to

health workers' career and personal development. Key Person 4 (stated above) explained the kind of sensitivity that is needed in connection with motivation and the unconcerned attitude of authorities when he said "*Definitely any health worker available will have to deliver the baby whether trained or not so we encourage and motivate them to help each other. Our superiors in regional capital are also aware of the situation but nobody is doing anything about it"*

When understood within the context of health worker retention in rural areas, workers must feel they are appreciated, even if they tend to do more work than they are paid for. But again, the health managers' narratives show that the health workers' successes depended mainly on level of interaction they had with human resources, who regulate what they are officially hired to do and the performance of additional tasks. This comes back to the question of whether well-defined policy-oriented bureaucratic standards allow room for flexibility. Based on my observations during the field work, flexibility is needed within the largely ineffective bureaucratic and administrative standards. In Ghana, more generally, views about work and ethics have attracted various interpretations, with these views being an outcome of age, gender, education and location. As such, the in-depth interviews I conducted with health workers in this rural region yielded much information on the local health-related realities, including the experiences and challenges faced by health workers in local facilities of the Upper East region of Ghana.

In summarising this section, health managers recognised task-shifting as essential in running health care facilities. They perceived this emergent practice as enabling health workers to identify their skills for future career progression. Because the main concern of health managers was to sustain health facilities in rural areas, little attention was paid to untrained health workers performing official clinical tasks, thereby neglecting the ethical issues connected to quality healthcare delivery. Health managers perceived the costs of implementing task-shifting by up-skilling health workers were cheaper than the traditional mode of training health workers from scratch. Because of lack of finances and commitment from authorities (those at the top of the hierarchy), local managers were usually unable to offer adequate training to health workers before additional tasks are handed to them. The next section explores the perceptions and experiences of health workers regarding task-shifting practice.

4.4 Health Workers' Perceptions of Task-shifting

From what has been described so far, it is essential to discuss the perspectives of health care workers on, and their experiences of, task-shifting given this has become a common practice in health care facilities in rural areas in the study area. In extracts above, some of the official and additional tasks performed by health personnel in health facilities were described, but what should be noted here is that perceptions about work are shaped by peer influences, which implies that the whole team has an impact on individual health workers:

> *As a Physician Assistant I do administrative work too such as appraising staffs. Apart from that we sit down to know the needs of the facility so that as a leader I can delegate for them to purchase certain things as you heard me telling somebody to get syringes and needles from medical stores. I don't have an administrator here so am a jack of all. I do disease surveillance at the sub-district level and report to the regional office. I also go for home visits to find out the challenges of the community members so that we can help to give them better services. As in-charge it is not my duty to do these things but I do them to keep the facility running. I have no specific roles because my services are demanded all the time. I cannot rest because I also attend to emergency services day and night but what is helping is that we work as a team so I sometimes delegate some of the tasks and make sure they are carried out properly by other staff. We help each other (PA 3).*

> *In these rural areas we work together as one people to help each other because the workload is too much and we don't have enough health workers here to assist. I am enrolled nurse but I sometimes conduct deliveries and even fetch water and clean this facility so we work together (EN 4).*

The narratives of PA 3 and EN 4 above highlight the need for staff to assist each other to accomplish tasks and they reveal the essence of teamwork in managing facilities. Discussions with health workers revealed a similar trend to promote teamwork. By seeking to work together to support each other to make sure that the work goes on, tasks are accomplished and expectations are met. Emphatically, it is teamwork that sustains the practice of task-shifting in these local facilities. A Community Health Officer (CHO 4) and a Physician Assistant (PA 2) explained further.

> *I am a community health nurse but I engage in almost every activity here even filling of insurance claims form and sweeping the compound. That lady [making reference to the worker that interrupted our interview session] came to call me now because there is a labour case. The woman is full [as in being in labour] so I have to go and assist the midwife to do the delivery. In case the midwife was not around I am supposed to conduct the delivery. That is not part of my work but if she is not around, I have to do it. I have no option then to conduct the delivery. I have started writing a report which I have to finish and these forms on my table are insurance claims forms. My in-charge asked me to fill the*

forms so that the facility can claim the money from the insurance people. Apart from all these things, one of my routine tasks is to visit communities for outreach services and you know it is not easy because our roads are very bad especially during this time of heavy rains. Sometimes when the in-charge is very busy in the consulting room, I go there to assist. The Ghana Health Service also has routine programs such as polio immunisation and child health promotion programs which I have to take part in. As you can see, this is too much work for me but because we don't have enough staff here, we have to support ourselves and work as a team so that we can save the lives of patients (CHO 4).

As an in-charge of this health facility, you know that there is nothing I can do to keep the facility running than to talk to the workers to take up additional tasks. When I am around, it's not a problem because I can supervise them but the problem is when I am not here and the work also needs to go on. We have only one midwife in this health centre, if she is not around and I am not also here, the community health nurse is called to conduct deliveries especially when they report with head in vagina but honestly speaking a community health nurse is not supposed to conduct delivery alone without a midwife. The only thing I can say is that, we are managing to save lives (PA 2).

Undoubtedly, CHO 4 acknowledges that the workload of a Community Health Officer in the rural facility where she finds herself is enormous, but she is not the only one who faces this challenge in rural areas. Most health personnel described similar experiences regardless of what they were trained to do and their positions in the health centre. The emphasis is on helping and supporting colleagues to ensure patients are taken care of. This occurs because of the relationship existing between colleagues and their clients, and between them and the wider society. In a social context and in workers' perceptions, what promotes or hampers progress on who get what and how is partly determined by the peer assistance a worker receives (de Souza 2013). Theoretically speaking, this kind of thinking can be explained by rational choice scholars, detailed in the previous two chapters of this thesis. For them, it is about creating a workforce whereby a worker will be able to find answers to the subjective questions of 'What works for whom, in what circumstance and in what respects and how?' (Ogrinc & Batalden 2009; Pawson & Tilley 1997). The perceptions of each worker are like an 'open system;' a system that acknowledges that one's connection to the other is prone to being affected by controlled and uncontrolled factors. Therefore, one cannot assume being a part of a team that does not have its ups and downs. Work in itself is not a constant state of being and doing. It changes over time, it is subjected to self-regulated and other-regulated cycles of interactive opinions and common reciprocal practices.

As the quoted statements of PA 2 and CHO 4 (above) indicate, apart from working in administration and disease surveillance within their sub-districts, their workload is extensive

and as such it has an impact on their perceptions (on the negativity and positivity) about task-shifting. As explained by Otara (2011), the experiences of workers have great influence on their individual perceptions, which further impact on their reflexive responses to their situations and the amount of energy they put into accomplishing their duties or tasks in their workplaces. Therefore, based on their individual experiences, the different cadres of health workers I interviewed had varied perceptions concerning their additional workload. As will be seen in the subsequent paragraphs, health workers had both positive and negative perspectives on task-shifting practice.

Regarding the positive aspects of task-shifting, many participants said they were happy and satisfied performing additional tasks in their health facilities. This feeling of happiness from engaging in more tasks than officially required stems from the benefits they intended to gain from task-shifting. The feeling of self-worth on the part of these health workers and their dedication to do more work is not just about the problems they encounter in working in rural areas, but the opportunities they gain for developing their skills and capacity for the future. By working in remote areas with fewer officials, they consider themselves to be knowledgeable and multipurpose health professionals. This, according to some participants, places them in a position to be efficient wherever they may find themselves.

> *I feel good helping my colleagues. Ghana Health Service encourages teamwork so it's good to help. Sometimes I go round to supervise what other people are doing when the in-charge is not around. This is not part of my usual work but when am on call, I do it. I see it as an opportunity to learn new skills. I don't know where I will find myself tomorrow (EN 1).*

> *I think they build you up. Though the workload might be too much and we are trained to do specific things, when you involve yourself in other tasks that you are not trained to do, you learn new skills and you will be able to help clients to survive since we do not have enough staff here. I am talking about the consultation and dressing of wounds because I am not trained to carry out those activities in this facility. If somebody gets an accident and is brought here you cannot say there is nobody here so you will not attend to the person. At least you have to do something to keep the person alive (Midwife 2).*

Some of the *in-charges* also regarded additional tasks as a demonstration of good leadership. According to them, their ability to do more work by taking up additional tasks said a lot about their level of leadership. Further, by encouraging health workers in their facilities to do more work showed their leadership skills, which subsequently put them in good position to be promoted. In part, this could also be because these *in-charges* are to a large extent responsible for managing their facilities and reporting progress to the regional directorate.

Because they could be called to answer queries regarding issues that arise in their facilities, they normally adopt their best attitude and are determined to go the extra mile irrespective of their age just to sustain the health facilities. While the motivation of older staff in taking up more tasks was linked to their desire to leave behind a good legacy, younger staff were focused on attaining higher levels in their career development, as explained by these Physician Assistants (PA 1 and PA 4) below:

> *I feel it's my responsibility to do additional tasks because as a leader you don't have to sit down to be served but you rather serve so I don't see it as a bother. Once am alive I always ask for strength from the Lord which he would always give to keep me going. As a leader if you go strictly by your job description it doesn't make you a good leader. You know you have to intervene in other areas so that together you can build up the place so that others can have confidence in you so that when you retire, people will still remember the good work you did (PA 4).*

> *When you are put in a managerial position, it means that a lot is expected from you and so as the in-charge of a health facility, there is the need to do more to help your facility grow and by so doing, people would see you as a good leader who is willing to sacrifice for the people. I can also receive promotion when I work hard and through that develop my career fast (PA 1).*

Additionally, health professionals in the study area believed patients' high expectations encouraged them to take on more tasks to meet the needs and desires of patients who visited their facilities. Patients' expectations also stemmed from their inability to recognise differences between various categories of health worker. In some rural communities, patients found it difficult to distinguish between the workers in the facilities. This belief was tested during field work, and when called upon to distinguish between different categories of health personnel, most patients made mistakes. Thus, it is difficult for patients to distinguish a doctor from a nurse, so they have the perception that nurses can do the job of doctors or physicians. Patients indicate the level of their expectations when they address these health workers as 'Doctor'. As far as patients are concerned, these health workers should be able to manage all cases in the rural facility. Health workers stated that patients sometimes became angry and refused referrals, which in some cases worsened their health conditions and led to death. Therefore, in attempting to meet clients' expectations, health workers are sometimes forced into handling additional tasks that they are not trained to do.

> *The people here don't know that there are different nurses for different tasks. They know a nurse is a nurse so you should be able to deliver to make them happy. Sometimes they refer to nurses as doctors*

so if you are exposed to many tasks it helps you to meet the expectations of patients which will make you happy (Midwife 4).

There are antenatal mothers who come and routinely we need to monitor their HB [haemoglobin] and other things so we refer them to Bolga regional hospital for scan and lab investigations. Others don't go and their conditions worsen and sometimes it caused death because they would tell you they have no money for transport. That is why means of transport is very important. If there is transport available I can gather them and take a number say 5,6 or 10 for their HBs to be checked but there is no transport so we do what we can and allow God to take care of the rest (GRN 3).

Other reasons cited for patients' high expectations of health workers (discussed extensively in Chapter 5) include lack of money to pay for transport to regional hospitals and for treatment, and the difficulties involved in accessing roads to regional hospitals because of the bad roads in rural areas.

Conversely, most health workers defined the additional tasks they undertake as stressful and tiresome. They complained that they are overworked to the point where they cannot periodically take a break from work for relaxation or to go on leave, amid the fact that they are working in sub-sectors they are not skilled in.

We are just overworking ourselves here. Yesterday I left here after 5pm and reported here very early this morning. I am hungry but there is nowhere you can go and take lunch or eat. And you can't even go because the people have lined up out there waiting to be attended to. The year has almost ended and I have not taken my leave. I have to sacrifice for other staff to go on leave. If I don't get my leave officially, I have to be a skeleton staff (on and off work) so I can get some time to rest. If I pick an official leave it means I have to stay away and if I apply for my leave now, it will run into next year which is not allowed so you can imagine what I am going through here (GRN 2).

In fact it is very tiresome, one is always overstretched but you can't do anything than to manage. Do you know that last night around 11:00pm I had two stressful labour cases? They were serious cases. Just when I was trying to figure out what to do to save the lives of these women, I was told there was an OPD case that needed immediate attention and this patient started shouting at me as if I was sitting down doing nothing. Meanwhile it is not my duty to handle that case. Tell me how one person can handle two different emergencies at the same time. This is too much work because you don't even have time to take care of yourself but you know we have to always manage to push things through (Midwife 3).

In the narratives above, there are examples of health workers engaging in extra tasks beyond their abilities to save lives and sustain health facilities. The words "*overworking and overstretched"* were used by participants to describe the difficult situations they find

themselves in. Although they are encouraged to do more to keep the facilities running, described by midwife 3 as *"we have to always manage to push things through"*, their own health could be affected by work overload. This has been established in studies which highlighted that levels of ill health related to psychological issues are higher in health care workers than other workers, and the most common work-related factors linked to this ill-health were demands from work, including workload, long hours and pressure from work (Harvey et al. 2017; Michie & Williams 2003; Wall et al. 1997). As seen in the quotes above, participants sometimes refused to eat because there were too many patients to attend to in the facilities, which could affect staff's nutritional status and subsequently their general well-being. Various African studies have revealed that stress resulting from heavy workloads and inadequate work supplies leads to job dissatisfaction in workers (Lehmann, Dieleman & Martineau 2008; Stilwell et al. 2004; Vujicic et al. 2004).

Another issue is that some participants regarded task-shifting practice as risky. According to them, the prescribing of certain medications to patients by health workers who have not been trained to do so could lead to complications and subsequent death. During interviews an enrolled nurse (EN 3), community health nurse (CHO 4) and Health Aide (HA) explained:

> *I am an enrolled nurse and am not supposed to prescribe certain antibiotics to patients but when the MA [medical assistant] is not around I have to prescribe these drugs to save lives. I must say this is risky because I have not been given any training and so if I make a mistake of giving wrong drugs, it can lead to complications and even death and I will face the law court (EN 3).*
>
> *Our superiors cannot say that they are not aware that people like us are performing certain tasks we are not trained to do. It can be dangerous and complicate issues (CHO 4).*
>
> *I must say that is not easy working in a rural area because you work too much. Though I have worked in this health centre for a long time, I am not supposed to prescribe medicine to patients and conduct delivery alone but I sometimes do that. The other day I made a mistake and gave wrong medicine to a patient which nearly killed him so it's serious. Our superiors need to train us to do the right thing since we are dealing with human lives (HA 5).*

Participants' narratives show their frustration in having to perform tasks they have not been officially trained to do. Despite the benefits of task-shifting, they were concerned about making mistakes when performing these tasks and further worsening patients' health. While health workers' willingness to do more work is needed to sustain health centres, as advocated by health managers, the statement of HA 5 that, "*the other day I made a mistake and gave*

wrong medicine to a patient which nearly killed him so it's serious" reveals the importance of adequate training and supervision from these managers in the implementation of task-shifting.

Apart from health workers regarding additional tasks as risky, stressful and tiresome, the frustrations associated with performing them could be due, in part, to the absence of incentives to motivate these health personnel. According to some of them, they are not given additional money to compensate their efforts. Participants explained the situation as follows:

> *In fact, it does not matter the number of additional tasks you perform, your salary is the same. They don't give us anything for doing more work which is not good because our colleagues in the cities run shifts so they can take up additional jobs to make more money but we cannot because this community is even too far from the city and we are on call 24 hours. At least they should give us some incentives to motivate us a little but there is nothing like that so you do more work but you do not receive anything apart from your salary which our colleagues in the cities also receive (Midwife 4).*
>
> *It's a mixed feeling. Sometimes I feel privileged handling new tasks and sometimes too I feel stressed up because the workload is too much and no matter what you do your salary is the same. I close from work late and cannot even cook food to eat and I have to carry clinic work home to do but my salary remains same. It's not easy. We need more staff to help us (GRN 3).*
>
> *The only thing I can say is that, the workload is too much for me here. I am the administrator, accountant, and consultant and I also supervise the other staff so you can imagine what I am going through. There is no motivation for doing all these tasks but I am managing (PA 4).*

The narratives above indicate that health workers expect to receive incentives for the additional work they do in their health facilities, such as increments in their salaries. They expressed concerns about receiving the same salary even though they do more than they have been assigned officially to do in their respective facilities. This practice of receiving less for more work done could lead to demotivation and subsequently affect the job satisfaction of health workers. In Chapter 2 of this thesis, factors that affect workers job satisfaction were examined, with the negative impact of job dissatisfaction ranging from decreased productivity, grievances, increased accidents in the workplace, intra-organisational conflict and employee turnover (Deriba et al. 2017; Tzeng 2002).

Most of the in-charges at health facilities admitted that the additional tasks undertaken by staff members overburdened them, but they managed to convince health workers by

encouraging them to be hopeful, because there would be periods when they would not have to do much work. Accordingly, managers in charge of health facilities explained:

> *What I see is that some of the staff think they are overburdened even me but what I use to console them is that, there would be instances where the workload would go down and during that time we could all have enough rest but that never happens because this is a busy place and so we have to sacrifice to keep the facility running. As the in-charge of the facility, I make sure that I regulate the times people go on leave so two nurses cannot both take their leave at the same time (PA 6).*

> *In fact to tell you the truth, the health workers in this facility are mostly stressed up with work because there is always too much to do here and the workers are not enough so they work more so that all the patients who report here can be taken care of. It's not easy but I always encourage them to work hard (PA 1).*

Emphatically, and contrary to the pessimism of PA 6 (above), another health worker expressed optimism when she said:

> *I see it to be normal because we have to manage to run the facility because you are not doing it because your superiors want you to do those tasks but you are doing them because health workers to carry out those activities are not available but it's very hectic because it at times takes you off your main duties. I am not supposed to officially prescribe but I sometimes do that because if you refer them to the next level, it's always a problem because they need to cater for extra cost such as money for transport and other cost in the regional hospital. They sometimes refuse the referral and worsen their conditions or lose their lives. So you will agree with me that there is the need to 'manage things' here (EN 3).*

The phrase "manage things" (also dubbed "managing") is a common phrase in Ghana. It means coping within extraordinary options with little or no innovative alternatives. Many health professionals in rural communities would use the word very often and with a small laugh to emphasise the sometimes-difficult situation beyond the control of the individual worker. The word "managing" runs through most narratives of the health workers and managers because they believe that whatever services they are rendering in those health facilities are better than none. As far as the health workers are concerned, they need to do something to save patients' lives. While some health workers feel happy and self-fulfilled in engaging in additional tasks, most of them feel it is stressful and as such they need to be motivated through the provision of incentive packages, signifying the need for a functional health system and government support towards the implementation of task-shifting.

As highlighted by Lehmann et al. (2009), the organisation, structure and resourcing of health systems are important issues that need serious consideration in the implementation of task-shifting. This is in accordance with Pawson and Tilley's framework approach, explained in the methodology section of this thesis. Drawing from the concepts of realist evaluation, the context and mechanism of a program are essential in determining its outcome. The mechanism, which is the process through which interventions are implemented, is very important because issues such as the target audience reaction and provision of adequate resources and capabilities determine whether a program will work. Therefore, mechanisms regarding the practice of task delegation, such as health workers' responses, adequate resources available for their training or the provision of incentives to compensate them for taking up additional tasks is crucial. This was explained by Key person 4 during the interview as follows:

> *I believe if we have available accommodation and even the staffs are allowed to pay the cost, it would be good. The community cannot get for our staff members the type of buildings that can make them comfortable because of the economic status of the community members. It not easy because sometimes when you go out and see where people who are providing health care are living, the condition under which they are putting up is very sad and appalling. As a manager you have to encourage the person but the question you ask yourself is assuming that gentleman [referring to a health worker] is your brother or son and that lady your wife or sister how would you take that. So it is not easy at all! But we are trusting God for something better [it was observed during fieldwork that there is a connection between the way the worker feels at work and his/her religious belief]. The human element in service provision is very important (Key Person 4).*

The situation described by Key Person 4, where health workers in rural communities who are performing more tasks than expected do not have access to suitable accommodation, is not encouraging and could affect the outcome of the intervention. However, to help address this challenge, the regional director is making efforts to seek financial assistance from the government and private partners. Key Person 5 explained the efforts underway in handling this:

> *The ministry in collaboration with a private financier have approached us with a proposal entitled Build, Operate and Transfer (BOT). They would build, operate and transfer the buildings to us [for the health worker] later. Our new regional director has also started engaging other financial institutions and our suppliers from whom we purchase the drugs, I mean the pharmaceutical companies, to also assist because if you give us drugs and there are no human beings to administer the drugs, it can't be*

feasible. Apart from accommodation, they have been asked to donate towards career development of the health workers (Key Person 5).

The findings in this section have provided insight into health workers' perceptions on task-shifting practice in the rural areas of the Upper East region of Ghana. These narratives have reflected workers' diverse views on task-shifting. Health workers are engaged in additional tasks sometimes beyond what they were trained to do because of inadequate numbers of personnel in health facilities. They regarded task-shifting practice as a means of working as a team to save the lives of clients, thereby sustaining these rural health facilities. They were encouraged to perform additional tasks and to acquire different skills to be multipurpose, which subsequently put them in position to be able to work in bigger health facilities. As explained by the health managers, this enabled the health workers to identify their areas of expertise for future career development. However, despite the benefits of task-shifting explained by participants, they also had negative experiences and perceptions which included work overload, stress and health complications of patients. The discussion in the next section draws together the key issues in relation to the findings of this chapter.

4.5 Discussion

As can be seen from the narratives of participants, it is evident that task-shifting has been the mainstay in rural health facilities in the Upper East region of Ghana, where health workers are called upon to 'manage' to the best of their abilities and against all odds. In Chapter 2 of this thesis, the nature, benefits, challenges and issues associated with the implementation of task-shifting were discussed from pertinent literature. The discussion at this point is centred on findings from the field work in relation to other relevant studies, highlighting the key issues.

Delegating tasks from one cadre of health staff to another, formerly referred to as substitution (Dovlo 2004), has gained international consideration in recent years. Over the decades, many countries used task-shifting as a mechanism to respond to an emergency, provide adequate health care at primary and secondary levels especially in understaffed rural facilities, enhance healthcare quality and reduce costs (Samb et al. 2007). The concept of task-shifting using nurses is emerging as a possible way of tackling recent physician shortages in low- and middle-income countries, especially in rural areas (Gyamfi et al. 2017; Kinney et al. 2010). This is evident in Ghana where Physician Assistants (PAs) have been used for many years to diagnose and treat different forms of sickness ranging from deadly diseases to common colds

(McPake & Mensah 2008). Currently, as the health workers' narratives reflect, task-shifting is actively practised in rural areas by physician assistants and nurses. However, there have been various arguments about its practicality, effectiveness and mode of operation since it was supported by the 2006 World Health Report.

The findings of the study show the importance of understanding the practicality and challenges in task-shifting. Across the health centres where field work was carried out, task-shifting was a common practice among all cadres of staff although the extent of implementation varied from one health centre to another. It could lead to improvements in access to healthcare because of the teamwork approach employed by health workers and the sense of urgency they attached to supporting each other in taking care of clients. Teamwork is crucial for the successful implementation of task-shifting, and supportive teamwork and supervision among health workers have been widely acknowledged as improving the quality of health care across the spectrum of health services (Bärnighausen & Bloom 2009; Lehmann 2008; Lewin et al. 2007; Nemcek & Sabatier 2003; Swider 2002). It is also encouraging that health personnel are willing to engage in additional tasks to save patients' lives. Recent studies indicate that great urgency has been attached to task-shifting to improve healthcare access because of general health worker shortages (Lehmann et al. 2009; Lewin et al. 2012). The World Health Report (2006) also advocates for the need to delegate tasks systematically to less specialised cadres of health workers to improve access to health care.

Health personnel are able to build their expertise by engaging in new tasks, but health managers explained that task-shifting also lowers costs in training professional health workers compared with traditional delivery methods of training. There is truth in this statement. In Ghana, apart from community health officers (CHOs), it takes more than two years to train a health worker, whereas a few months of training could be given to health workers during task-shifting practice. This is consistent with studies conducted by Dovlo (2004), where it was highlighted that, *"these substitutes usually receive shorter pre-service training"*. However, training must be adequate and proper supervision is needed.

Adequate training should be given to health workers before additional tasks are handed to them because the lives of human beings are involved. Health workers clearly stated that they engage in tasks for which they are not trained, and they expressed concerns about the risks associated with such activities, including health complications and in the worst situation, death. They are motivated to do more save the lives of people in these rural communities, but

issues of medical ethics that protect people's health need to be considered. If one of these health workers prescribed the wrong medication to patients in attempting to deliver healthcare, even though it might not be fatal it could lead to other health conditions which needed to be investigated and attended to accordingly. While inadequate numbers of health workers in rural areas lead to serious accessibility problems (Salafsky, Glasser & Ha 2005) and comparatively high mortality rates (Adzei & Atinga 2012; Buykx et al. 2010a; Chen et al. 2004), use of unqualified health personnel has also led to greater morbidity and poorer health outcomes for patients (Sun et al. 2013; WHO 2006a).

The negative consequences of engaging in additional tasks can be minimised through proper supervision. For instance, community health officers who are not officially trained to conduct deliveries should not be allowed to perform that task without supervision from a qualified midwife. However, the low number of health workers has hindered proper supervision. Baker et al. (2007) have suggested that this could be achieved if some health workers were trained and released from some of their existing tasks to enable them to supervise additional tasks performed by other staff members. This would not only lead to quality health care delivery but could lessen the workload of health workers who have taken up additional tasks.

Adequate training and supervision are key in the implementation of task-shifting, to build staff competence and ensure that quality healthcare is not compromised (WHO 2006b, 2007; WHO & PEPFAR 2008). However, these were observed as generally lacking in the study area. Adequate training was not usually provided before additional tasks were assigned to staff members who, as and when they were confronted with issues, were called upon to manage to the best of their capabilities. Although this is in accordance with their expectations of learning on the job, not only could the situation lead to compromised healthcare but also create discontent and de-motivation for some health personnel who feel exploited rather than having the opportunity to learn.

Additionally, it was observed that in some cases the additional assigned tasks overburden staff and cause stress that could also lead to low motivation and defeat the purpose of the intervention. Research has established that too much stress from increased workload on the part of health workers could lead to low motivation (Dieleman et al. 2011). Perhaps one of the most common means of addressing the problem of low motivation, as suggested by the health workers, is the use of incentives, commonly grouped as financial and non-financial incentives. Many options are available to policy makers beyond the provision of financial

incentives. Studies have found that non-financial incentives, when implemented appropriately, are able to attract and keep health workers in rural and remote areas (Bennett & Franco 2000; Martineau 2003).

Managers in the study area believed that ensuring adequate training for health staff before allocating additional tasks to them requires commitment beyond the provision of finances from the appropriate authorities. This is supported by findings from other studies which suggest that, for successful implementation of task-shifting, the organisation, structure and health services should be given the necessary consideration to enable the formulation of a suitable monitoring outline for training and building management capability (Baker et al. 2007; Lehmann et al. 2009; WHO 2007). However, this is not to say that additional tasks should not be accompanied with incentive packages to motivate staff members, because money is what puts food on the table. Findings from other studies suggest the need to provide appropriate incentive packages for additional tasks performed by health personnel as a form of compensation for task-shifting practice (Baker et al. 2007; Lehmann et al. 2009; Pereira, Caetano 2010). However, not all work rendered can be paid for, especially where workers love doing the tasks and where they are not expecting recognition or compensation for taking up additional tasks. The issue of motivating health workers through incentives is explored in Chapter 5 of this thesis.

4.6 Conclusion

In this chapter, I have explored the extent of task-shifting implementation in rural health facilities in the Upper East region of Ghana. This includes health workers' experiences regarding the diverse official and additional tasks they perform in their respective health facilities, their preparation and preparedness before additional tasks are allocated, and their general perceptions regarding task-shifting practice. Health managers' perceptions on task-shifting were varied, seeing it as a means for health workers to build skills and expertise through to its role in sustaining rural health facilities. Findings have revealed that health workers generally engage in tasks they have officially been trained to do although they sometimes take up additional tasks because of lack of staff in health facilities.

Health workers and managers have different perceptions about task-shifting. Health workers in the study area perceived task-shifting was part of working as a team to sustain the health facilities. The practice led to health workers acquiring additional skills and becoming

multiskilled, thereby enabling them to take on greater responsibilities in bigger health facilities. Findings suggest that, although beneficial, task-shifting presents challenges including lack of training before tasks are assigned, lack of supervision, inappropriate task allocation, lack of motivation, risk of harm and health worker burnout.

CHAPTER 5
INCENTIVE PACKAGES: ISSUES, NEEDS, COMPETING PERSPECTIVES AND THEIR IMPACT ON RETENTION OF HEALTH WORKERS

5.1 Introduction

In the preceding chapter, the process of implementation of task-shifting among the different cadres of health workers within the health facilities was examined. The success of task-shifting depends to some extent on whether health workers are given adequate training and supervision and are motivated to take up additional workload. Motivation includes the provision of appropriate incentive packages to compensate health workers who take up additional tasks.

In this chapter, I present findings on incentive packages put in place to motivate and retain health workers in rural health facilities. Contextual factors that affect the implementation of incentive packages are considered, the competing perspectives of health workers and managers on incentives are explored and finally, incentive packages that could serve as a source of motivation for the retention of health workers in Ghana's Upper East Region are suggested.

5.2 Contextual Factors Influencing Implementation of Incentives

When workers are made aware and are encouraged to be part of policy processes relating to work incentives it becomes easier to regulate not just their work but also their commitment to what they do. In practice, there is consensus among practitioners across health sector policy institutions in Ghana that providing incentives for work is a key variable in assessing both performance and productivity, which is an outcome of motivation. It should be noted, however, that incentives are just one way of gauging the performance of workers. Critics of the use of incentives (attending to those who are critical of the way the Ghanaian health sector is regulated) have argued that because it is affixed in the binary of power relations, it may not account for latent indicators of performance with indirect impact on non-controlled push/pull factors, including, among others, workers' health status and intellectual capacity. The paying of incentives to workers who are working, say, in remote locations can also be interpreted as a control mechanism. In the end, while workers may see the financial/non-

financial incentives at their disposal, they are powerless to challenge policies, developed and regulated by those in authority who determine pay and conditions.

Incentives can work in both directions. They can promote efficiency or inefficiency, and with inefficiency comes the problems of bribery, embezzlement and abuse of power. Hence, we must ask: what can be done to militate against incentives becoming a tool for institutional oppression and, with this, the subjugation into subservience of ordinary workers, whose ideas, however small, have a role to play in the strengthening of human resource governance in the health sector? Several scholars have called for transparency and accountability in the regulation of incentives (Franco, Bennett & Kanfer 2002; Henderson & Tulloch 2008; Hongoro & Normand 2006; Munga & Mbilinyi 2008), but their recommended panacea is problematic because it cannot draw a link between the political and interpersonal factors that determine the allocation of incentives. It is against this backdrop that I present a conceptual framework that I hope will act as a template for the measurement of the conditions that require the push and pull factors that promote either an increase or a decrease in the use of incentives, and their associated political impact. This framework, which I constructed from the thematic analysis (incorporating the realist evaluation framework) of the factors that affect health worker retention, highlights the issue of 'context.' Though this framework has been presented in chapter 3, there is the need to retain it in this chapter to address the core issues explained in this chapter.

Contextualisation of incentive allocation creates the enabling environment for understanding the existing structures and other elements that shape the incentives (financial or non-financial) workers receive. These elements include political systems, workers' economic and social status, technological innovation and administrative efficiency, the demographic profile of the client population and the diseases prevalent in their communities, global processes that regulate government policies on incentives, and gender issues in human resource/health sector policy development and budgetary considerations.

Collectively, these factors are essential to understanding the impact of incentives on workers' productivity and motivation. In the framework, incentive packages that underscore the proclivity to work or not to work are identified, along with advancement and management skills that, each worker is expected to demonstrate. The broad factors discussed above operate directly or indirectly to determine the outcome of policy interventions on whether health workers remain in rural areas or not. This is shown in Figure 5.1 below.

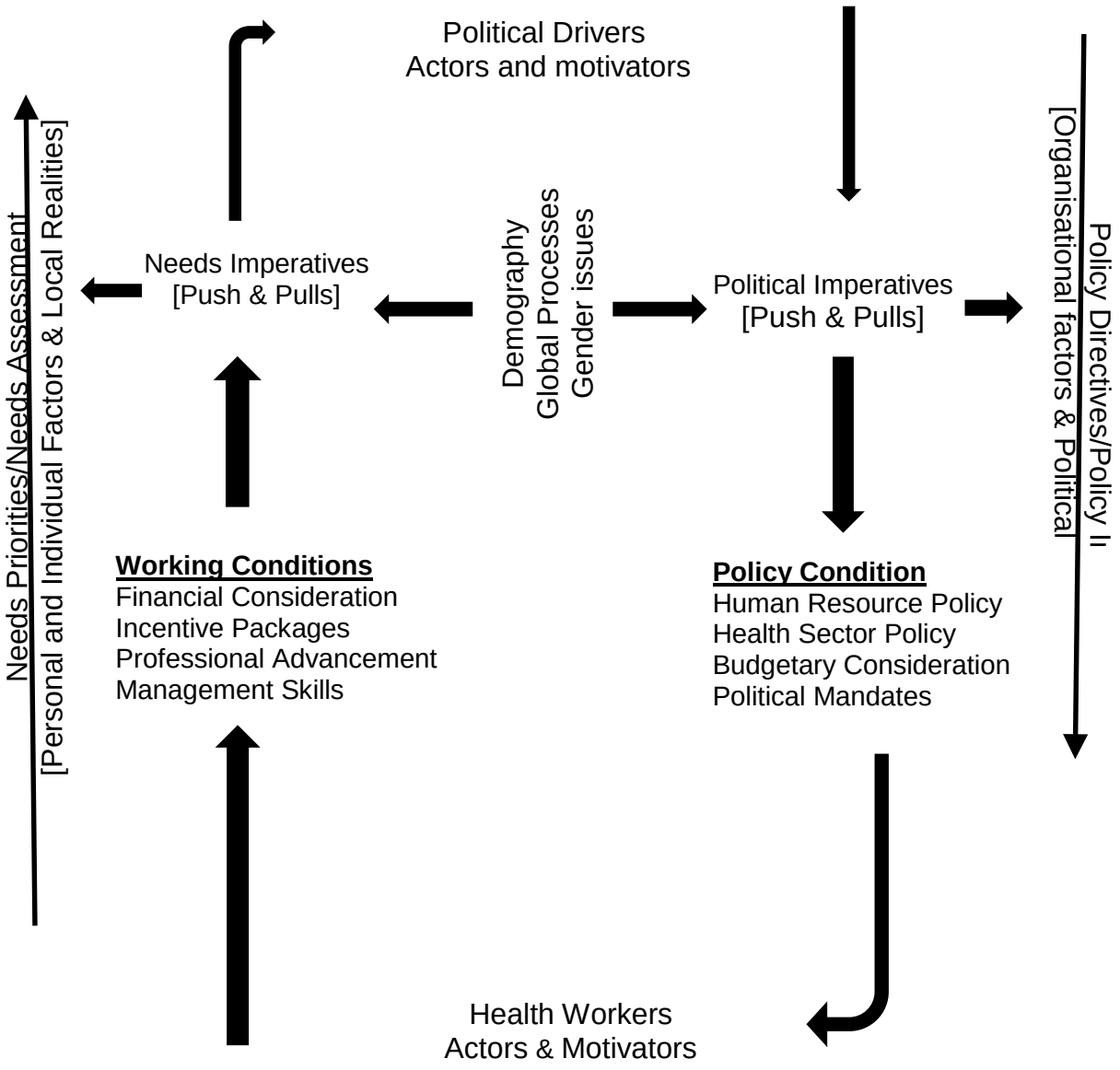

Figure 5-1: Conceptual framework of factors affecting rural health worker retention

In this template are shown factors that play a key role in the determining whether incentives, as a mechanism for the retention of workers, will work or not. It is not retention strategies *per se* that work, but factors such as those relating to (1) measurement of health workers' reactions to the incentives, (2) availability (or unavailability) of adequate resources, and (3) the ability of finance and human resource departments to sustain incentives over the long term.

Despite the evidence of an existing problem, adduced from what we have said so far, there exists a limited corpus of research output (attending especially to Ghana and neighbouring countries) on workers' perceptions of their incentive packages, on one hand, and the multiplicity of bureaucratic channels that must be followed in the regulation of these incentives, on the other. These channels include those relating to national and international policies and micro-/macro-level procedures at the implementation phase.

Emphatically, therefore, in Upper East of Ghana these issues are key drivers of the patterns of, and impact on, recruitment of health workers. In addition, it is helpful for both researchers and practitioners to understand push and pull factors, and the successes and failures of the public health sector at the local level within the country as a whole. During field work, the trust I was able to build with the interlocutors (which followed Flinders University's ethics committee's guideline) led them (the interlocutors) to speak openly about the good and bad, workable and unworkable, ethical and unethical practices in relation to incentives, and what they believed must be done to militate against the negative impact (seen and unseen).

One negative factor is the issue of administrative bureaucracy in the management of incentives. In most cases, remote communities are not spared the hassles associated with government bureaucracy. These are poor communities, and the use of computers and the internet is very limited and sometimes non-existent. Instead, there is reliance on paper-based filing systems, which in turn presents another challenge. This is the chronic problem of unreliable data on the number of workers who should receive incentives, which itself highlights bureaucratic bottlenecks resulting from the lack of information technology in rural communities. Bad practices were identified, including the common 'Ghost Worker' phenomenon whereby non-existent workers not officially deployed on sites are shown on pay-rolls to receive salaries, and corruption including the misappropriation of workers' financial incentives.

There are also positive outcomes in the use of incentives. From my observations, I was able to identify that these positive gains are directly related to the roles that incentives play in the motivation of workers and the promotion of their welfare and that of their dependent family members. In relation to the latter point, incentives have enabled workers to create a good balance between family and work, and between the idea of medical humanitarian work (not forgetting that their unpaid/voluntary work is humanitarian) and the socialised community

engagement with their families and acquaintances, which also leads to feelings of satisfaction in these remote communities.

These disclosures (and observed opinion) are intriguing. As a result, there is the need to study workers' understanding of incentives. What insights can be gained from theories, and how do these correspond with what workers believe happens in practice? How can both theories and practice be used to understand performance indicators associated with the use of incentives? These matters are also informed by political questions of concern to the overall management of the health sector. In these, the focus is drawn to the intended political gains (or losses) that come with the implementation of incentive policies in regions with dissimilar economic situations. Of course, this should not be taken to mean that the use of incentives in all remote regions, especially in the Upper East region where I conducted field work, was encouraged only where they were given in exchange for political returns.

Against this backdrop, in this chapter, I will discuss these issues in relation to the key findings. The data from the field indicated, first, there are various incentive packages put in place to motivate health workers to accept postings outside the national and regional capital cities and especially in the least-developed communities within the Upper East region of Ghana. Second, the level of awareness of incentives packages varied among health workers in health facilities. Third, there are various challenges associated with the implementation of incentive packages, and finally, health workers do not regard certain incentives as attractive enough to retain them in rural areas. In this chapter, discourse narratives are used to address these. To better grasp the relevance of these field data, the discussion will be shaped around three themes:

- Incentive packages put in place to motivate health workers, and their awareness of the existence of these incentives,
- Competing perspectives between health workers and managers on incentive packages,
- Suggested additional drivers that could motivate health workers to stay in rural areas.

Readers are advised that while efforts were made to examine these issues independently, the overlapping of participants' discourse narratives made it difficult for these issues to be

completely separated. As such, there are instances where a direct quotation may reflect worker's thoughts that should fall under the next issues. To this end, while this study explores the various incentive packages that have been given to participants and the extent to which beneficiaries (health workers) have regarded this effort as "incentive", content analysis was used to explain these interconnected issues comprehensively.

5.3 Incentive packages put in place to motivate health workers, and their awareness of the existence of these incentives

Despite the constraints, my interlocutors (health workers) consider themselves the rightful agents of their destinies. Therefore, their narratives on incentive packages tell of their frustrations, aspirations and possibilities in working towards ownership of their lived experiences within these facilities. One of the many ways they use to appreciate their present circumstances in relation to incentives for work is through an understanding of what incentives are, as opposed to what they are accustomed to. Awareness about incentives can come from peer-to-peer education or the directives of the administrators. Whether it happens through individual probing or administrative means (to promote transparency), these workers have come to appreciate the role that awareness plays in their motivation to perform their formal and informal duties. Administrators are not oblivious of the fact that transparency in the distribution of incentives plays a key role in promoting workers' motivation. To this end, during field research I witnessed workers' sensitisation meetings (organised to create awareness of present and existing issues within the health facilities). Observably, most of the rural facilities owned by the GHS and the CHAG that I visited during fieldwork were engaged in awareness-raising programs, including frequent use of *brown-bag* sessions (casual meetings that usually took place during break times) to inform workers of opportunities and resolve their grievances.

Despite the intense engagement with their workforce, health workers in GHS and CHAG facilities have competing understanding about their incentive entitlements. This is not to say that measures being put in place to capture trends, raise awareness about processes, and capture both short- and long-term impact of incentives have not been successful. They have had success at least in maintaining the workforce in rural areas. However, despite these interventions, my findings reveal variation in the level of awareness at the individual level. Interestingly, even amongst those who are knowledgeable about incentives, their way of making sense of their impact is complex. These complexities should be understood in relation

to the gender, family size and level of education of individual workers, their positions within the hierarchy in facilities, and the location of the facility itself, whether it is in a rural, peri-urban or urban area. Added to these, there is a time factor, because some workers' understanding of incentives is based on time, that is, the number of years they must work before they are qualified to receive certain incentives. For instance, in interviews some participants disclosed that they were aware that after a few years of work, they were entitled to 'leave-with-pay' incentive packages to enable them to undertake further tertiary studies:

> *The incentive package I am aware of is that in the city, you have to work for 5 years before you would be permitted to go for further studies but when you are working in the village, they say you can go to school after you have worked for 4 years. This means that after the 4 years I can go on study leave with pay. I know there are other incentives which I am not aware of (CHO 1).*

> *I understand that the standard years of work to qualify for study leave is 4 years but at the rural level is 3 years so if they [the authorities] are able to go by that we would be very happy. This is the only incentive I know. In fact if after 3 years I am not permitted to go to school, I will be demoralised. It would affect everything including my work. I am saying this because I have heard that sometimes even when your time is due for study leave the directors do not allow you to go (EN 2).*

> *You know when you work, you are given a number of years to go to school but as at now they have not informed us of the number of years we need to work before we can go for study leave and without study leave you cannot leave this place. Some people say is 5 years and others say 4 years. I only pray and hope that by 4 years' time they would release me to go to school (DCO 4).*

Most discussions showed a similar pattern of narrative, both about the time factor and a general uneven lack of awareness about details of their incentive entitlements. There were power differences between those at the top of the hierarchy and their subordinates. Most discussions showed that health workers were generally unaware of the details of incentives they were generally entitled to. As noted by EN 2 and DCO 4, at certain times, the distribution of the incentive packages is virtually left to the decision of authorities to approve or not. Although these narratives on power expose the inherent complexities, the quotes above show that participants are aware of sponsorship for further studies. More education can increase professionalism and raise workers' awareness of many other unexploited incentive packages available to them. However, the inability of some to state the exact term of service needed to qualify for study leave (which would have been stated in their employment conditions of service/terms of reference in their appointment letters) or, better still, to

remember other incentive packages promised to health workers also exposes the unevenness of workers' knowledge about their benefits.

On one hand, the lack of information and workers' unwillingness to ask questions about incentives are contributory factors in these shortcomings. They also reveal issues that are largely ignored in the scholarly scientific study of health workers' retention. Firstly, they expose the role that workers themselves play in the creation of problems associated with the uncertainties of their work and future development. For the sake of argument, in the event of the termination of a known incentive package, the worker would be left with two options: to accept that there are no extra benefits forthcoming and keep working at the normal salary (which will affect motivation and performance) or to resign and seek another job opportunity which may or may not offer job security and better incentives.

Other workers who are aware of incentives may feel they are not benefiting to the full extent of what is rightfully theirs to enjoy. A health worker in-charge at one facility explained the situation:

> *The incentives were some of my expectations and motivation for accepting postings here; I have heard there is something called rural allowance which I have not benefited from. At least you are entitled to accommodation and a lot of things. I have accommodation here but is in a bad state that's why am staying in town. These are the things we know are attached to the conditions of work at the rural areas. I have also heard that there are rural incentives that would be attached to my salary. At least something to top-up my salary. I heard this from the news and labour experts who do talk about them. I have interest in labour issues so I do listen to these issues and search for information to read. This region we have heard that there is retention package for some rural workers such as fuel for work so we as medical assistants [also referred to as physician assistants] try to see if they could provide retention package for us but they don't. Even fuel for work is a problem. I personally fuel the motorbike for work. Sometimes I talk to my director if he could allow the facility to once a while fuel my motorbike but because the health insurance people don't pay this facility on time we are all hard up. We hope that one day things would be good and the facility could pay our fuel for us. I have worked in this facility for more than 4 years but I have never received any of the incentives I am talking about. If authorities can provide us with these packages we would be motivated (PA 2).*

As the saying goes, 'knowledge (and one's place in society) is power'. A closer look at this worker's explanation reveals key words, which he used to give us an understanding of what he believes should be used to determine the reach of these incentives. The use of phrases such as '*never heard*', '*search for information*', '*never received*' and the statement: "*If authorities can provide us with these packages we would be motivated*" (PA 2, emphasis added in

italics), backed by the time factor, gives a clearer picture of the reach of incentives and their impact on workers in the remote villages of the Upper East region of Ghana. Thus, providing incentives to health workers is one thing, but ensuring their reach and adequacy is another. The explanation given by PA 2, above, indicates that although he is aware of existing retention incentive packages which are part of his conditions of work, such as rural allowance, salary top-up and fuel for work, he has not benefited from them despite having worked in the community for more than four years. Although he was offered the incentive of accommodation close to the facility, he was unable to use it because it was not in a good state of repair. Instead, he rented accommodation in the city and transports himself each day to the facility. This shows that having incentives in place is not enough; they must also meet the needs of recipients if they are to serve the intended purpose. As PA 2 explained, his motivation for accepting employment in a rural area was linked to the availability of incentives and so he expected to benefit from them. Nonetheless, his satisfaction level regarding what he received was important because extrinsic factors such as incentives and management abilities have been identified as affecting job satisfaction of workers (Martin & Schinke 1998).

Those who have benefited, as CHO 3 states below, are of the view that what they have received is not adequate, and this inadequacy affects the individual motivation and performance of workers:

> *The only Ghana Health Service incentive I know is the one gallon of fuel given to us and the 20 cedis but one gallon of fuel cannot do any work. I use my personal motorbike for the home visits which should not be so and no fuel. one gallon of fuel is just 4.5 litres which is not enough for even a whole week's work. My in-charge [head of facility] said she knows that the fuel is not enough but there is nothing she can do about it (CHO 3).*

Additionally, and by way of enhancing the discussion further, it can be argued that the number of years workers spend (on study leave) gaining the necessary qualifications demonstrates a connection between post-study motivation and the burden that a worker's level of awareness imposes upon the incentive packages. Put another way, if Worker X sees Worker Y benefiting from study leave incentives, then Worker X would enquire about the source, aspire to, or actually use it. The return to the workforce of both workers may then lead others to enquire, this recycling of information may lead to competition and increased performance which in turn will lead to an increase in awareness about incentives packages. In

time, the greater awareness will create a burden of expectation about the allocated packages, and the additional problem of managing the increased workload created as a result. There would be an increase in number of applications to be evaluated and grants administered annually, and the problem of recruiting staff on short- or long-term secondments to perform the duties of those granted study leave.

Staff who are not granted study leave because no replacements are available may be given a 10% increment on their salaries as an incentive to motivate them to remain working for an additional year or two while suitable replacements are sought. However, as they pointed out during interviews (when asked for clarification about the impact of not getting approval for further studies), individual preferences and discretion of the authorities would sometimes come into play. A General Registered Nurse (GRN 3) and a Physician Assistant (PA 4) had this to say:

> *Apart from the 10% increment in salary I have not heard of any other incentives for health workers in rural areas (GRN 3).*

> *What I know is that health workers in other facilities have 10% of their salaries given to them as incentives but we don't receive such incentive here in this facility and I don't know why. But I will say that if I am given a car as a personal motivation I will be happy to stay here and work for a longer time and also if this facility can be pulled down and new one built, it would be good because this place is too small to accommodate all the units so additional structures should be added (PA 4).*

Apart from the 10% pay incentive to stay on, midwives also receive an additional 10% for every baby delivered and a new work uniform is provided every six months as an encouragement. As ambassadors in their communities, these incentives make midwives willing participants in the public education of pregnant women in their neighbourhoods, telling them about the danger of self-care and the need to attend the facility for delivery, thus reducing the incidence of maternal and neonatal deaths and morbidity. As expected, at least from the viewpoint of a public health researcher, not all are satisfied with this extra 10%. There are periodic work assessments where their performance is assessed (fair, good and best) and prizes awarded through ethical benchmarks, although in some cases non-awardees feel they are not treated fairly. One midwife noted that:

> *At first they use to give us 10% of our deliveries and the district where I was previously working, they use to give us uniform every 6 months, that's Bongo district. I think the district paid for it, about 6-12 yards for each worker. Over here we have something called quarterly midwife review where they*

assess our work performance and give us a prize. So last time they gave me a token for being first [given the best award]. I was given 40 Ghana cedis just last month. It is a form of motivation but it's not enough because spending your whole life in the village where you are prone to reptiles [easily be bitten by snake], 40 cedis cannot be an enough motivation. We don't know how they come out with their incentive packages but at least if that money can get to hundreds, it would be very good. I mean 100 Ghana cedis or more would be a very good motivation. We don't pay for accommodation but we pay for light and water bills here. So during the review last week we told our superiors that if we have to pay for our light and water bills then there is no need staying in the village to work because it is the same with our colleagues in the city. I have accommodation in the city too because I don't come from this village and so my family cannot come and stay with me here. I might not be married but I have kids who need to grow in a good environment (Midwife 2).

While Midwife 2 has benefits including accommodation, a midwife in a different health facility said she has no free accommodation. She explained as follows:

Since I entered Ghana Health Service [GHS], I have not had anything called incentive but I heard there is an incentive for the midwives but not for us here. I pay for my accommodation and utilities. I have worked in this facility for almost 5 years (Midwife 3).

Some health workers explained that they receive allowances, such as a risk allowance to compensate workers who ride motorbikes within the communities. Participants from a CHAG facility explained about some of the incentive packages put in place to motivate them:

Yes I have heard of it [incentives]. They say if you are in the rural areas, 2 to 3 years, you should be able to go to school. They will give risk allowances since you are riding on motorbikes to the communities and rural allowance. Because this is a CHAG facility, they give us rural allowance but this does not come from the government. It is so small, about 30 cedis. They calculate 5% of your basic salary. This also depends on how much money the hospital generates and if the hospital gets more money from the people managing the insurance. It is something small to buy phone credit [recharge card] (GRN 2).

I used to work in a Ghana Health Service facility before coming here and there are no incentives but for CHAG [Christian Health Association of Ghana] facility we have some monthly little allowance that we benefit from but not enough. It is supposed to be monthly but other units in the hospital give that money every 3 months instead of every month. That allowance is supposed to be 7½% of your salary but they don't give that. They give me 20 cedis a month as an incentive which is peanuts and not all the staff receive this money. If you are here and given a car you will be happy but now we are handicapped because some of our colleagues in the cities, we cannot catch up with them. They are upgrading themselves very fast (CHO 4).

From what we have seen so far, and as is currently the case for many countries in sub-Sharan Africa, there is a difference between having a policy and implementing it. While the issues of policy development and implementation are addressed in a different section of this thesis, it is encouraging to note that some health workers have benefited from incentives, though it took them more years than expected before they qualified for study leave. In addition, PA 3 mentioned workshops and study leave as incentives she has benefited from and which served as a source of motivation for her, although she thinks they are not sufficient motivation because staff in the cities also benefit from similar incentives. She said:

> *For now the only motivation is being invited for a workshop which those working in towns and cities also receive. Recently we had this conference and the facility sponsored me to go for the conference. Sometimes they give you study leave so that at least you would be taking your salary as a form of motivation. This is a good incentive. When I had an admission to do my Physician Assistant course at Kintampo College of Health school, I was sponsored by the GHS [Ghana Health Service]. They paid for my fees and I was on study leave. But do you know that I went for further studies after I had worked for 13 years in rural communities. Just think about it and tell me if it's a good thing (PA 3).*

Policies that offer similar incentives for health workers working in different settings (for example, urban and rural communities) need attention. This is because conditions in each area are different. As PA 3 stated above, even though she recognises study leave and attendance at workshops are incentives for rural health workers, the fact that health workers in towns and cities also enjoy such incentives reduces their attractiveness and ability to serve the intended purpose. However, she did not mention the number of years health workers in cities are supposed to serve before being granted study leave. Sharing similar views with PA 3, a Disease Control Officer (DCO 2) stated that he benefited by accessing loans from banks in Ghana because he is a health worker. However, none of my rural participants made mention of the fact that health workers in cities are also entitled to loans, and as such the loans are not motivating enough:

> *I will say one of the incentives is the ability to go for loans as a health worker from various banks in the countries. Last year I went for a loan which really helped me a lot but I cannot say this is a good incentive because if you are a health worker working in a facility in the city or town, you can go for loan at any time and they [city health workers] even get the loans quick and it is the same interest rate we both pay. The bankers would not say because I am working in a rural community, I will pay less interest on the loan (DCO 2).*

In this research, an emphasis is placed on the role of 'location', among others, in shaping the push and pull factors affecting the retention of health workers. In the main, closeness to the seat of power of the health sector decision-making bodies, namely Parliament that legislates health policies and the Ministry of Health that formulates and implements these policies, is a major determinant of what incentives workers can access, when and under what conditions. This is what the Disease Control Officer sought to convey when he stated that those in the city have access to loans.

Inevitably, the loan entitlements issue that emerged during interviews requires a critical follow-up question—one that we must not lose sight of when trying to understand the dynamics in the movement of workers from rural to urban settings. We must ask 'Why give preferential treatment to city health workers, who, when compared with their peers in the remote villages in the Upper East region, are better off? Some see this as the creation of a façade that is intended to paint a picture of a well-resourced and effective health sector to the international community; the donor community whose core staff are also stationed in the bigger cities. In the view of at least some of the research participants, it is designed to create the impression that what they are seeing in the cities is a representation of what is happening in rural areas. However, a few participants also observed that the focus on city health workers could be a subtle move by some holding top positions in government to give the impression to the WHO that the government is meeting its obligations toward promoting the welfare (financial and otherwise) of all health workers. In reality, it is mostly those in key hospitals in the national capital who are entitled to sureties from their workplaces that enable them to secure loans from private and public finance institutions.

In this section, I have discussed the awareness levels of health workers about existing incentive packages for motivation. Generally, health workers were not aware of all incentive packages they were entitled to despite efforts by health mangers to create awareness on such issues in health facilities. Apart from these efforts, health workers sought information on their incentives entitlements through the media or friends, and while some workers have benefitted from them, others have not. Most of the health workers did not regard the incentives as attractive enough because their colleagues in the cities also benefited from similar incentive packages. In the next section, differences between health workers' and managers' perspectives on incentive packages and implementation issues will be explored.

5.4 Competing perspectives between health workers and managers on incentive packages

The strengthening of the health sector remains a core priority for the Ghanaian government, as part of its international obligations under WHO policies for African countries. To achieve this, since the 1970s it has been working in partnership with regional governments and international health promotion partners to place Ghana at the forefront of combating communicable and non-communicable tropical diseases, promoting family and reproductive health, health equity and healthy environment, health systems development, and health security and management (GDHS 2008; Ghana Health Service 2010, 2011). From the non-participatory observations of the researcher, the development of these benchmarks, with praise for associated successes or criticism for failures, should be contextualised. In particular is the lack of involvement of ordinary workers, right from development phases through to the parliamentary deliberations that gives these benchmarks political legitimacy, even though these workers are beneficiaries of these health developments. In this regard (and a view shared by WHO [2014]), the competing perspectives of health workers and management on incentive packages and the administrative issues associated with their implementation should be understood against three factors: a) Types of policies on public health governance, including those that seek to integrate perspectives on how to treat urban and rural health workers (which is the issue raised by the Disease Control Officer, quoted above); b) social and economic indices of concern to community and public health services; and c) indices of health status of the population.

Focusing on these issues, theoretical aspects of the discipline also tend to ignore one key variable, the relationship between ordinary health workers and management. Predominantly, when mention is made of this relationship in the literature, the focus is on whether their co-operation was necessary for the prevention of illnesses or whether tension between them resulted in the transformation of illnesses into biosocial phenomenon. Consequently, in the case of Ghana, little has been done by public health researchers to understand the impact of competing perspectives of workers and management on incentive packages and their regulation, nor the effects of such differences on the phenomenon of health worker retention, which determines the success or failure of public health policies of the government (and the international community including WHO) in Ghana.

In this section of the thesis, I ask: are there competing perspectives between these actors in relation to the management of incentive packages and on administrative issues concerning the management of implementation? Of course, the argument that there are such differences is not unique to the case of Ghana, nor is it new. But what makes the case of the Upper East region of Ghana unique is the question of how to determine who should receive incentives, when and in what manner. In the previous chapter, it was clear that the shortage of workers meant the line between workers and management was blurred, with many staff performing both clinical and administrative duties.

In theory, it is expected that management should be concerned with planning, implementation and evaluation of policies, and where it is called for, recommend change (Webb & Gulson 2013). They are/should be charged with responsibility for administering public health services and in the regulation of health systems, in line with acceptable international technological standards. Use of technology must conform to agreements on trade-related aspects of intellectual property rights, a matter of concern in aid-dependent countries such as Ghana. Management are also expected to be concerned with ensuring that appropriate professional standards are maintained. This calls for in-depth anthropological research and visits to facilities to meet with workers and patients and ensure their views are incorporated into policies. Ordinary workers, conversely, are expected to be at the centre of policy implementation.

The focus of discussions often becomes the gap between what ordinary workers want out of incentives (whether sufficient or not) and what management is willing to offer. More often than not, both policy intervention and outcome will lead to situations whereby areas in which there should be co-operation between groups become instead areas for competition. Conversely, where there should be competition, there are instances where compromises (sometimes with win–win or win–lose outcomes) have occurred. In the end, whether the parties can resolve their differences or not, it is patients who are affected, despite being oblivious to what takes place in the administrative corridors. In the main, workers I spoke to during field work see incentives as favours, implying that the authorities decide whether to give incentives to workers. One participant explained the situation as follows:

> *I learnt that if you are in the rural area, your motivation is to go to school earlier than your colleagues in the cities but it's now the opposite because I have been here for almost 5 years but I have not had the chance to go to school but my colleagues in the regions have gotten the chance to go. I went to the region*

to inform them about my intention to go to school but was told I was not qualified for a study leave. I told them I had my appointment in 2011 and I was qualified for study leave. When they checked and realised that I was qualified, they told me that, my seniors and my bosses are there and I want to fly so they didn't allow me to go to school. There should be rural incentive from the district. They sometimes give me money as incentive but our superiors decide how much to give and when to give the money so I sometimes get 20, 30, 40, or 60 Ghana cedis monthly (GRN 2).

The views expressed by GRN 2 in the quotation above tells of a consciousness of power that is symmetrical. In the Marxist–Hegelian sense, for power and its associated consciousness to produce a positive impact on the lives of the less powerful (in this case, GRN 2) the actions and reactions of the powerful (the manager who told her not to try to by-pass her bosses) should produce a win–win outcome. This did not happen, because GRN 2 was left disgruntled even after receiving some additional cedis (money) as an incentive. Put another way, the 'powerful' management officer had used a position of authority to get GRN 2 to do what she would resist, if left to her own volition, by insisting on her rights to get what was officially hers to exploit for her educational advancement. This would give her the kind of power that has been used to suppress her wishes. Against this backdrop, it would have been asymmetrical had she been in the position of power to influence the outcome of her discussions with her boss towards her favour. As Lukes put it, when writing about the use of power (and power-induced words) to maximise control over others, it is the ultimate exercise of power to secure the obedience of others by directing their opinions and wants (Lukes 2004). For once, GRN 2 felt her thoughts were being re-engineered to maximise the outcomes that her boss wanted, and not what she (the owner of her thought—which speaks about her right to education—desired).

Indeed, throughout our discussions, GRN 2, like many of her peers, kept on talking about the autocratic way in which incentives are being used as tools of dominance. She acknowledges the fact that the procedural use of 'power to' (get the work done, even if that would mean an increase in the pressure of work) would serve as the basis for increased performance. However, the manner in which she was spoken to meant that her views and her being were irrelevant when it came to matters concerning the regulation of incentive packages—i.e. who gets what, how and when.

Proponents of both rational choice and Maslow's needs-based theories believe tendencies of progress should be central to the regulatory processes that institutional hierarchies call for. However, the assertion by GRN 2 shows that progress was compromised when her managers

did not accept her right to be a beneficiary of incentives. This led her to conclude that she was a victim of the abusive tendencies of her bosses. Thus, the nature of resistance displayed by those on higher rungs of management hierarchies may be considered as 'abuse' by their subordinates, and this is one factor that has worked against health workers' motivation. It has led to instances of abuse of power, which instils a sense of worthlessness in ordinary workers. When pressed for more information on why she felt as she did, GRN 2 reiterated that when incentives were not managed to achieve indicative performance benchmarks, they become a part of the problem. In such a situation, those who want to maximise their corrupt tendencies would make sure the intended impact of incentives is unachievable. One way of doing this is to rely on power narratives that speak of workers' subservience to the will of their bosses and not the ethical narratives that encourage bosses to become servant-masters. Another participant, CHO 4, explained the situation:

> *This is a CHAG [Christian Health Association of Ghana] facility and there is something they call 7½, which they give to health workers as an incentive. Last year I received an amount of about 80 cedis. This year when my colleagues went for their money and I followed up for mine, I was told that my in-charge [head of the facility] had cancelled my name and so I wasn't given the money. I know it is due to a little problem I had with him which concerns this headgear [head cover] I always use to cover my head. I am a Moslem and my religion mandates me to cover my head so I put this on anytime and even Ghana Health Service permits us now to use it. My in-charge went straight to the director and reported me so the director called us and told him that it's allowed provided I wear my uniform and perform my duties at work. Even after the meeting with the director, my in-charge still took my name out of the list because of that problem I had with him and because he is the master and I am the servant there is nothing I can do about that but I thank God he has been transferred from this health facility and not here anymore (CHO 4).*

From a researcher's point of view, the subjective ways in which health workers have interpreted their statuses in relation to discourses of 'power-over' (a form of arbitrary control) and 'power-to' (a form of control that produces humane outcomes) in their understanding of the personal and impersonal aspects of incentives is more nuanced. Firstly, it is about the use of 'rights'. They believe their right to their needs should not be sacrificed because of the wants of bosses (the rich and powerful), and this view is consistent with Maslow's needs-based theory, Secondly, workers believe any use of administrative or political power by their superiors should be directed towards resolution of their grievances. If these grievances are not resolved, the power should be used for the re-conceptualisation of policies to create a balance between the political drivers behind the development of incentives and the administrative

intentions for their implementation, including (non)financial and substantive policies. If such a balance exists, it dramatically increases the probability that the fundamentals of inequalities affecting human resource management in the health sector will be mitigated.

Apart from the difficulties encountered by health workers in accessing incentive packages such as furthering their education, sometimes they must also contend with lack of adequate tools needed for their work, even though the availability of these tools is an incentive that would serve as a source of motivation for them. This was stated by a Psychiatric Nurse (PN 1) in one of the health facilities. He explained:

> *As a psychiatric community nurse, I sometimes have to visit my patients in the community and I need a strong motorbike and fuel to do that. That would help me a lot. At least it would motivate me more to do my work but I don't have a motorbike though my in-charge told me I should be given one for my work. I sometimes have to walk to some of these nearby communities and there is nothing I can do (PN 1).*

The words of this participant (PN 1), as he talks about deprivation as a demotivation factor, reveal two other issues. First, there is a general lack of operational materials and, second, incentives and work-related tools may only be available to those at the top of the hierarchy. Relating this to Freud's psychoanalysis (Frued 2005), we see that ordinary health workers are constantly in a struggle to avoid 'pain' (in this example, associated with the lack of a motorbike and the need to walk between communities) and augment the 'pleasures' (in his words, "*that [which] would help [him] a lot*") that come from both the financial and material aspects of their work.

Other participants also talked about the wider historical context of the nexus between deprivation and power. On one hand, one party (the health worker) wants changes that would bring a degree of ethical consideration into the management of incentives. On the other hand, the other party (management, or at least most of those in authority) wants to maintain the status quo. The question of who will win is a separate issue that is beyond the scope of this thesis, but it is the impact of workers' perceptions about incentives that is important here. This impact may vary in response to the emergence of administrative tensions between the two parties, those with power and those who want it. It can be argued that workers' perceptions explain the rise of irrational forces in the human resource portfolio of the health sector in Upper East region of Ghana. Such irrationality appeals to what can best be described, in the Freudian sense (Freud 2005), as unconscious, uncontrolled, and ultimately

destructive perceptual forces that have led to the eventual poor state of health workers' performance in the region. Workers wanted to devise a method for the development, implementation and distribution of incentives that would bring 'unconscious' managers under the control of the rational consciousness of ordinary workers. This is not to say that the administrative actions of the managers/in-charges are based on irrational, albeit unconscious, motives, but health workers' narratives showed they believe that the ways their views and needs have been positioned was about power. By power, they are talking about that which was used consciously to put them in a position of disadvantage where their views could be taken for granted. Other health workers explained the situation:

> *In fact what is happening in our health facilities is not fair at all but there is nothing we the health workers can do about it because those making the decisions up there are our bosses and so they are using the power they have against us. I am saying this because if there are incentives to motivate me as a health worker, why do I have to come and beg for what I am supposed to enjoy and even sometimes after asking for what I believe is mine, they will not still give it to me. This is not good but nobody is doing anything about it so I want to move to the city* (GRN 4).

> *I am a midwife and have worked in this rural area for more than 4 years. Next year will be my 6th year working here but if you ask me what I have achieved all these years, I cannot mention even one. When I was coming here, I heard that there are incentives they will give us to encourage us work hard in this rural place but our superiors [management members] don't give these things to us and some of us are afraid to even ask. Just last year I went to regional office to tell my boss that it was time I go for further studies but my boss got angry because he said we don't have enough midwives here. I left the office angry because I think our bosses don't think about our future. They are using their positions to frustrate us. Sometimes they should also try and consider our views a little because we are also human beings. They cannot just sit on top there and control us anyhow because they are our superiors and have been given the power to control us. Our bosses are just playing on our minds and we will continue to fight for what belong to us so that we can also give our best to the community members* (Midwife 5).

The narratives from GRN 4 and Midwife 5 demonstrate the tensions existing in their health facilities. Although these views are subjective they are common among the workers. The 'human personality'—which has stood the test of uncertainties in the health milieu of Upper East region of Ghana—could be explained using what Freud (2005) referred to as 'id', (the inherent tendencies to achieve immediate gratification), 'ego' (the instinctive drive towards behavioural tendencies to cope with or rebel against the tendencies of others, which will eventually lead to tensions), and 'superego' (which allows one to seek pleasure and avoid pain). Collectively, these three psychological factors may become apparent through forms

such as words and body language to give us an understanding of the unconscious impact that the actions and reactions of people are having in the health sector. To this end, this Freudian narrative is very relevant not just in psychology, but in our appreciation of the individual workers' competing perspectives on incentives and motivations; retention and dejection; job satisfaction and dissatisfaction. Not considering this issue when deciding on the nature, extent and timing of workers' incentives, shifts the pendulum on the discourse of 'power-over' to the mindset, if not mind developments, of people about the purposive use of incentives in the health sector.

Freud's use of these concepts was aimed at depicting the human psyche as a process of progression through developmental stages. Unconsciously, managers might not be aware of the effects of their actions on the developmental stages of health workers, including their career progression. This resonates well with what Midwife 5 said: *"our bosses are just playing on our minds and we will continue to fight for what belong to us so that we can also give our best to the community members"*. The narrative explains her behaviour in fighting for what is rightfully hers, even though this could eventually create tensions between herself and management. Relating this to Freud's concept of 'superego', the intention of midwife 5 to persevere to access her education incentive is part of her desire to avoid the pain of neglecting her career development by working in a rural area for years.

The workers' narratives have not gone unchallenged by managers. The following quotations illustrate the tensions between the parties:

> *For the policy on study leave, you know GHS [Ghana Health Service] believes in supporting every employee to attain his or her career goal. This we do trying to establish the congruence between the desires of the staff versus the needs of the service. You know it's not always the case that the area of choice in terms of the career development of an employee would be the same as the interest of the service so as much as we can the course a health worker selects to read should be relevant to the service or indirectly we would end up encouraging attrition because if you don't get the opportunity to implement what you have learnt, the motivation to leave the service would be high so we always try to strike the balance. Another thing is that we cannot allow most of the workers to be leaving the facilities for further studies since patients have to be taken care of and some of these health workers are not happy with that so sometimes issues come up between the management and the workers but we are trying our best to keep these facilities running (Key Person 3).*

> *As a policy you have to serve for 5 years to qualify for study leave with pay if working in the city but if you happen to be working in any of the 3 northern regions like Upper East, even if you serve for 3*

years and you want to go to school and we know that the program you are going to study is of priority for the region, you will be given study leave with pay. What it means is that, it's difficult attracting certain professionals into the region so if we have a staff or an employee whose interest we have been able to harness towards that particular professional area then we try to encourage more people to go by just allowing them to serve even 2 years sometimes which is less than what the national requirement is (Key Person 4).

The statement by Key Person 4 shows that where the health facility is in need of particular skills in a health worker, the required years of service to qualify for study leave are reduced, to enable the needs of the facility to be met. Managers think the needs of the health facility should be achieved, in terms of an adequate skills mix among workers, but health workers have the view that their personal needs and interests should be considered by management and as such they should not be forced to attend courses they are not interested in. Some health workers explained that even when they were permitted to enrol in further studies, their authorities did not always allow them to select their preferred courses. Instead they were forced to undertake further studies in areas that would be approved by their authorities and management. As explained by Key Person 4, management at the regional level identifies areas for further study based on the needs of health facilities. A Physician Assistant and a midwife explained:

Sometimes even when you talk of further studies, it's like you are not allowed to think of what you want to pursue so they force on you the course to read. They are no provisions to options. They give you a form to fill to declare your intention of going to school but when you apply for a particular program, they would tell you that they don't need that. It's not bad for them to decide which programs they want us to offer but as to whether I can perform to my expectation or get to where I want to get to is another thing. We should be allowed to air our views on the programs we want to do so that we can be satisfied after the course. You know when you do a course of your choice, it helps to increase your satisfaction on the job you do (PA 3).

You know initially I was working as a Community Health Officer. I applied for study leave but they did not approve my application. My boss told me that the region needed midwives so if I am willing to take that course, I would be given a study leave. I agreed to that because I could not go to school without study leave with pay but I didn't want to become a midwife so I don't have much happiness in my current job as a midwife (Midwife 2).

The narratives show the need for management to consider the interest of their workers in pursuing their career ambitions. As stated by PA 3, management should not compel health

workers to take up courses against their interest. He points to the fact that the ability to excel in studies depends to some extent on the level of interest and willingness of the individual to pursue the course offered. Psychological theories that explain causes of subjective well-beings of individuals have established a link between fulfilling human needs and happiness (Diener, Oishi & Lucas 2003; Sousa-Poza & Sousa-Poza 2000; Veenhoven 1996; Walter-Busch 2000). According to these scholars, a person will be happy if his/her needs are satisfied in the present condition, with these needs ranging from basic to general human needs. Therefore, the concerns of Midwife 2 expressed as *"I don't have much happiness in my current job as a Midwife"* could stem from the fact that her need relating to her career progression was not fulfilled. As such, although she is currently working as a trained midwife in a health facility, she is not happy and this could lead to job dissatisfaction and demotivation and subsequently affect her job performance.

In summarising this section, perspectives between health workers and managers in relation to the management of incentive packages, including the administrative issues regarding the implementation, are explored. Managers are sometimes faced with implementation challenges of who receives particular incentives, and when and how this happens. In the process of allocating incentives to health workers, they consider the needs of health facilities and exert influence on health workers about the type of courses for further study. Health workers, on the other hand, are not pleased with the extent of influence from their managers and believe that their views are disregarded concerning incentive packages. Many health workers face challenges when trying to access incentives because their distribution is mostly left to the discretion of those in management to decide whether to approve them. Some health workers do not regard certain incentives as sufficiently attractive, especially when their city-based colleagues benefit from similar incentives. In the next section, I present a discussion of participants' views on preferences about incentives that would motivate them in rural areas, to gain an understanding of the distance between what participants would like and what they receive.

5.5 Suggested packages to motivate health workers and increase their length of stay in rural areas

Several writers have argued that policy makers need to consider possible consequences before formulating policies that may encourage (or discourage) workers to keep working and, where possible, increase the length of their service in areas where they are more likely to face

operational constraints. They have also suggested what policy makers should do to achieve their stated regulatory aims (Berlan et al. 2014; Cerna 2013; Elmore 1979; McDonnell & Weatherford 2016; Webb & Gulson 2013). Before considering these suggestions, it is important to note that they were made with cognisance of the dilemma of not knowing whether policy choices would positively influence worker motivation in the short and long term. Policy makers have been urged to allow workers to have input or at least be given the opportunity to state their preferences for incentive packages. By doing so, the platform is created whereby workers would be willing to perform their duties. This willingness stems from the fact that workers are made to feel empowered because they have a say in what they receive alongside their salary. In this sub-section, I examine this issue of what workers desire compared with what they receive. Participants' views on their preferences for incentive packages that would motivate them are presented and discussed, and related to the conceptual framework that guides this thesis. This section is very important because it enables an understanding of how ordinary workers may influence policy choices and directions.

During the in-depth interviews, participants explained incentive packages that they considered attractive and which could motivate them to stay longer in rural health facilities:

> *You know that it would be good for them [management] to increase our salaries just to motivate us because I cannot be hiding in this rural community and receive the same salary as those in the cities. As a community health officer [CHO], my salary is not enough at all. I even feel shy to talk about it so if our superiors can increase my salary by 50%, at least it would motivate me to stay in this village and work for more years. I am a woman with needs and children to take care of and I cannot get any part-time work to do in this small community (CHO 2).*

> *I will say 10% increment in salary compared to those in the cities would be good because they [health workers in the cities] have opportunities to get more income. This facility is managed by the Catholic Church so every month because I am the head here, they give me 30 Ghana cedis as rural allowance but you will agree with me that this is not money. If allowance can be increased to 100 cedis I will be happy. If all these things are provided I can be here for even 5 or 10 years (PA 1).*

> *The truth is if I can continue to work in this rural community, they have to double my salary because as you can see there is nothing good in this community that motivates us to work. Since you [referring to the interviewer] didn't come here in an aeroplane, you can confess how bad and dusty the road is. So even if the government gives, we those working in these rural communities 100% increase in salary, there would be nothing wrong with that because we are suffering (HA 1).*

As shown in the quotations above, different cadres of health workers had different views on the size of salary increment that would motivate to stay longer in their respective health facilities. While HA 1 suggested a 100% increment in salary, CHO 2 and PA 1 proposed 50% and 10% respectively. This trend reflects their ranks in the Ghana Health Service. Thus, PA 1 is in the highest rank followed by CHO 2, with HA 1 in the lowest rank. Consequently, there are significant differences in the salaries and allowances they receive. As such, increments of 50% to 100% as suggested by the lower-ranked health workers would make a great difference to their salaries when compared with their counterparts working in cities. This clear distinction would direct attention to their working conditions.

Participants argued that where the margin of difference in salary or allowances is not big enough, it cannot serve the intended purpose. A Disease Control Officer (DCO 2) had this to say:

> *We need rural allowance and risk allowance because we have been falling from these motor bikes on several times because the roads are very bad. Now that there is no rural allowance and risk allowance when I fall and hurt myself, nobody would mind me apart from the in-charge [head of facility] saying sorry. They can give us about 150 or even 200 Ghana cedis every month as rural allowance. I am saying this because if they give us little money, it cannot do anything (DCO 2).*

Participants mentioned the need for Ghana Health Service (GHS) firstly to modify some existing incentives especially those relating to study leave policies. Second, they called for the reinstatement of some incentives from which they previously benefited, including the reinstatement of waiver for vehicle importation. This was introduced to support health workers who import vehicles for personal use and by allowing them to pay a lower rate of import duty, but currently health workers do not benefit from this incentive. A midwife and a General Registered Nurse (GRN 3) explained the situation:

> *This waiver for vehicle importation has been taken off the list of incentives now but this is a good incentive for me. The only thing is that, it was even for all the health workers so those in the cities and rural areas were also benefiting. Responsibility allowance would also be good for those who work 24 hours in the rural areas. If even its 100 cedis it would be good because it can pay for the light and water bills and would motivate us a little to go an extra mile (Midwife 2).*

> *I don't think I can stay over here for even another year because it is not easy. What I expect our superiors to do is to give those in the villages limited years to serve before going to school and this can even motivate us to come back and work in these facilities. Because those in cities run shift at work so they work for 6 hours, close and go home but when you are in this village, you are on 24 hours call.*

That means if you are staying here for 2 years, you can't have time for your family so you only leave your kids in the care of maid servants in the city and you can't tell whether they are taking good care of your kids. The village nurse like me after 2 years should be allowed to go to school if the person is willing to because we are suffering (GRN 3).

Apart from suggesting modification to incentive packages, participants further pointed to the need for a responsibility allowance to compensate for the extra hours of work undertaken, especially because there is not the staff to enable them to work shifts in rural facilities as happens with staff working in cities. Consequently, staff who live in accommodation close to the facility could be called to attend to patients at any time.

Compensation in the form of financial or non-financial incentives given to health workers who engage in extra work will motivate them (Lehmann et al. 2009). However, managers would have to consider many factors before putting them in place such as availability of resources, which determines the sustainability of interventions. Reducing the period of service needed to qualify for study leave to two years, as suggested by GRN 3, would be an effective motivator for rural health workers, but it would be challenging for management in terms of human resources to sustain these facilities. If health workers were released for further studies at the end of every two years, there may be no staff in some health facilities because, except for Community Health Officers and Health Aides, it takes more than two years to train other cadres of health workers in Ghana. However, the general willingness of health workers to return to these communities after further studies is quite promising, as explained by PA 3 below. It seems participants regard the opportunity for further studies as an attractive incentive, and some would be willing to stay in unsuitable accommodation to work and get the opportunity for study leave. A Physician Assistant in-charge (PA 3) of facility lamented:

Give us the chance to go to school because if that is done, people would be willing to come and stay in rooms with leaking roof because you know that next year you will be moving a step ahead in your education (PA 3).

PA 3 was 32 years old and his views had popular support among other participants. For instance, a Psychiatric Nurse (PN 1) and an Enrolled Nurse (EN 2) posited that,

Money is not everything so my concern is moving ahead in my career. Our superiors should give us the chance to go to school. If you hear your colleagues in the cities going to school and you are still here, it's not motivating. Money is good but not all (PN 1).

Nobody would be given support for further studies and would refuse to come here. After the education you would want to come and brighten the place since in the mist of blind people, one eyed person is the chief (EN 2).

While young people are interested in career progression, older workers have less interest in advancement. Instead, their attention is directed to incentives that could make life comfortable after their retirement from service, such as cars or motorbikes for their personal use and additional income. This could be because, as workers grow older, it becomes more difficult for them to access the study leave incentive package. Furthermore, as they approach retirement, additional years spent acquiring new skills might not be very beneficial to them or to the Ghana Health Service (GHS), because of the limited years available for them to use the skills acquired. An Eye Specialist (ES 1) in a CHAG facility, who has four years to go until retirement, had this to say:

We are talking about rural enterprise. In fact if the government can come in with some packages, at least you would lose something elsewhere which can be compensated with something that you also cherish. The young people would want to go to school but at my age I am not interested in education but if the government can give me a personal car or motorbike, it would be good but they don't even give us a bicycle. In big towns when they retire, the guys at least go and do some part-time somewhere or meet and sit together and discuss issues or enjoy but here, when you retire you go home and sit alone like an orphan. You can't go anywhere (ES 1).

The concerns of young people do not end with being given the opportunity for further studies but also include modification of the various courses to be undertaken. They argued that the courses available should be modified because some courses do not reflect the qualification they receive at the end of the program. A Community Health Officer (CHO 4) had this to say:

When I put in my application for further studies, the course they told me to apply for will not upgrade my certificate but I will end up getting the same thing but we all go to school to upgrade ourselves and to become better people in future so I refused to go for that course (CHO 4).

A key person involved in staff management supported the statement made by CHO 4 and explained why some health workers regard opportunities for further studies as not attractive enough. Key Person 1 explained the issues:

A worker's aspiration is that the next stage he goes should be a degree but most of the courses which are needed are post basic which means that at the end the qualification that would be given to you is a diploma so people are wondering why they should go for another diploma. They prefer to go for degree programs which are not in the critical areas needed in these health facilities so it would be good for

those courses to be accredited as degree level. For the midwifery we have two forms which is the direct entry which you would complete with a diploma and the post basic which you will complete with a certificate. Now the CHOs [Community Health Officers] and enrolled nurses who are encouraged to do these post basic midwifery programs already have a certificate when they completed the midwifery college or enrolled nurses' training school. Then you ask them to go and do midwifery which they would expect to get a diploma but at the end they get a certificate. So you see them struggling to better their results to give them a direct entry which would give them a diploma though they can go for the post basic so this serves as a disincentive for the health workers. Though they will spend more years when they go as direct entry they prefer that because nobody would want to go for a certificate when he already has a certificate so is a big problem (Key Person 1).

As earlier mentioned, the concern of health workers, especially younger ones, is centred on career progression while managers are more concerned with sustaining health facilities. As indicated in the narrative above, some workers are interested in undertaking courses that will upgrade their status and increase their salaries, but unfortunately these courses are not in areas of critical need in health facilities. Although modification of these courses is beyond the scope of the managers, it would be an important step to enable them to serve the needed purpose of motivating health workers in rural areas, thereby improving their job satisfaction. Incentives such as increased salary and development opportunities have been identified as influencing health workers' job satisfaction (Deriba et al. 2017).

Family issues can be challenging for health workers in rural communities and could serve as a push factor, thereby deterring health workers from staying in them. Some participants mentioned having their spouses close to their places of work as a potential incentive that could serve as a good source of motivation. Again, this might be outside the scope of managers, especially if the spouses in question do not work in the health sector, but it is not impossible. To meet this, an intersectoral approach with collaboration would be necessary. For instance, if a man working in the Department of Agriculture wants to move closer to his wife who is a health worker in a particular district, the rules and regulations governing the movement of workers in the agriculture sector apply. However, these rules could be made flexible if there was a pre-existing arrangement between the Health and Agriculture departments. A Disease Control Officer (DCO 2) explained her concerns:

I am working in the Upper East Region and my husband is working in greater Accra region. You are aware that it takes almost a whole day to travel from this region to Accra and even some weekends I attend to patients because I cannot leave the facility empty. I see my husband once a while but if the Ghana Health Service could help my husband to get transfer to this region, at least he would be closer

to me than Accra [regional capital]. I must say that my husband is not a Ghana Health Service staff but I just hope that something can be done so we can get closer (DCO 2).

Intersectoral collaborations can also contribute to implementing additional incentives suggested by health workers, such as good road networks leading to the rural communities and suitable markets in them. The quotes below explain further:

Our roads are not good and need to be renovated. At least it would motivate us. If you get a case that need to be referred by the time the car gets to this place, the condition of the patient has worsened. Even if they could provide motor king for us it would help because if you work and you are able to save lives of people, that alone are an incentive (Midwife 3).

….do you know that there is no good market in this community that I can get even things to buy to even cook good food to eat. We have to go to the city and the roads are not good. It is a big problem so if the government can provide good roads and good market it would make me happy (EN 1).

Adequate equipment for work and availability of transport give workers the ability to undertake the tasks assigned to them, and were mentioned as incentives that could motivate health workers in rural areas. Suitable equipment creates work efficiency and increases performance, which subsequently could improve job satisfaction (Rowe et al. 2005; Willis-Shattuck et al. 2008).

Three participants explained this during interviews:

They should make transport available to us for outreach purposes. There are about 5 motor bikes which are all spoilt. They repair them and when you take them to field, you have to push them here because they always get spoilt on the way to the field. So you have to use the motor that you have used your own money to buy for field work which is not good (DCO 1).

As I said, if I am given comfortable accommodation where I can stay comfortably over here, I will not need fuel and if there is an official vehicle here which can be used to convey our drugs during community outreach programs it would also be good. Most of the times we rely on motor kings to carry our drugs to this place. The medical stores at times do door to door delivery of drugs but at times their car breaks down and we need to use our own vehicles when we need drugs urgently (CHO 1).

We have a problem with vehicles so when there is an emergency case, it is difficult to refer. Our district director asked us to call when there is an emergency so that his pickup vehicle can be used to assist in that but when you call during midnight, his phones are off. We have been given a motor king which doesn't speed. A woman with PPH or head in vagina cannot lie in the motor king so when you get such a condition, you only pray that God should help you to manage it because before the car would get here, you would be tired and the situation would have gotten out of hand. If they cannot provide us with

incentives for work then I don't think they would be willing to increase our salaries. We are just coping over there so if something could be done, it would help us (Midwife 4).

Social amenities, such as reliable sources of drinking water, good schools and seasonal gifts were mentioned as incentives that would motivate health workers:

I worked in a different district before coming here and we had a mechanised borehole that gives us good drinking water which we don't have here. It was a religious organisation handling the health facility I used to work but here we have to fight with the community members for water from the borehole. If there is pipe where you can just turn on for water and good schools for our kids it would be good. At least we would feel that we are enjoying something (PN 1).

In making these suggestions, participants are not ignoring the importance of financial incentives. These remain important, especially when considering the cost of living in Ghana these days. One interviewee said:

There can also be a seasonal kind of incentive packages such as rice, oil or any of the food stuff especially during Christmas and New Year festivities. We could laugh a little when we receive these things. I don't think you can expect additional pay beside your monthly salary but increment of the salary would be good (GRN 3).

However, and as noted in the opening of the chapter, financial incentives can account for few indicators. Against this backdrop, some participants were of the view that other non-financial incentives such as supervision, counselling and showing appreciation may be important as motivators. Appreciation in this regard also includes respect for the sacrifices workers make that sometimes compromise their religious practices, including church attendance, as a 31 year old GRN in a CHAG facility concluded in the second quotation below:

We need the 10% money given to us on the deliveries we conduct but the supervision and counselling they give should be more since these are all forms of incentives. Even saying 'thank you' shows that our bosses appreciate the hard work we do here and I must say that it is a good source of motivation (Midwife 4).

Sometimes too supervision is good incentive. I can stay for more than 4 months in this community and I don't see my boss coming over to visit to see how I am doing or how the work is going. The only time they come around is when they hear that staff has done sometime bad. They are only results oriented but they don't care about the welfare of their staff. Once a while follow-up should be done. If they do regular monitoring they can identify those who are working hard and encourage them to do so and those lazing about. Just the word "thank you" is enough to keep some of us going. One Sunday I was here alone working and one Reverend father came around, shake my hand and said thank you for the

good work and so I asked if I was pardoned for not attending church. He said you are doing the healing aspects of Jesus Christ and that I work like a bulldozer. It was the happiest day in my life (GRN 2).

Additional incentives identified include the provision of fences around health facilities to improve cleanliness and professional security services to ensure that staff members are safe, because attacks from robbers in communities cause fear and panic:

Fence wall is needed here because the donkeys and cows move around the facility and make the environment dirty. Armed robbers also come around to attack us occasionally so we need professional security here because our lives are in danger (PA 4).

Early access to information, in-service training and workshops are other forms of incentives mentioned by participants. Training should include the use of sign languages to enable communication with people who have speech and hearing impairments. A Physician Assistant (PA 6) and Midwife 5 explained the situation:

There is the need for in-service training and workshops which should include a sign language because those who cannot talk report here and we are not able to communicate to them. In the rural areas there is nothing. ICT trainings are also very important to enable work progress well. All these things are good incentives that would help our work to progress (PA 6).

Even we in rural areas get information late. Before you hear what's happening, the information is dead news. Any incentives they are willing to give to us would be good but we want them to deliver information to us on time. As we are here, we don't hear about anything happening in the cities. You don't even know what's due you to fight for in the regional office. I know am in the remote area but if am motivated it would help me to do my best though I am still doing my best to serve my people (Midwife 5).

The concern of Midwife 5 on the need for health workers in rural communities to get timely access to information is very important. As discussed extensively in the first section of this chapter, access to information could increase the awareness level of workers about the various incentive packages they are entitled to. Essential information needed to improve their work could be provided to them on time, subsequently improving the general well-being of community members.

In this section, I have provided health workers' views about their preferences for incentives that could serve as a source of motivation for their work in rural communities. Their desired incentives have been compared with what they actually receive. These desired incentives

range from significant increase in salary, providing responsibility allowance, reinstatement of tax waiver on vehicle importations, modification of existing incentive packages on study leave and qualifications offered, provision of adequate equipment and vehicles for work, seasonal gifts (rice, oil, work uniform), fences for security reasons, family proximity, the provision of social amenities such as reliable sources of drinking water, community markets and good schools. Participants believed it was also important for managers to express appreciation for the work they do.

Health workers stated the need for a responsibility allowance to be instituted to compensate for the extra hours of work they undertake. They suggested that the period of service for study leave be shortened to two years and that they are given the power to decide which courses to study without interference from managers. They also wanted courses that provided an appropriate level of qualification on completion. Further modifications suggested by health workers were connected to the content of in-service courses and workshops that are occasionally organised for them. Although they regard these as good incentives, they explained the need to include sign languages to enable them to communicate effectively with those with speech and hearing impairments. To facilitate the work they do, health workers stated the need for management to make adequate tools available because the satisfaction they derive from their jobs is also connected to their ability to save lives in the community. Apart from giving their best to save lives, health workers regard their own lives as important and mentioned adequate security measures as form of incentive that could motivate them stay longer in rural areas.

Additionally, to minimise loneliness and prevent marital disharmony, participants wanted to be closer to their families, especially spouses and children, which further implies the need for the good schools in rural communities. As seen in Chapter 4, health workers considered adequate supervision, counselling and appreciation from management as good sources of motivation. The subsequent section provides a discussion of the key findings for the three issues discussed.

5.6 Discussion

Adequately supported and motivated health personnel are essential to efficient functioning of health systems (Deriba et al. 2017; Gilson, Alilio & Heggenhougen 1994; Henderson & Tulloch 2008). Other scholars have argued that to improve the health workforce in rural

areas, government intervention is needed to tackle factors that influence recruitment and retention in particular contexts, which includes the provision of appropriate incentive packages to motivate health workers, especially those in rural areas (Kingma 1999; Kwansah et al. 2012a; Lehmann, Dieleman & Martineau 2008; Mathauer & Imhoff 2006). As detailed in Chapter 2 of this thesis, financial and non-financial incentives both play an important role in motivating health workers, thereby influencing their retention particularly in rural areas. The study findings revealed that various incentive packages have been put in place by the government of Ghana through the GHS and MoH to motivate health workers in rural areas of the Upper East region.

However, the intended beneficiaries of incentive packages, namely health workers in the study area, were generally not aware of their full entitlement to incentives put in place to motivate them. This is important because raising health workers' awareness of incentives could lead workers to appreciating them more. It is expected that where people are unaware of their full incentive packages, it would indeed be difficult for them to accord value to such incentives, which would defeat the purpose of offering incentives. As such, there is the need for health managers to increase awareness about the availability of incentives among health workers in rural areas. It is also necessary to institute appropriate mechanisms for the distribution of incentives if the desired impact is to be achieved, because some health workers have benefited from certain incentives while others have not benefited despite efforts to access them. It is apparent that the distribution of incentives is complicated, with participants regarded them more as a 'favour' on the part of authorities than an entitlement for rural health workers as policy stipulates. The lack of awareness about incentive packages and the complexities associated with their distribution, as detailed in earlier sections of this chapter, could have influenced the perceptions of health workers about the attractiveness of existing incentives.

Generally, most health workers in the study area do not recognise the incentive packages as sufficiently attractive. In part, this could be because their colleagues in urban areas benefit from similar incentives. As explained in Chapter 2, the situation expressed by health workers in rural areas can be explained by the neo-Marxist theory of job satisfaction, that job satisfaction is not only about employees in the same workplace but extends to other institutions seen as similar employment places (Milkovich & Newman 1990). In other words, the satisfaction of health workers in rural areas is influenced by the satisfaction that health

workers in urban areas enjoy. This neo-Marxist thinking sees satisfaction as something that cuts across social and economic boundaries and adopts a transnational outlook. The realist evaluation framework which is core in this thesis, explained in Chapter 3 and in the opening paragraphs of this chapter, also emphasised the need for policy makers to understand issues surrounding the context and mechanisms in the implementation of interventions (Pawson & Manzano-Santaella 2012; Pawson & Tilley 1997). The mechanism, which is the process through which interventions are executed (Ogrinc & Batalden 2009), is important because it is not the intervention *per se* that is influential but rather reactions of the target audience to it, in this case the health workers in rural areas. It is therefore necessary that the location of health workers is taken into consideration when developing incentives because conditions differ between rural and urban areas. This is essential because if workers in different localities are made to benefit from similar incentive packages, rural workers will resist.

In addressing this challenge, as explained by the realist framework, the context needs to be considered to enable policy makers to understand 'what works for whom in what circumstances'. Context describes the structures of a locality and other factors such as relationships, technology and economic status. Put another way, understanding the circumstances in these different localities could influence policy makers to gain a deeper understanding of incentive packages that could work for different cadres of health workers in their various places of work, by taking into consideration differences in age, gender, education levels and other relevant characteristics. It is expected that when these appropriate mechanisms and contextual issues are considered, appropriate incentive packages could be instituted which could serve to motivate and retain health workers in rural areas. As explained in the health workers' narratives, support from sectors outside the health sector are also necessary if the needs of workers are to be met. In other words, intersectoral collaborations need to be strengthened to enable the health sector to function efficiently (Adeleye & Ofili 2010; Nutbeam 1998).

Another possible explanation of why health workers in the study area regarded incentive packages as not attractive enough could be the fact that they were not involved in planning and implementation of incentive packages. Sometimes, approaches adopted from developed countries have been implemented even though the context and mechanisms are different. Dolea et al. (2005) show the need for thorough assessment of theories and practices developed in Western countries before they are adopted in less developed countries with

different contexts, for even within a country, incentive packages could vary from region to region and among districts. Webb and Gulson (2013) also recommend the need for policy makers to allow workers to be given the opportunity to state their preferences for incentive packages because this would empower them and subsequently enable them to perform their expected duties willingly.

The findings of the study indicate different incentive preferences are held by different cadres of health workers in various health facilities and across age groups. For instance, older workers preferred incentive packages such as cars, motorbikes or additional income, while younger health workers were more interested in opportunities for further studies. This is consistent with the argument put across by Humphrey et al. (2009), that no single incentive package could satisfy all categories of health workers. Hence there is a need for policy makers to put together different incentive packages to meet the needs of the wide population of workers. Furthermore, individuals' needs change over time and as such it is important to collate data regularly on health workers' preferences for incentives, so that retention strategies that produce desired results can be developed (Snow et al. 2013). Another issue is that health workers complained about the unfair manner by which incentives were allocated, and this shows the need for adequate monitoring and supervision mechanisms to be instituted to improve the pattern of distribution (Humphreys et al. 2009).

Almost all health workers involved in the study were aware of the study leave incentive package and regarded the opportunity for further study as attractive. They expressed high interest in knowledge acquisition through in-service training and workshops. These means of knowledge acquisition were regarded by health workers as an essential component needed for building their capacity within the health sector. Health workers who undertake frequent training and relevant workshops could contribute immensely to upgrading their capacities and enhancing their professional advancement, although participants described the contents of some in-service training as inadequate. Studies have established that regular professional advancement has positive influence on quality healthcare delivery, enhances workers' job satisfaction and could subsequently aid in recruiting and retaining health workers in rural areas (Lehmann, Dieleman & Martineau 2008; Wilson et al. 2009). Although the study leave incentive was popular among all cadres of health workers in the study area, many expressed frustration at not being able to access this opportunity. Standards for mid-level cadres of health workers, which include most staff posted to rural areas, change from time to time and

as such health workers expressed frustration that they could not get study leave to upgrade their professional skills and attain higher level qualifications. In another study conducted in the regional capital of Ghana, medical students who were about to graduate identified professional development as their most preferred incentive (Kruk et al. 2010).

Apart from access to education opportunities, supervision, counselling and appreciation from management were highlighted as essential components in any incentive package geared towards retention of health workers in rural areas. As highlighted in the previous chapter on task-shifting practice, supervision and counselling are essential to ensure that mistakes made by health workers are corrected, thereby enhancing worker competence and adequate healthcare delivery. The study findings imply that health workers in the rural areas of the Upper East region of Ghana recognise the need for counselling and supervision from managers who are usually their senior counterparts. They acknowledge the role counselling plays, which includes nurturing good relationships and interactions among workers, providing guidance on career pathways and expert advice to health workers. When health workers interact and share ideas with managers who are more skilled, it minimises the feeling of being neglected in these rural communities, thereby increasing their sense of belonging within their working environment.

Health workers in the study area regard supervision as a good incentive that could help improve their work performance and enable management to identify and show appreciation to diligent workers. They expressed their disappointment associated with limited supervision from their management, explaining further that their superiors generally visit health facilities only when there is a problem to be solved. In contrast to these positive observations, a similar study in Kenya and Benin showed that health workers regarded supervision as a control exercise and as such not useful (Mathauer & Imhoff 2006).

Apart from what has been discussed so far, inadequate accommodation and lack of security were mentioned by participants as key issues hindering recruitment and retention in rural areas. Health workers reported attacks from armed robbers in the rural communities where health facilities are located. Robbers attacked with knives and guns and stole their computers, money and other essential accessories. Discussions with health workers revealed that there had been instances where robbers had killed or injured health personnel. Maslow's (1949) basic needs theory explains that basic needs must be met before one can achieve the highest needs, described as self-esteem and self-actualisation. Health policy makers must first ensure

that health workers in the field have reliable and sufficient income, suitable accommodation, security, stability, confidence, a well-looked-after family and good relationships at work. While it is essential to address these needs to improve health workers retention in rural areas, these actions were generally lacking in the area where the study was conducted.

5.7 Conclusion

In this chapter, I have considered various incentive packages put in place to retain health workers in Upper East region of Ghana, and the competing perceptions of the beneficiaries (health workers) and the implementers. Incentive packages, either financial or non-financial, could influence health workers' choice of location to practice (rural or urban). The effectiveness of incentives (positive or negative) depends on the type of incentive and health workers' preferences. To improve their effectiveness, health workers for whom these incentives are intended should be involved in the process of developing and implementing incentives package. In other words, the views of these workers are necessary to improve performance, and to gauge their willingness to stay for longer periods in rural facilities.

In this chapter, I have discussed the financial and non-financial aspects of incentive packages, and workers' view about what they would like compared with what has been provided by the government. I have examined policy implications of the use of incentives and associated connections to power and influence over the workers' individual aspirations, capabilities and attitudes. In the next chapter, the focus shifts to the governance, political and legal systems that influence interventions in health workers' retention.

CHAPTER 6
GOVERNANCE, POLITICS AND LAW IN GOVERNMENT REGULATION OF HEALTH WORKERS' RETENTION

6.1 Introduction

In the previous chapter, the discussion revolved around the issues, needs and competing views on the question of incentives and their overall impact on the retention of health workers. There I highlighted the complex interplay between financial and non-financial aspects of incentives in the production of the conditions under which individual health workers set their preferences and devise ways of influencing their attainment. It was also noted that class, gender and other social factors have a role to play in influencing the incentives workers can receive, as opposed to what they desire. Essentially, the question of what workers receive, as argued in that chapter, is dependent upon the policy imperatives, political interests and general governance conditions that affect governments' commitment to meeting the incentives needs (and wants) of individual health workers.

In this chapter, the discussion is expanded to include, from a discursive point of view, a historical overview of the development of government policies. Next, and by way of exploring how the government has conducted itself, there is a critical analysis of government policy documents on human resources for health issues in relation to the information gathered during field work (in-depth interviews). Details of the processes of analysis were presented in Chapter 3 of this thesis. The purpose here is to get a deeper understanding of the content of policies and the feasibility issues associated with their implementation through a discussion of the stages involved in the appointment, posting and financing of the GHS. In the final part of each section, the influence of perceptions in the governance of the health sector is examined. Although largely neglected in the study of public health, the political dimension is still very important, not least because it sets the conditions that make it desirable for people to use the narrative 'it is my right' to demand their rights to incentives. It is also what spurs workers on to exploit prevailing conditions for the furtherance of their desires for incentives and to form unions to protect their rights to better conditions of service. In turn, this directly affects their motivation to work and their receptiveness to policy directives that call on workers to respect the codes governing worker retention in all health facilities. On the part of

the government, it is the political imperative that determines the policies that should be instituted to achieve the intended aim, to promote the health and well-being of the people.

6.2 The Emergence of the Ghana Health Service

By definition, when we talk of policy (and its associated processes) we are talking about a set of static or flexible rules or approaches that are systematically developed to guide the operation of an institution (Ward et al. 2016; World Health Organisation 2014). As rules, they should enhance the capacity of the institution to achieve its stated priority goals. There are two types of policies: private and public. Private policy is concerned with the management of the private sector (of, say, corporations and private businesses). Public policy, on the other hand, is concerned with the management of all sectors (e.g., government departments and agencies) that are created and regulated by government (Ball 2015; Thomann, Lieberherr & Ingold 2016). This does not mean that the public and private sectors are faceless. People with emotions run the day-to-day affairs of their respective institutions. However, when policy is developed, these people must be seen to be working within guidelines (as stated in the written policies of the institution) in the performance of their day-to-day responsibilities, their relationships with other institutions and the wider society. To this end, all policies have an impact on the society and therefore should be regulated by the overall policies of the government. One characteristic feature of policy (whether private or public) is that it should be goal-oriented. Throughout their formulation, implementation, evaluation, and their continuity or change, policies should be directed towards the attainment and/or satisfaction of the public good. To achieve this, policy should be characterised by the following: accountability, transparency, flexibility, long-term forecasting of future trends, firmness, and legitimacy (by legitimacy, it should have popular support and should not violate the law, the constitution or otherwise) (Bouckaert & Kuhlmann 2016; Loorbach 2010).

It is in the light of these requirements that the Ghanaian government, since its inception following the country's independence from Britain in 1957, has taken steps to develop and regulate the public sector, of which the health sector is one key area of the government's public sector governance priority (Ghana Health Service 2011; GSS & Macro 2009). The government accepts, in line with the laws of the country, that the health and well-being of the Ghanaian people is a fundamental human right. With 'health' being a fundamental human

right, the government must continually look for ways to develop an efficient and effective health sector. Against this backdrop, there has been a move away from health policies that focus solely on patients towards the development of policies that consider health workers, including their needs, concerns and welfare, and professional development. These matters play a role in recruitment and retention of workers in the health sector, as in other human services sectors of the state (Ghana Health Service 2011). One way of doing this is through the creation of efficient human resource base. The change of emphasis from patient to worker does not mean patients are neglected, but recognises the fact that good patient care requires an effective and efficient human resource base.

In Ghana, the question of the effectiveness of public policy as it relates to the health sector came under scrutiny in the 1990s. In October 1990, an appraisal of the Ghana health sector was commissioned. Under the chairmanship of Jerry Rawlings, who was head of state and leader of the Provisional National Defence Council ruling junta, the appraisal was an inter-ministry activity jointly carried out by the Ministries of Health, Development and Decentralisation/Local Government. The aim was to gauge progress in the operational and financial aspects of the health sector between 1978 and 1990, and identify shortcomings and opportunities. One shortcoming identified was the problem of coordination. Horizontally, the health sector had too many separate departments, and would work better if they were merged into one department (Cassels & Janovsky 1992). For instance, different departments were responsible for managing programs for malaria, tuberculosis and HIV/AIDS. To resolve this, the panel recommended the formation of an expanded program of immunisation to regulate all primary health care issues. Vertically, district health facilities were separated from the control of the central health ministry, and as a result, the problem of effective management developed. District facilities were placed under the control of district assemblies, which were political bodies comprised of elected representatives.

Prior to the 1990 health sector review and continuing during it, the Ghana government had introduced ill-fated austerity measures—otherwise known as ‘structural adjustment’—in the regulation of financial and recruitment policies, and this had its own consequences. There was over-centralisation of the health sector, originally intended as a way to manage scarce resources more effectively. Included in the austerity measures were reductions in government spending and a cut in the number of personnel that were recruited and retained. Concurrently, there was a call for the expansion of the health sector into previously isolated rural areas.

Most post-colonial governments after the 1970s paid little attention to the health sector until they realised that over-centralisation could serve a political purpose. Thereafter and until recently, people's health and well-being were associated with political successes, especially in the northern sector of Ghana. Governments have tended to use politics to determine which regions should or should not benefit from postings of expert health workers. Generally, politicians choose to distribute resources to areas in the hope of increasing votes, instead of concentrating on more deprived regions (Effective States and Inclusive Development 2016). Thus, in pro-government regions in Ghana, health facilities were fully staffed by expert workers. Regions that were considered anti-establishment, especially the north, experienced political neglect and their health facilities were under-staffed. Consequently, people in the north reverted to their cultural belief systems because they believed they could no longer trust government health facilities (Asante & Zwi 2009; Asante, Zwi & Ho 2006; Cassels & Janovsky 1992).

This was the prevailing situation. To resolve this (and other associated problems, which are beyond the scope of this thesis) the appraisal team also identified two opportunities. The first was to exploit the already extensive reach of district health facilities, which were a priority of district assemblies, as a platform on which to build a decentralised health sector. The ruling junta was of the view that removing district health facilities from the control of district assemblies and transferring them to the central health ministry would lead to better national coordination of all facilities (Cassels & Janovsky 1992). A similar approach was taken with the decentralisation of other government ministries. However, this change had its own challenges. Among them was the possibility that the transfer of these facilities to the central ministry would have the reverse effect to that intended, in that instead of promoting decentralisation there would be an over-concentration of resources. Their identified solution—which was the second opportunity—was to decouple the health ministry from the traditional structure (and associated bureaucracy) of the Ghana Civil Service through the formation of the GHS as a semi-autonomous government agency (GHS 1996).

The formation of the GHS did not come about fortuitously. Rather, it occurred after lengthy consultations between the government, the people of Ghana, and by qualified extension, the international community and international consultants engaged by the government and its international sponsors (Ghana Health Service 2015). In writing about the prospect, the consultants at the time reported that the recurring theme and political focus during these

consultative processes was on structural change: how to achieve it and how to prevent it from disrupting the health sector-related socio-legal and political structures of Ghana (Cassels & Janovsky 1992). They were neither sure which organisational form such structural change to the health services should take, nor were they totally prepared to manage effectively any unforeseen financial, political, administrative, legal and social consequences of their actions.

In the main, the most widely accepted idea was to develop a health service that was funded publicly by consolidated funds and which was outside the oversight of the civil service. This was to enable proper financial management of the sector in ways that would enhance worker recruitment and retention. This decision, of course, not only set the GHS apart from other civil service bodies but its very structure was to be different although inter-related. In this regard, Cassels and Janovsky reported,

> "The MOH's [Ministry of Health; a civil service body] key function would be providing clear guidance to the executive [the board of the GHS] concerning trade-offs between objectives of equity and efficiency in the conduct of its operations. The organisational structure of a national service can be more or less decentralised" (Cassels & Janovsky 1992, p. 152).

It was further noted in the appraisal report that this arrangement favoured "the political needs of local government at the expense of the managerial requirements" (Cassels & Janovsky, p. 152) by fitting the overall needs of local governments to the priorities of the central health ministry. If the National Health Service (NHS) was to rely on this kind of arrangement, there was need for a well-codified policy that would spell out the terms of reference and determine the procedures around the recruitment and retention of workers. Without this, there would be a major negative effect on the structure of governance in the country. Fortunately, after a few more years of negotiations and consultations, the GHS and Teaching Hospitals Act (dubbed Act 525) was passed into law in 1996.

Among its many provisions, Act 525 made clear that all institutional policies were governed by the national constitution of the country. It also contained details about the objectives and functions of the GHS, its membership and governing body, administration and management of institutions in GHS including services rendered at state-owned hospitals and health stations (regional and district), and budgetary considerations (annual estimates). The Ghana Health Service has as its objectives to "implement approved national policies for health delivery in

the country, increase access to improved health services and manage efficient resources available for provision of health services" (Ghana Health Service 2011). To achieve these objectives, GHS performs functions such as to ensure access to healthcare services throughout the country, through direct provision of services or by contracting other recognised healthcare providers to provide health services (such as CHAG). It also plans, organises and administers quality and comprehensive healthcare services emphasising on primary healthcare, promote the efficiency and advancement of health workers through in-service and continuing education. Additionally GHS sets technical procedures to attain policy standards that are instituted by the Ministry and also develop strategies to distribute healthcare facilities across the country (rural and urban areas) (Ghana Health Service 2011, 2014).

6.3 Government Policies on the Human Resource Sector of the Ghana Health Service and the Ministry of Health: 2002–2015

Successive Ghanaian governments have recognised, in principle, the importance of health in their overall plans for accelerated national development, post-independence. In furtherance of this, since 2000 there have been increased efforts to develop a robust human resource base in the health sector. These efforts were partially successful in that they achieved a baseline level of staffing, but more was needed. To enhance their efforts and move to something more substantial and sustainable, the Ministry of Health in the year 2002 developed a five-year policy document titled *Human Resources for the Health Sector*, to "serve as a guide to implementing agencies, both public and private" (MOH 2002, p. ii).

Unfortunately, after a series of changes in the government and political leadership, the recommendations contained in the policy document were not fully implemented, creating a vacuum that left the health sector with an uncertain future. This vacuum was, however, short-lived. In 2006, the then Minister of Health, Courage E. K. Quashigah, called for a review of the dysfunctional 2002–2006 policy. This review was to take into consideration ways of incorporating better management strategies for mainstreaming the constantly evolving challenges affecting the health sector, together with inclusion of projections for the future. This was indeed a significant move, one that was to change the way things were done within the human resource sector of all health facilities nationwide. In the past, there had been little or no uniformity, but this ministerial review called for (and succeeded in) moving the country's "health goals and policies to strategies that will ensure wealth creation for the

nation" (MOH 2007, p. iii). The Minister was, however, of the view that achieving these goals would "require harmonization of national health policies [through] the development of human resources for health in both public and private sectors" (MOH 2007, p. iii).

Without much discussion, this revised policy was reviewed, tabled before and approved by parliament, and released in September 2007 (and later amended in 2011). It did reflect the MOH's position "regarding planning, training, recruitment, deployment and management" (MOH 2011, p. 1). It also recognised possible challenges that could compromise the effective implementation of all policies. To prevent these challenges from derailing government's efforts and to resolve other unforeseen challenges, the revised policy also included two frameworks for action. The first was concerned with the resolution of inter/intra-health facility/health sector disputes arising out of the clash of their expanded terms of reference. The second dealt with all possible avenues for the effective negotiation of "adequate resource allocation for effective human resource for health service delivery in Ghana" (MOH 2011, p. 2).

After expiration of the 2002–2006, 2007 and 2011 policies, the government ordered another appraisal that took into account both the political and governance aspects of its mandate. To better explain the interplay of these, the illustration below is presented (Figure 6.1). It was developed for this thesis from a thorough review of government documents and was supported by field interviews (some of which are included in the sub-section containing the discussion). This illustration demonstrates the various influences that shaped the government's re-appraisal of its performance in the development, implementation and evaluation of the 2007–2011 policies.

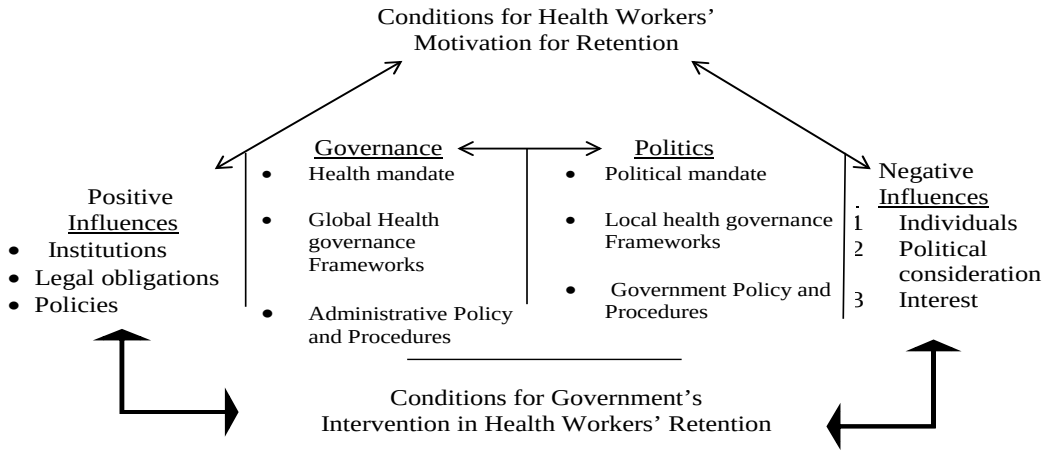

Figure 6-1: Factors that influence the reappraisal process

6.4 Ghana Health Service Policy on Appointment and Postings

This sub-section begins with details of Ghana Health Service (GHS) policy on appointment and postings and proceeds with health workers' perceptions of these policies. This is important because it gives an understanding of the processes involved in the hiring and posting of health workers in the study area and the push and pull factors associated with these processes that influence health worker retention in rural areas. Thus, the question of how health workers are appointed and posted to their places of work and their views on these policies is presented to give an understanding of how ordinary health workers may influence policy choices and directions.

According to the Ghana Health Service (2011), appointment involves the hiring of a person by appointment authority to fill a vacant position. The different types of appointment within GHS include intake of fresh cadres (permanent or temporary), re-appointment of returning officers, elevation of serving personnel to managerial positions, upgrading of serving personnel on attainment of higher qualifications, conversion to another job class/occupation after obtaining the skill or qualification on the job, and re-engagement of retired personnel on contract (fixed term appointment). After hiring, health workers are sent to various health facilities across the country to deliver healthcare to the Ghanaian population, which is referred to as posting. The guidelines on posting state that newly appointed staff shall be

posted to serve in facilities where their services are needed, and requests for posting out of a region shall be approved if the staff member has served in the region for a minimum of three years. Therefore, at certain times health workers are posted directly to health facilities without their consent. Some accept these postings to obtain jobs because of the high level of unemployment in the country (GHS, QHP & USAID 2007).

The policy on postings also explains that marital status may be considered in posting health workers. Where possible, a couple may be posted to the same place or to the nearest possible station relative to opportunity depending on the availability of vacancies. Moreover, workers' mobility from and to other government agencies and institutions is permitted, and in GHS policy this is referred to as transfers (for long-term replacement of retiring or dismissed staff) or secondment (mostly for short-term replacement of staff who are engaged in other assignments, on maternity leave or have resigned) (GHS, QHP & USAID 2006, 2007). Secondments have allowed GHS to benefit, in the short or long term, from the expertise of officials assigned to it by the Civil Service Commission of Ghana. Secondment of staff following a personal request is considered a privilege, and employees on secondment are paid well and receive other forms of compensation or incentives, depending on the area where they are sent.

6.5 Workers' Perceptions of Appointment and Posting Policies

6.5.1 Health Workers' Perceptions

Participants were appointed and posted to various places of work through various means, including direct posting immediately after completing school and transfers (resulting from inter-/intra-departmental shuffling) from one health facility to another. As expected, while workers are required to accept transfers and postings, it can be difficult to decide whether to accept:

> *It was not my choice coming to this community to work. When I completed school I was posted from the national office to this region and they posted me to this health centre* (CHO 1).

> *What made me to accept the posting to this place was that they are my superiors and there is nothing I can do. I either accept it or quit the job and you know that there are no jobs available in this country so if I don't accept the posting, I will be jobless* (GRN 3).

Initially, a type of posting described by participants as “random posting” was instituted and under this, on completion of their courses participants had to select three regions where they preferred to work. Some were fortunate enough to be sent to one of their selected preferences while others were posted to places they did not choose. Those who got their preferred places to work considered themselves lucky compared with their counterparts who did not. A Disease Control Officer (DCO 3) and an Enrolled Nurse (EN 2) stated:

> *Our posting is mostly done from the municipal level. At first when you finish school after the interview, you are asked to choose 3 places you would prefer to work. I chose Bolga municipality first, Kongo district (Talasi Nanton) as second and Bonko as third. When I got to Bolga municipal they asked me to go to the directorate and they further posted me to one of their facilities. Luckily for me I was posted to Bolga municipality. So I will say the postings are random* (DCO 3).

> *I got here by random postings. Initially before you complete school, you are made to choose 3 regions you would prefer to work so when I completed school, I was asked to choose 3 regions, preferably where I would want to be posted to. My first choice was Northern region which is my hometown, the second was Upper West region and the last, Brong Ahafo region but unfortunately I wasn’t posted to any of these regions chosen. I landed in Upper East region and was posted to this community* (EN 2).

The direct postings described by participants above apply to health workers who have just graduated from health institutions in Ghana. Normally, after having worked in a particular health centre for some years, a process known as ‘reshuffling’ takes place. As the name implies, these health workers are transferred to different health centres within the same region although some workers think it is not organised fairly. Midwife 4 and Physician Assistant (PA 4) described the process they went through:

> *I received a letter from my regional director informing me that they are doing reshuffling of health personnel within the region so I could also be reshuffled. Not long after receiving that letter, I was sent here to work. I accepted the postings because they are my superiors so there is nothing I can do. I either accept it or quit the job* (Midwife 4).

> *As for me I was working in another district some years ago and then reshuffling occurred so I was transferred to this health centre. I have been here for 5 years now so I know very soon when another reshuffling takes place, I can be posted to another district but this time I am praying that I get closer to the city because it’s not easy staying here. I must say that sometimes the reshuffling is not done fairly but what can we do* (PA 2).

Reshuffling sometimes occurs because health centres are in critical need of certain cadres of health worker at a particular time. In such situations, health managers discuss with the health

workers the need for them to be transferred to other facilities. Midwife 5 and Physician Assistant (PA 4) explained:

> *I was posted here by my superior who is the director of nursing services. She called me one day and told me to come and help the midwife in this facility since she is the only one here and the workload was too much for her to handle. I have worked in Paga for 5 years so this is not [my] first time working in rural areas* (Midwife 5).

> *The district director told management that there was the need for me to be here since the medical assistant was going on retirement. They needed someone to take over his duties so my name was mentioned. They discussed it with me and I saw it as a big challenge but I accepted. It's a challenge because it's my first time of managing a facility and my main challenge is how to manage the staff. You know in the big hospitals there are people who are higher than you so if you face any challenge you quickly run to them for help but here all eyes are on me waiting for me to perform* (PA 4).

The quote above from PA 4 confirms the policy on postings which stipulates that health workers upon completion of an approved course can be posted out because of their specialised training. It should also be noted that, usually, workers see these postings as a responsibility that overrides their individual wishes and spurs them to accept or reject. Another participant explained this further:

> *I was initially working in another district in this region and obtained sponsorship to do the physician assistant course so after my training as a physician assistant I was just posted here to work. I did my internship at Bongo and then the regional director brought me to this facility. I have worked in other rural communities. So because it was not my first time, I was ok. I just felt it was one of my responsibilities to accept posting to any place* (PA 2).

The inference from Physician Assistant 2, (above) '*I just felt it was one of my responsibilities to accept posting to any place*' is important. It illustrates the part the evaluative role plays in a worker's assessment of the impact of individual choice on health policies, and the collective impact of choice and policy on the performance of workers. In practical terms, health workers may consider they have a morally binding obligation to follow the stated rules governing the terms of work (in this case, postings), even though a moral obligation is not always legally binding. In turn, a worker's superiors may think that the worker deserves a positive response. If, for example, after accepting the posting, the work of Physician Assistant 2 resulted in the saving of many lives by a drastic reduction in the high incidence of maternal mortality rates in the community, he may be praised and receive an increment to his incentive package.

Alternatively, if he had felt it was his responsibility to be posted to the community but refused to perform the duties expected of him he may be regarded as blameworthy.

Thus, to believe that a health worker is worthy of pay increases or deserves blame (based on a policy directive that may or may not explicitly define 'responsibility') is to regard him/her as a responsible agent employed to carry out specified and unspecified duties. These duties are tied to the 'responsibility factor' by the expectation that the individual has the capacity and ability to yield positive outcomes. However, there are examples of self-directed ascriptions of responsibility, as the narratives of Physician Assistant 2 (above) denote. In a situation where the worker's response to an issue is morally based on intuition or feeling, the reaction—in the form of pay increase for a job well done or criticism for not doing the job—might also influence self-directed appraisals and/or outcomes. Hence, depending on the prevailing situation, the motivation behind and the effect of self-directed compulsory duty lies in one's performance and the intended outcomes of such performance.

Health workers might consider appointments as a responsibility that supersedes their individual desires about accepting postings because their contract terms were not clearly spelt out to them before postings were done. As detailed in Chapter 5 of this thesis, most participants lacked detailed information about how long they were expected to stay at post in rural facilities and there was a dearth of information about processes for transfers and 'reshuffling' which subsequently affected their perceptions on posting. Some health workers explained the frustrations associated with the organisation of their postings.

> *To tell you the truth the way our superiors go about the postings is not clear at all. They posted me to this village 5 years ago. I was thinking that in 2 or 3 years they will transfer me to another facility in the town but I am still here while some of my colleagues who came to meet me here have already been reshuffled to Bolga health facility which is in the city. This is not fair at all and if I continue to think about this I will also be frustrated* (DCO 1).

> *I personally don't think there are any organised procedures our bosses [those in authority] follow in going about the postings because I for instance I worked in village for some years and was again transferred to this place which is another village and this is not fair. Now as I am talking to you [referring the interviewer] another reshuffling is going on in the system and I don't know where my superiors will send me to because next year will be my 7 years of working in rural areas. So you see that there is no transparency in the postings. If you don't have any family member or friend who is powerful to speak for you, then you will stay and work in rural areas all your life and this is a big problem* (Midwife 2).

There are several push and pull factors that determine workers' perceptions of posting and government policies regulating postings. These factors include, but are not limited to, workers' aspirations to achieve goals, peer influence, workers' upbringing, incentives that hard work attracts, the command that calls on health workers to perform, and the nature of blame and/or punishment that failure to perform may attract.

Participants have different perceptions regarding the postings policies instituted by the Ghana Health Service (GHS). Some expressed their unwillingness to accept postings to rural areas because of their lack of rural practice exposure, while those with previous experience of working in rural areas were happy and more willing to accept posting to them. Some health workers mentioned rural training, internships and orientation as means that had prepared and encouraged them for rural practice. Some had trained in rural areas while others had had opportunities to engage in rural internship programs. According to participants, these experiences and exposure prepared them well by improving their desire for rural practice, and they accepted postings to rural areas without complaint. A Psychiatric Nurse (PN1) and a Community Health Officer (CHO 3) with rural internship and training explained how their previous rural orientation prepared them psychologically to accept postings to their present place of work:

> *I even had the experience of working in a village like this place when I was doing my internship as a community health officer so when I was posted here psychologically I had already prepared myself so I took it cool. Ideally I knew that where humans live my services are highly needed. Even during the weekend when my service is needed I stay and work. I must say that the internship program really prepared me to work in rural areas* (CHO 3).

> *My colleagues are not happy when they were posted here to work so they always complain but I will say that I am ok working here. I don't complain because I don't see it to be a problem working in a small community because during my training as a psychiatric nurse, I used to come for outreach programs and attachment in remote communities. I will say that because of the exposure I had my desire to go to small communities to help the people increased so when I was posted here I have always been static in this health centre* (PN 1).

Participants also identified that the type of orientation and the coverage of materials given to health workers during their training before they were sent to work in rural communities were effective in preparing them for rural practice, because most participants had lived in cities throughout their lives. This was explained by Physician Assistant 2 below:

> *During training we were made to understand that training of medical assistants [also referred to as physician assistant] is for rural communities as the motto [slogan] of the school goes 'service to rural areas' so right from day one I knew for sure that after training am likely to move to rural community to serve. Apart from that before we started working here, our authorities had orientation gathering for us and they explained some of the challenges in working in villages and other things which also helped me a lot to prepare my mind because I have stayed in Accra [biggest city in Ghana] for a long time* (PA 2).

Pre-employment rural training, internship programs and orientation were considered valuable in equipping health workers who were assuming duties in rural areas for the first time. Another factor was long periods of rural service, which were mentioned as a means through which workers were encouraged to stay and work longer in rural areas. Health workers who had previously worked in rural areas more easily accepted transfers to other rural areas because of their initial experiences and exposure. Some participants further explained that, because they already had previous experience of working in similar areas, they knew what to expect and as such were not bothered by a rural posting. A physician assistant aged 50 years (PA 3) and a general registered nurse aged 58 years (GRN 2) who was nearing retirement emphatically explained:

> *After my training as a physician assistant I was just posted here to work. I did my internship at Bongo and then the director brought me here. I have worked in other rural communities before I went for further studies. So because it was not my first time, I was ok. I just felt it was one of my responsibilities to accept posting to any health facility in the country* (PA 3).

> *As a nurse who has been working in rural areas for a long time, I knew what to expect from working in places like this and I also know that I am not supposed to refuse posting to any place. For the young ones who don't know this when they are asked to go to the rural areas they are always grumbling. I don't have any problem working in the rural area* (GRN 2).

Studies have established a link between rural training and the willingness of health workers to practice in rural areas (Dieleman & Harnmeijer 2006; Lehmann, Dieleman & Martineau 2008). These scholars further explained that health training schools located in rural areas are able to offer rural practice that subsequently prepares and motivates students to work in rural areas after completing school. In the study conducted by Rosenblastt et al. (1992), students' willingness to practice in urban rather than rural areas was attributed to the fact that many medical schools are urban-based. This is similar to the situation in Ghana, where Community Health Officer (CHO) training schools are located at the district level, but most other health training institutions are in urban areas. Therefore it is challenging to expect health workers

who trained in the city and who have no rural exposure to accept posting to a rural area willingly.

Another challenging issue is the language barrier. Participants identified this as an important reason why they are unwilling and unhappy to accept postings to rural areas. As such, this needs to be considered by management before posting of health workers. Participants said:

> *You know I am a Fante by tribe and these people also speak Frafra so the communication is a problem. When they talk I can't understand and when I also talk they can't understand so that's really a problem. I think our superiors would have to think about some of these things before posting workers* (CHO 1).

> *I wanted to work in Northern region due to language issues because they are my people and so it would have been easier communicating with them. Over here sometimes I have to take an interpreter because I don't understand their language and this you know is a big problem but what can I do* (Midwife 4).

Some participants specifically suggested that policies on postings should take into consideration tribal issues, which are connected to participants' home towns. They explained that the districts health workers come from should assist in sponsoring their education so that they can be posted to these places to work after completing school. They said this would make them happy and motivate them to work in these rural areas, because working in their home towns gives them the opportunity to show love to their family members. Some health workers who were currently working in their home towns said:

> *Actually after school, I was posted here to work from the municipal health directorate. I was happy because I was born in the village so working in this village means am here to help my own people, I mean my tribe mates. I will say that our authorities should provide some legal documents to the districts we come from so that they can sponsor us for school so that after school we can come here to work* (Midwife 4).

> *It was normal for me when they told me to come here and work because I come from this village so it was more or less a home coming and I get fulfilled serving my family. This is a small community so we are all related to each other* (DCO 3).

It should be noted here that Ghana Health Service policies on postings currently do not take into consideration issues of language and tribal affiliation as expressed by participants, but this needs attention from policy makers and management for quality healthcare delivery (Gyamfi et al. 2017; Stern et al. 2017). As can be seen from the above quotes (CHO 1 and

Midwife 4), people in the northern sector of Ghana which includes the study region generally speak different languages from those living in the southern parts of the country. As such posting health workers who do not understand these languages to the northern sector could lead to difficulties in communication between health workers and patients and consequently affect efficient healthcare delivery.

In contrast to the quotes above (Midwife 4 and DCO 3), other participants were of the view that their careers had been hindered because they were posted to their home towns. These health workers explained the difficulties they faced, such as community members failing to observe appropriate protocols in health facilities. Because of the personal relationships existing between workers and community members, patients request preferential treatment when they report at the facility which disrupts work and sometimes increases workload.

> *Here I will learn a lot about human relations and different diseases. But the issue is that because here is my home town, people try to make my work difficult because they don't want to follow the appropriate proceedings in the facility. Everybody wants to be treated in a special way and it's because I am related to most of them and we speak the same language but I have been managing things so I think its ok* (PA 5).

> *It is not easy working here at all because we all speak the same language. The good side is that the community members feel comfortable dealing with me but the other thing is that they all want me to take care of them when they are sick which increases my workload. I try to explain to them that I cannot do the work alone but they don't seem to understand and that is a problem for me and sometimes some of the patients even ask me for money to buy drugs and food because they know am one of them* (PA 2).

The phrase *"the good side is that the community members feel comfortable dealing with me"*, used by PA 2 above, explains the role language plays in health seeking. According to participants, patients report to them for treatment because they can communicate easily with them although this contributes increased workloads for these health workers.

Additionally, proximity to family members was identified by many health workers as a very important factor that needs to be considered by authorities during posting because it affects their willingness to stay and work in rural areas. According to some participants, when their spouses, children, parents or other relatives are near to them, they can focus on their work because they do not have to travel for a long time to visit family members. Married workers further emphasised that distance created between couples could lead to divorce because it

becomes difficult for the wives or husbands to perform their marital duties. This concern was raised more often by female health workers in the study area, while unmarried participants were worried about finding suitable partners in a rural area. Three female participants had this to say during interviews:

> *When director asked me to come I later thought it is closer to Navrongo where my kid is and my sick mother so I can visit home. I want to even get more closer to my family members, I mean staying with my husband in the same room so that I can perform my duties and he can also take proper care of me and the child. Where I am staying now is not too far away from him but still he can go for another woman since we don't stay in the same room and this can lead to divorce. I am planning to go to school next year and I can't stay longer because I have been in the system for 10 years now so would want to get closer to my family. I was at Builsa district before I got married and am still in the same district* (GRN 1).

> *In fact before I completed school my husband was already working here so I chose Kassena Nankana district and luckily for me I was brought here. I came here because of my husband. Even though am not in the city where I can enjoy big opportunities, the fact that I will be able to visit my husband easily is enough reason for me to be happy to do my work* (EN 2).

> *I don't know why our superiors have to post people like me who are not married to this village to work. There is no way I can get a good man to marry from this community and you know as a woman I need to marry. So I think our superiors should not post young people who are not married to villages* (Midwife 1).

As explained by EN 2 above, the closeness of her husband was enough motivation to opt for rural practice. In other words, although she has forfeited certain things she described as *"big opportunities"* she is still happy working a rural area because of easy access to her husband. Although health professionals who grew up in rural communities easily accept postings to rural areas, studies have established that women are normally less likely to accept postings to rural and remote areas especially if that could result in family separation (Chaudhury & Hammer 2004; Doescher, Ellsbury & Hart 2000). Additionally, while men's movements are mainly connected to economic reasons (Songsore & Denkabe 1995), the movements of women are closely linked to marriage or family considerations (Boakye-Yiadom & McKay 2007; Quartey 2007). Other studies have also concluded that while females in the field of medicine opted for part-time jobs or left full-time work because of family responsibilities, their male counterparts did so because of higher wages (Foster et al. 2000; Fox, Schwartz & Hart 2006; Mayorova et al. 2005).

Ghana Health Service policy on postings supports health workers to be close to their spouses but this only applies where both partners work in the health sector. Even this has not been effectively implemented, because many participants mentioned this as a major challenge. On the other hand, one cannot overlook the difficulties that could be created for policy makers and management if such a policy was implemented, especially when the spouses work in different institutions. Nevertheless, it is an important issue that participants consider as an incentive that could motivate them to accept postings and stay longer in rural areas (as detailed in Chapter 5 of this thesis).

While many health workers emphasised the need for policy makers and management to enforce the postings policy on family proximity, there were a few who expressed different opinions. Reasons stated ranged from the poor economic situation in rural areas compared with cities and towns, and the desire to avoid financial pressure from extended family members. These workers argued that staying close to relatives could disrupt their work because of the numerous demands they were expected to fulfil. These included requests for financial support from nuclear and extended family members which sometimes put workers under undue stress. CHO 3 and DCO 1 explained:

> *The truth is that because this place is far from home, I can work without any interruptions from extended family pressuring me for money. You know how our family system works so as I am working in the north and my family in the south, it would be difficult for them to travel over here to request for money and other things so I am working here. You know that if they come and I am not able to give them what they want, they will call me a bad person* (CHO 3).

> *I like staying in this village to work because the living conditions are better here. I mean the amount of money you spend on food and other things are less expensive compared to Bolga town* (DCO 1).

Like many African countries, people in Ghana, especially in the northern sector, rely largely on support from extended families. This includes social and financial support. In some situations, an individual who fails to render support to extended family members is labelled *"a bad person"*, as can be seen in the first quote above. Therefore, to avoid family disputes and the confusion that could arise from an individual's inability to perform family obligations, some people opt to work in places that are far from where their families live. They believe this could prevent family members from getting easy access to them. Some health workers use this as a means of motivation to stay and work in rural areas, together with

other factors such as the low cost of living in these areas and the opportunities to be skilful and multipurpose (as detailed in Chapter 4 of this thesis).

6.5.2 Health Managers' Perception and associated political challenges

Health managers are faced with various policy issues during implementation. I have discussed the existence of policies aimed at the retention of health professionals in rural areas, but not all existing policies clearly describe methods for maximising retention. At best, what may appear to be suggestions about retention are in themselves subject to the politics of selectivity and the intersubjective interpretation of workers and their superiors. For example, while selective application is not approved in policies, in practice, political considerations have meant the creation of a class of untouchable and untransferable workers who, because of their political connections, cannot be posted from their comfortable locations. According to health managers, while some staff refuse postings to rural areas, at times orders are received from headquarters to release certain health workers from any obligation to accept transfer to other regions. Workers with fewer political connections who refuse to accept postings are reported and headquarters would then take the decision to dismiss them. This is what one human resource stakeholder, who spoke on the condition of anonymity, had to say:

> *The element of political involvement is also another challenge. Sometimes in trying to implement the policies, the political interference is overwhelming and you are sometimes compelled to just give in to their demand. Just yesterday, one of the pharmacists was posted here and has resumed work. We encouraged him to stay and he is working. I just received a call from headquarters which is the seat of government that there is a demand for that person to be sent back to Accra [regional capital]. I was surprised because 15 pharmacists were posted here but only 4 turned up and just after 2 months you call me demanding that one should be released to Accra which is already choked with professionals. The others refused to come. So as managers sometimes you have your own way of doing things but the political interference is a major problem* (Key Person 1).

Apart from political interference affecting the retention of rural health workers, another health manager expressed concerns about existing policies and suggested the need for modifications if the required impact is to be achieved. These included but were not limited to the policies on training and posting.

> *To retain health staff then there must be a whole lot of policy change. I think that a lot of mistakes are made right from the training of the staff to their postings to salary administrations and everything. How do they select the health workers for training and who does the selection? Everything is centralised. University of Ghana medical school conduct their interviews and select the students but*

are the people themselves committed and ready to serve in any part of the country including rural areas? I think before you are admitted to the health school you should first agree that you will go to the rural area to work instead of looking at high grade points, or the individual's family status in Ghana. If we begin to change from that point, we would see some improvements (Key Person 4).

In fact the government should do sometime about the posting policies. I will say that instead of posting the health workers to a district, rather post the salary since this can force the worker to report and work because that person can only access his salary if he gets to the district. This is very important because if you post a health worker to a rural area and he refuses to go, the person manages to stay in the city and work. So as the system makes it possible for people to reject postings, the people will continue to reject postings. Again why do the government pay a health worker in Accra the same salary as those in Navrongo? This is not fair at all. They have to reduce the salary of the person in Accra and add it to those in rural areas (Key Person 2).

According to the participants above, the processes of selection of health workers need to be revised by policy makers together with the content of training and then postings. They further explained that postings of health workers should be tied to various districts in the country to ensure compulsory service after school. This implies that, instead of the government handling health workers' salaries, the district to where they are posted should be responsible for salaries, consequently forcing health workers to accept that posting. This system could contribute to improving the health workforce in rural areas because compulsory service has successfully increased the number of health workers in rural areas (Reid et al. 1999). However, the challenge in implementing this measure could be the availability of appropriate structures in various districts. In accordance with the realist evaluation framework proposed by Pawson and Tilley (1997), the existing structures of a locality, which include elements such as systems, technology and economic status, are important to the successful implementation of interventions because they could influence the outcome of the intervention. Therefore, when trying to modify or institute new policies on postings for health workers policy makers need to assess contextual issues.

Although compulsory service has contributed to the retention of considerable numbers of health professionals in rural areas, the difficulties associated with managing it have been acknowledged by policy makers, leading to the introduction of financial incentives such as rural allowances (Lehmann, Dieleman & Martineau 2008; Sempowski 2004; Wibulpolprasert & Pengpaibon 2003). In the previous chapter I examined the use of financial incentives to get workers to perform their duties. In the next section, I will discuss the processes involved in creating these incentives and their overall impact on the health sector in Ghana. This is very

important because it gives the reader an understanding of the resources available to manage the health sector and what proportion is allocated for the provision of incentive packages to health workers, especially those in the rural areas.

6.6 Ghana Health Service Policy on Finance and Budget

The funds used in running Ghana Health Service facilities and teaching hospitals are obtained from the consolidated fund provided by Parliament, fees paid by patients to access health facilities, investment income and other sources. Before analysing finance and budget policies in place between 2002 and 2011, and the current policy through to 2021, it is important to give an overview of legislative processes involved in designing these fiscal policies. Not all fiscal policies have to be approved by Parliament because some post-fiscal budgets are expedited administratively and given Presidential approval, mostly in emergency situations. Most budgets, however, go through Parliament and it is important to understand the processes because they help us understand the reactions of workers which in turn affect their retention in rural areas.

Unlike other policy-oriented processes where Bills can be proposed by any public sector in the country, budgetary aspects of the Ghana Health Service require horizontal and vertical processes. Horizontally, local health facilities do their costings based on the overall needs of the localities in partnership with the health desk offices of the respective local councils. After this is done, costings are forwarded to the offices of the District Medical Officer (DMO) where they are given a thorough review. The DMO, in consultation with the district council, examines what has been costed and takes into consideration many issues, including, among others, population needs, the number of workers in each health facility and their levels of education. When the DMO is satisfied, the costings are forwarded to GHS headquarters for evaluation by the Minister for Health. This is usually done three months before the close of each financial year. The Minister of Health sends the draft budget to Parliament, where committees on Health, Human Resources and Finance deliberate on the content. During its passage through Parliament the Fiscal Bill, which is normally submitted by the end of the financial year, goes through five stages or ‘readings’: first and second readings, committee stage, third reading and finally, Presidential assent or approval. These stages are collectively known as the legislative process (GHS 1996; GHS, QHP & USAID 2006).

During the first reading, the bill is introduced to Parliament. A motion is called for the bill to be assigned to relevant committees, and a unique number is given to it. Once the committee has approved the timeliness, substance and clarity of the bill, they ask for the bill to be sent to the second reading. The approved draft of the bill is then read for the second time, where the focus is on technicalities. It is during this stage that the members of the Finance sub-committee will call in experts to evaluate the costings against a series of benchmarks, most of which revolve around donor conditionality. Examples of these benchmarks are evaluated through answers to questions such as: What has been costed? How can it be funded? Will it be based on value for money? Which sector will receive most, and why? Does the costing take into consideration the demographic needs of the community? Can the government afford to allocate the requested amount to the health facilities requesting it? If so, how will it impact on the share of other facilities and, in tandem, other non-health related sectors? These and many other pertinent, though mostly political, questions are answered.

At the third reading, the suggested amendments made in line with the expert advice from the second reading are prioritised. If the majority of committee members are satisfied with these amendments, they approve the amended bill to be tabled in Parliament for deliberation on its core areas. The focus is now on whether the government can afford what has been amended and approved by the committees involved in the previous stages. If the House of Parliament approves it at the 'House Committee' stage, it is then sent to the President of the Republic of Ghana for his signature. This final stage is known as the assent. The granting of this assent is methodically done to give the legislative process an executive seal of approval. Once approved, the bill ceases to be called a bill and is thereafter called an Act of Parliament.

These are the processes involved in creating the fiscal aspect of health workers' incentives. However, the interplay between the due process of the law and political due diligence, the administrative and legislative processes, become over politicised. Consequently, ordinary and mid-level health workers and management are somewhat excluded from this cumbersome, politicised process, although, in reality, this exclusion is more a perception than fact. In recent years, legislative and administrative processes have been subject to national laws on anti-corruption, freedom of information and peoples' participation (that is, when channelled through the stated procedural rules of both Parliament and the GHS). Even so, as will be explained in the discussion sub-section, even though workers are allowed to be part of the

process, those in the provincial areas, especially in the study area in the northern sector of Ghana, are sometimes discriminated against.

Regarding budgetary support for incentives and expenditures, the policy introduced to replace that which expired in 2011 included a performance benchmark put in place by the Government of Ghana. This benchmark centred on the use of investment in the human resource sector as a form of income generation, based on forward estimates of expenditures for the health sector. These expenditures included a projected average increment of 0.5% in the allowances of workers in selected health sub-sectors if the returns or dividend exceeded what was invested (in billions of cedis). Expatriate doctors from countries like Cuba, Egypt and China received about 12% of the total allocated allowances while locally trained Ghanaian health practitioners and workers received on average about 3% more. This appears to be a trend in the way the Ghanaian government funds the health sector. For instance, in their report, titled *Human Resource Policies and Strategies for the Health Sector 2007–2011*, the MOH (2011), in partnership with the World Health Organisation and the Quality Health Partners Consortium, reported that,

> "In 2004, 10.5 billion cedis was paid to health workers in 55 deprived districts from the Highly Indebted Poor Country (HIPC) [Initiative] inflow. However this incentive scheme was not implemented in 2005 [as recommended] due to difficulty in accessing funds from HIPC inflows, thus raising doubts about the scheme's sustainability. The MOH [was] therefore [forced by the prevailing situation to] reconsider ways of accessing funds for this scheme by incorporating the deprived area incentive (DAI) budget into the annual service [that is the GHS] budget of the sector" (MOH 2011, p. 10).

By this incorporation, the MOH took a unilateral decision to reduce the monies allocated to GHS for workers' incentives. In the end, GHS had no alternative but to rank its funding allocation based on preferences. Deprived areas, especially facilities in the north of the country, were already overlooked by central government, but the GHS placed them at the bottom of their preferences (Effective States and Inclusive Development 2016). This continued neglect has had a major impact on cash inflows from the MOH and GHS to remote health facilities in the north of Ghana. Conversely, with most expatriates working in the elite hospitals such as Korle-bu Teaching Hospitals, the MOH removed these hospitals from the direct control of the GHS and placed them under the control of the central government's

MOH. Now the Minister of Health had political oversight for these hospitals and the incentives paid to health workers in them differ considerably to the meagre sums that health workers in the north receive, that is, if they are even able to access such funds as and when are needed.

Without discounting the contributions of expatriates to the health sector, the discriminatory manner with which incentives are distributed exposes the problem of oversight. On one hand, the MOH has, as part of its policy, a requirement that calls for the involvement of GHS in the management of incentives to rural/remote health facilities. On the other hand, it took the political decision to reduce the annual budget of GHS by 10% (after 2015) and what was removed was later returned to the GHS budget under the category 'deprived area incentives'. What this means is that GHS was told, indirectly, to spend 10% of what was allocated to them annually by the government through the MOH to finance workers' incentives in the health facilities outside the control of the MOH. If the GHS has responsibility for and fiscal control over less important hospitals, why has the MOH not given the same rights to the GHS to oversee the financial activities of hospitals like Korle-bu Teaching Hospital? Irrespective of the competing answers to this question, one thing is certain, there is the need for a policy adjustment. The MOH (2011, p. 10) itself is aware that one key "retention strategy [is] the payment of additional duty hour allowance (ADHA) to health workers". The political heads of the MOH justified a reduction in funding to GHS by arguing that wage increases in the health sector in rural areas were not matched by an increase in workers' productivity. This rhetoric takes the discourse of political obligation to the largely poor populations in rural areas and replaces it with one about political gains the government, acting through the Minister of Health, intends to achieve in these areas.

The impact of such actions on staff attrition is considerable. The MOH conducted a review of numbers of vacancies, dismissals, resignations, retirements without replacement, terminations of appointment and deaths for the years 2007 and 2011 that revealed the downward trend (Ghana Health Service 2011). Health worker productivity mapping for the years 2006 and 2015 indicated that "the ADHA payments and salaries [for these years] accounted for 97 percent of the total government health expenditure and 67 percent of total government and donor health expenditure" (MOH 2007, p. 10). That notwithstanding, the MOH noted that the sector was aiming to negotiate for a comprehensive salary structure that would take into consideration the contributions of all sub-sectors of the GHS and the various categories of

health worker. As an outcome of these negotiations, the new salary structure to be in place by 2020 will reflect the roles of health professionals and their output, for the purposes of balancing the budget deficit. Some of the suggested ways for this to happen include the implementation of a new pay and incentive structure for the ADHA and the abolition of preferences for the health facilities under the direct control of the MOH, and the institution of new health training courses and schools to make it easier for health workers in remote areas to access education and training without having to go through the bureaucratic processes imposed upon them by their managers, as explained in Chapter 5.

6.6.1 Health Managers' Perceptions on Finance and Budget

Health managers have various perceptions regarding finance and budget considerations. Generally, they are of the view that insufficient funds are allocated to them to run facilities. Because the budget forwarded to Parliament is sometimes not fully approved, participants believed that this affected their capacity to provide appropriate incentive packages to workers. They also argued that money intended for the procurement of equipment for health service delivery priorities is inadequate. Hence, they experience difficulties in their efforts to provide adequate salaries, incentives and other assistance that would reduce workloads and associated stressors. One key stakeholder in the human resource sector of the GHS expresses what he believes were the causes and effects of the lack of oversight in the financial and budgetary aspects of health sector policies of Ghana; and, in tandem, what should be done to alleviate the situation:

> *You know when workers further their studies it would lead to upgrading which comes with increased salary. It also positions the worker for leadership roles such as heads of department, it also gives them some recognition in public because people feel that is those who pass their exams who go for degree courses and those who fail go for certificate course so as a health worker obtain a degree it means that person is good academically. All these things serve as incentives for the workers to improve their skills. Initially we use to pay their full school fees for them on condition that when you finish you will come to work in the facility for some number of years. Now we are not able to do this because funding has become difficult to access so we are not able to pay the entire fees. We only pay the admission fee but even that is for those who are going to school to do programs that are within the skills needs of the hospital so we look at our critical needs and pay for those who are going for such programs* (Key Person 2).

Some participants further explained that because resources were limited, especially for accommodation, the fringe benefits allocated to all health workers on a yearly basis have

been subject to political demands that are contrary to administrative policies. Without an effective administrative policy to balance excessive political involvement, the provision of incentive packages is not prioritised in the annual budget estimates. According to a participant, *"management makes these things privileges not a policy in their health facilities so as to minimise demands from the health workers"*. He went on to state that, overall, the situation is not what it seems. For him, it is not the pay that motivates people to work. Rather, what they do should be considered as part of their personal sacrifices, amid the commonplace instances of political and administrative corruption that are understood here to mean bribery, embezzlement and abuse of power and office:

> *You understand that resources are limited so we give incentives when we have the means. For accommodation and other allowances we don't make it a policy because if you make it a policy, people would demand their right so we make it a privilege. We recognise the sacrifices you are giving and we also give you a privilege because once you make it a rule then you have to defend the rule. The extra duty allowance is no more. There was a salary structure where some money was paid to the BMCs [Budgetary Management Centre] to pay allowances to staff who engage in additional hours of service but along the line they realised that management was abusing that system so now we are dealing with the single spine where your basic salary is fixed then your market premium which is based on so many factors that I cannot list is calculated in terms of money and added to the basic salary* (Key Person 4).

> *In year 2000, 10% of the salaries were added to those in rural areas but instead of the government doing that from Accra [the regional capital], it was delegated to the heads of the facilities to pay those monies so for a hospital, the medical superintendent was the one to administer that package so it got to a point that they could not pay due to lack of money so it died off. There was a waiver on car importation, means duty free but it was for all health workers not only for those in rural areas. At a point, it was taken off and only doctors were enjoying that but as at now nobody is enjoying that benefit after the change of government* (Key Person 1).

Adding to the challenge, there is the problem of misallocation and the inability of authorities to translate policy to action. Put another way, there have been situations where the budgeted funds approved for disbursement to the various districts within the study area were not made available to some centres. In some health centres visited during field work, participants disclosed that while records showed they were given certain amounts of money, they were unable to access these funds, which would have enabled them to provide health workers (especially those stationed in rural areas) with adequate incentives. However, care should be taken here. While the entire region where my field work was conducted is considered rural, there are also discrepancies in the manner in which the limited resources are disbursed.

In Chapter 5, I discussed the way in which the urban–rural politics of attraction (to the donor community) have affected the work of GHS. I explained how the presence of donors and NGOs in urban areas seems to have shaped the extent of the government's over-concentration of resources in urban areas when, in fact, they were expected to do more in the far-remote rural areas. This can also be seen in the nature of interventions within remote communities in rural areas. Some sections of these rural communities are considered peri-urban and others remote. As occurs in the metropolis of Accra, there is an over-concentration of interventions in peri-urban areas. It is not uncommon for health workers stationed in peri-urban areas to be better off than their counterparts (on the same level on the appointment scale) in rural areas. These, of course, are some of the isolated issues that have not been considered when analysing the impact of policy on incentives. To make it less 'Orwellian', the health managers have relied on their own discretion in the allocation of incentives:

> *The general criteria for choosing those qualified for the study leave incentive have been enshrined in the policy but we as managers implementing these policies also have element of prerogative to exercise and that is where we consider those who are working in the remote communities. If somebody in Bolga regional hospital and those in Zorko or Garu apply for further studies, we consider those from the rural areas. If they are more than necessary, we shift them to the next year* (Key Person 3).

> *There used to be what we call deprived area incentives where staff working in the rural areas where given 20% of their salaries but that didn't last long due to the 'no money syndrome'. I think it lasted for 2 years. The budget is always not enough so we have to manage but it would be good for them to take the needs of the facilities into consideration before allocating the money to the region* (PA 6).

As can be seen from the narratives above, because insufficient funds are allocated to health managers, described by the participant as the *'no money syndrome'*, they are unable to provide adequate incentives to motivate health workers in the Upper East region of Ghana. As detailed in Chapter 3, although the Upper East region where this study was conducted is considered predominantly rural, certain areas within the region are considered more remote, and as such there is need to give priority to health workers in these areas when allocating incentives. However, as expressed by Key person 3 above, the policy on posting and incentives does not allow consideration of the individual conditions in the localities where health facilities are located. No wonder some health workers expressed dissatisfaction and frustration at being transferred from one rural area to another. While it is encouraging that some health managers are aware of these important demarcations and use their discretion during transfers and reshuffling, the lack of clearly specified documented guidelines and

procedures comes with its own challenges, some of which were identified by health workers and described in the previous two chapters. These challenges include abuse of power, favouritism, unfair treatment and lack of transparency.

In summarising this section, the Ghana Health Service has various policies that regulate health workers in rural health facilities in the study area. These policies govern recruitment, postings and budgetary management. The narratives of participants have revealed that the money allocated to run the health facilities is insufficient at times, and this has limited the ability of health managers to provide adequate incentives to workers in rural areas. In addition, there was a problem of misallocation of available funds, whereby budgeted funds approved for disbursement to districts within the study area were not made available to some health facilities, which consequently made it difficult for them to obtain appropriate equipment for work and to provide incentives to motivate health workers. The terms of employment contracts were unclear about recruitment and posting policies, some important issues were not considered, and health managers used their discretion in tackling those issues. In the next section, the key issues that emerged from this chapter will be discussed.

6.7 Discussion

Appropriate policies contribute to establishing a well-organised and functional health system which responds in a balanced manner to the needs and expectations of the population by improving the health status of the people and providing equitable access to healthcare through an improved health workforce (WHO 2010). In Chapter 2, I explained in detail the essence of policy in regulating in the health system. Broadly put, these rules enhance the capacity of health institutions to achieve stated priority goals (Ward et al. 2016; World Health Organization 2014). In the formulation and implementation of policies that regulate workers, we have seen the creation of countless perspectives at both global and national levels alongside benchmarks that have been developed to access, monitor and evaluate policies (Daniels et al. 2000; Navarro 2008). The assessment procedures used in this study to analyse policy documents on recruitment, posting and finances coupled with the in-depth interviews revealed various delimiting issues that affect the success and failure of these policies.

In the Upper East region where this study was conducted, participants had different perceptions regarding these policies. While many health workers recognised the basis for being posted to rural areas, they conveyed unhappiness and dissatisfaction with the posting

process, which they further expressed, unfairness and non-transparency with the postings. The unfairness and non-transparency arise because contract terms are not clearly stated in the posting policy and hence they are not able to plan their career progression and their lives in general. As detailed in Chapter 5, most workers accepted that they had to work in rural health facilities but expected to be transferred to urban areas after working for a specified number of years. In practice, these workers remained working in rural areas for more years than anticipated and without knowing when they would be transferred. This is despite the Ghana Health Service policy on posting, designed to ensure that health workers posted to rural areas do not stay there for more than three years in these areas without being transferred (Ministry of Health Ghana, Quality Health Partners & World Health Organisation 2007). Because of this and other factors including uncertainties regarding the 'reshuffling' process and postings negotiations, health workers have seemingly lost trust in the posting system. They argued that, usually, postings that include transfers or reshuffling require an influential person to intervene on their behalf. This was what health managers described as political interferences.

Health managers in the study area considered interference from people in authority was a major challenge to successful implementation of policies on regulation of health workers' movements and their retention in rural areas, and this is consistent with complaints made by health workers. In Chapter 2, I explained that policies do not exist in a vacuum but rather they are created for and regulated by people, who despite their desires to enhance the welfare of the collective also have their individual competing needs and aspirations. However, it is important that the needs of the policy makers, politicians and other people in positions of authority do not override policy guidelines, because this could demotivate health workers, promote job dissatisfaction and negatively affect retention of health workers, especially in rural areas (Kwansah et al. 2012a). Other studies have recognised the need for implementers of policies to be seen as working with specified guidelines in carrying out their day-to-day activities by working towards the attainment and satisfaction of the public good (Bouckaert & Kuhlmann 2016; Loorbach 2010). This would enable the significant impact of policies to be realised by society in general, and more especially by the people for whom these polices were developed. To achieve this, policy should be characterised by accountability, transparency, flexibility and legitimacy, with popular support and not violating laws or the constitution.

Accountability and transparency are necessary for effective policy implementation, but these seem to be lacking in the policies used to regulate health workers in the study area. Health

managers explained the absence of specific guidelines for carrying out certain procedures, including transfers, reshuffling and distribution of incentives among health workers. In the absence of appropriate specified procedures or guidelines, health managers have no option but to use their own discretion in running health facilities. Consequently, where their efforts benefit only a few workers, which was observed in the study area, other workers feel neglected, demotivated and dissatisfied with their jobs, which affects their recruitment and retention in rural healthcare facilities.

The feeling of being neglected in rural health facilities was one concern of health workers in the study area. They attributed this to a lack of supervision from their superiors and their inability to access what was due them. This feeling of being neglected caused health workers in these deprived areas to lose hope about building their careers and improving their lives. It also deterred health workers in urban areas from moving willingly to rural areas to work (Kwansah et al. 2012a; Lehmann, Dieleman & Martineau 2008). This could be interpreted in the context of health workers' responses to their postings in the study area. Most workers had accepted positions in these rural facilities out of fear, dependence and lack of alternative jobs. In other words, they considered they had to do as their superiors directed. This is consistent with a study by Mensah (2002) who looked at why workers remained at their posts and identified directives from management as a key factor. As reported by health workers in the study area, failure to comply with directives from superiors regarding their postings implied they were prepared to lose their jobs and remain unemployed, which comes with its own problems.

In addition to points already discussed, several push and pull factors were identified that influenced health workers' perceptions of rural postings and government policies regulating their stay in rural areas. As explained earlier, these include factors such as workers' aspirations to achieve their goals and availability of basic necessities such as accommodation, security, social support and education. Health workers' desires to achieve these, as detailed in the previous chapter, could have affected their perceptions of existing policies. The push and pull factors can best be explained by Maslow's basic needs theory. In making sense of this basic needs theory, in relation to the recruitment and retention of workers in rural areas, African Health Placement (2014) contends that health workers should gain satisfaction from the various types of jobs they perform and the existence of a suitable environment for

workers to be willing to take full responsibility for what goes on in the workplace. In turn, this willingness brings with it a sense of achievement and personal development.

To a large extent, the inability of health managers to meet the needs of health workers is due to the insufficient funding allocated to health facilities, as the policy on finance and budget allocation stipulates. According to health managers, limited funds are often used to purchase immediate items needed to run the health facilities, such as drugs and other supplies. Little attention is given to meeting the basic needs of health workers. For instance, the effects of inadequate accommodation in rural areas are magnified when health workers realise that their colleagues are leaving because of these poor conditions. This both intensifies the workload and increases the awareness of loneliness (Dieleman et al. 2011). In relation to social support, health workers explained that loneliness is a common feature when practising in rural areas, but this can be either a pull or a push factor. It could be attractive to live far from the city to prevent financial pressure from family members, but rural health workers must cover long distances on bad routes to purchase basic food items and to see spouses and other family members. It becomes tiring and time-consuming when one has to travel several hours to accomplish everyday activities.

To this end, it is obvious that the level of implementation of policies for regulating health workers in rural areas is quite complex and needs to be amended for effective implementation.

6.8 Conclusion

This chapter has been written with the purpose of giving the reader an understanding of GHS policies and associated procedures on recruitment, posting and finance. It also touches on workers' perceptions of these policies, as a way of building on the suggested policy recommendations presented in the sub-sections of the concluding chapter. Divided into three parts, in the concluding chapter I present a summary of what this study has achieved and identify what should be the focus for policy makers and further research needed on the issues covered in this thesis.

CHAPTER 7
RECOMMENDATIONS, POSSIBLE IMPLICATIONS AND CONCLUSION

7.1 Introduction

Shortages of health worker in the Upper East region of Ghana remain a major challenge and this has necessitated the institution of interventions such as task-shifting and provision of incentive packages to improve worker retention. This study was designed to assess the strategies and policy interventions put in place to address health worker shortages in rural areas in the selected region and to get a better understanding of the push and pull factors that influence retention. Thus, the perceptions and experiences of health workers and managers regarding task-shafting practice and the existing incentive packages were explored.

In the first chapter, the introduction and background to the study were provided. A detailed analysis and discussion of theories and other literature relevant to the core issues of this study were presented in Chapter 2. In Chapter 3, the methodology used to conduct the study and its limitations were discussed. The study findings discussed were presented in Chapters 4, 5 and 6 of this thesis, wherein the objectives of this study were addressed. The first and second objectives were to explore existing interventions put in place to retain health workers in rural areas of the Upper East region and the extent to which those interventions worked, the third and fourth objectives required examination of the extent of task-shifting practice and the push and pull factors that affected worker retention in these primary health care facilities.

This concluding chapter will begin with a summary of the key findings of this study. A summary of what the study has achieved will be presented, showing the contribution of the study to existing knowledge on addressing rural health worker shortages. I will discuss the possible implications of the study which offer possible ways forward to improve task-shifting practice, incentive packages, and the push and pull factors that affect health worker retention in rural areas in the Upper East region of Ghana. I suggest what policy makers should focus on and identify issues where further research is needed. The chapter ends with the general conclusion to this thesis.

7.2 Summary of Key Findings

This study has shown that apart from performing their official tasks in healthcare facilities in the study area, because of insufficient numbers of health workers the different cadres of health workers also engaged actively in additional tasks to sustain health facilities. The study has revealed the positive and negative perceptions and experiences of task-shifting as detailed in Chapter 4. Positive experiences included contributing to teamwork, meeting the expectations of patients, and being encouraged to take up additional tasks to save the lives of patients and acquiring new skills, thereby enabling workers to identify their areas of expertise for future career progression. Negative experiences were linked to increased workload causing stress, lack of motivation and concerns about making errors in prescriptions for patients. The study identified issues such as inadequate training and lack of supervision as factors that negatively affected the successful implementation of task-shifting practice.

Although report from the World Health Organisation (2006) recommends adequate training as an important component for task-shifting practice, most health workers in the study area were not trained before additional tasks were handed to them. As such, sometimes they did not know how to carry out medical procedures appropriately, such as conducting consultations with patients or assisting pregnant women to deliver. This lack of knowledge sometimes resulted in threats to the health status of their clients, showing the dangers associated with the lack of training in task-shifting practice. Almost all participants were aware of the possible implications of their actions but were more concerned with 'going the extra mile' to save patients' lives. This demonstrated their level of commitment towards their health profession. The strength, encouragement and satisfaction gained by taking on more tasks were derived from the teamwork approach employed by health workers. As documented in other studies, teamwork and training motivate health personnel and lead to increased satisfaction (Stilwell et al. 2004; Wibulpolprasert 1999). This is important because health workers' satisfaction has a great influence on motivation and this affects their job performance and further stimulates their retention (Deriba et al. 2017; Stilwell et al. 2004). Despite the increased workload experienced by health workers because of task-shifting, they also felt a sense of self-worth for taking up additional tasks. In the perspectives of these health workers, especially the in-charges (heads of the health facilities), taking up tasks beyond their abilities in health facilities was necessary for workers to demonstrate their competence to patients and their superiors. Workers perceived that showing their competence

in such a manner could enable them to gain recognition from their superiors which could eventually be accompanied with rewards such as promotion and easy access to incentive packages, although they complained of not receiving adequate motivation.

The willingness of health workers to do more work than they were officially trained to do, regardless of outcomes, has to some extent served as a source of motivation for health managers to encourage them to engage in additional tasks so as to maintain health facilities, as discussed in Chapter 4. However, the actions of these health workers and managers call into question the value attached to medical ethics in regulating health centres. In his study on the role of managers and leaders, Otara (2011) explained that although managers are assigned employees with whom they must work to achieve the objectives of the organisation, this should not be interpreted to mean they are exempt from exercising their responsibility to uphold organisational ethics in the performance of their duties. In this study, health workers were encouraged to take on additional tasks by health mangers, who are supposed to ensure that appropriate medical ethics are observed in health facilities. This implies that participants have compromised the ethical considerations governing the management of rural health facilities.

Another important finding in this study was discovery of the complexities associated with the distribution of incentive packages to health workers. Workers and managers had competing perspectives and experiences regarding incentive packages, and workers identified suggested incentives that could motivate them to remain in rural areas. These issues were covered extensively in Chapter 5 of this thesis. Although the level of awareness of incentive packages varied between different cadres of health workers in the study area, most were generally not aware of the full package of incentives they were entitled to, and this shows the need for intensified efforts to create awareness among health workers. This is relevant because it is assumed that if individuals are not aware of the full package of incentives, they cannot attach importance to it. Apart from lack of awareness, many health workers had not been able to access their incentive entitlements as stipulated by policy. As detailed in Chapter 5, the distribution of incentives is complex because it is left to the discretion of managers to decide who should benefit, instead of allocating them to staff who are entitled to benefit from them. The power exhibited by managers over health workers regarding incentives distribution has resulted in health workers losing trust and hopes in their managers. This shows that managers need to use power appropriately in regulating health workers.

However, there were challenges for health managers concerning incentives allocation because of the absence of appropriate guidelines to adhere to and their desire not to compromise the needs of health facilities in their attempts to distribute incentive packages. These experiences and perceptions have resulted in considerable tension between health workers and managers. Nevertheless, some health workers who did benefit from incentive packages believed they were not attractive enough to serve the purpose of retaining them in rural areas, partly because colleagues in urban areas benefited from similar packages. As explained by Pawson and Tilley (2007), issues about conditions of localities need to be considered for effective implementation of interventions.

Health workers also suggested additional incentives they regarded as attractive and which could motivate them to stay longer in rural areas. Participants suggested modifications to some existing incentive packages, reinstatement of previous incentives and the institution of additional incentives. As detailed in Chapter 5, incentives that needed modification were courses and certificates offered in health training schools, a reduction in the number of years of service needed to qualify for study leave, and improvements in workshops and in-service training materials. The incentives workers wanted reinstated included deprived area allowances, work uniforms and waiver of duty for imported cars. Additional financial incentives that participants suggested could motivate them were responsibility allowances to compensate for additional hours worked, increases in salaries and rural allowances. Some health facilities, especially those run by CHAG, have instituted allowances called '7½', where 7½% of a worker's basic salary is given as an incentive. This is an internal arrangement in health facilities, but its implementation is problematic because not all the health workers had benefited from it.

Participants also suggested additional non-financial incentives such as provision of adequate accommodation, frequent and adequate supervision, proximity to family in postings, displays of appreciation from superiors, and opportunities to attend more workshops and in-service training. Staff called for walls to be built around health facilities, and for security staff to be employed to give protection against robbery and other havoc. They believed seasonal gifts of foodstuffs such as cooking oil and rice, and social amenities such as appropriate schools, markets, and reliable sources of drinking water would aid retention and they also called for work-related incentives such as motorbikes and fuel for work, ambulances to speed up referral processes, water storage containers and work equipment. Some of the incentive

packages identified were specific to particular health facilities in the study area, showing that even within the same district there were differences in the types of incentives health workers might benefit from. This has created an imbalance in the distribution of incentives that health workers were aware of. They usually compared what they received as incentives with those received by their colleagues in other facilities, and in situations where great disparities existed among those who received few or no incentives became demotivated. This reflects the importance of restructuring the policy regulating various aspects of health facilities in rural areas, including incentives packages.

As discussed in Chapter 6 of this thesis, this study revealed details from an analysis of policy documents related to health facilities, and participants' perceptions and experiences regarding these policies, specifically on recruitment, postings and financial considerations. Health workers regarded recruitment and posting processes as unfair because the terms of their employment contracts were unclear. They wanted clarity and transparency about recruitment and postings, with the processes for transfer and reshuffling clearly specified, together with details of their incentive entitlements. These changes would enable health workers to regain their trust in the health system. Health facilities are adversely affected by inadequate funds and misallocation of the available funds. From time to time, health managers experienced interference from politicians or their superiors which negatively affected successful implementation of policies. Different push and pull factors that could influence health workers' perceptions of these policies included family proximity, feelings of loneliness and concerns of unmarried workers that they would not find suitable partners in rural areas. Therefore, policies need to be modified by clarifying terms and contracts for health workers and by incorporating additional guidelines and procedures. Health workers and managers should be able to follow procedures without interference.

7.3 Implications of the Study

The study findings offer policy makers, health managers and health workers a deeper and better understanding of task-shifting practice, incentive packages for motivating and retaining health workers in rural areas, push and pull factors and the impact of government policies in the management of the health sector in Ghana. The study has highlighted essential issues of human resource management in the health sector by explaining the perceptions and experiences of health workers and their managers, which have greatly affected the running of health facilities in rural areas. The study provides various stakeholders in the health sector

with awareness that health workers in rural areas have varied perceptions and experiences regarding task-shifting and incentive packages, and these perceptions influence their retention and in turn, healthcare delivery in these areas.

Generally, in the study of management—understood here as the practice of developing an adaptive culture of regulating people, their inputs and outputs—the dynamics of human behaviour is complex. This complexity is borne out of the dilemma of not knowing, firstly, how to measure the motivation and/or demotivation of employees; secondly, not knowing whether change and innovation can occur where there are differences of opinion and competition between governance policies and political mandates; and thirdly, not knowing whether quality and performance of service delivery can be assured in situations where ethics are weighed down by self-seeking interests. The perceptions of health workers and managers have revealed tensions in the way that interventions-for-motivation are managed, and the long-term impact of such interventions on the processes of coordination (including the coordinated ways workers' competing perspectives are mainstreamed into policy). What this study reveals is the difference in perspectives between the managers and the managed. The former, trained in the Weberian diktat on managerial bureaucracy, is expected to aspire (at least in the Ghanaian context) towards enforcing the traditional, rigid approach to the management of the facility and the worker, the managed (that is, the ordinary worker) aspires towards reaching that time when policy will focus on change and where the work will be less complex and more rewarding.

However, the findings of this study do not suggest that managers and workers lack awareness of the plight of the other. Rather, the problem has to do with the inability of both parties to tailor their perceptions, eliminate differences and work towards building healthier work-related experiences. For instance, the competing perspectives of health workers and managers on incentive packages revealed strong tensions between them, which indicate the need for appropriate mechanisms to be put in place to build a healthy working environment for quality healthcare delivery. It is evident from the study that most health workers in the study area are not aware of their full package of incentives and they also regard certain incentives as unattractive. This shows the need for a mechanism to raise health workers' awareness about their incentives entitlement, because the ways in which people receive and understand information shapes their perceptions. This, coupled with other findings on lack of clarity in working contracts, posting and reshuffling processes, has shaped health workers' trust and

perceptions about existing interventions. Other factors that shape health workers' perceptions include their unique frame of reference—that is, how their experiences influence their reflexive responses to the different situations they find themselves in and the amount of energy that is put into accomplishing a task within healthcare facilities. In the study of organisational behaviour, these issues as discussed in Chapters 4, 5 and 6 are very important although often ignored, despite their tremendous impact on the trends and processes of an organisation's management structure.

The perceptions and experiences of health workers and managers on task-shifting, specifically on health workers performing clinical tasks in rural health facilities without adequate training and supervision, signal the need for change in the organisational management structure in regulating health facilities. This should take into consideration issues of superiors' influence on ethical work practices, workers' enthusiasm for their work, specialisation (in one or more areas) and workers' social backgrounds, because these factors affect perceptual processes in organisations (Otara 2011). The findings suggest the need for health managers to develop positive influences towards adhering to ethical work practices regardless of the circumstances in rural areas for quality healthcare delivery, which includes ensuring that health workers are well trained before engaging in additional clinical tasks and supervising them to ensure that tasks are performing accordingly. From the health workers' perspectives, the expectations of patients and the enthusiasm they have for their work pushes them to take up additional tasks beyond their skills to save lives and satisfy patients. The issue of patients' high expectations of health workers has led to their refusal to comply with referrals to higher health facilities for appropriate treatment, which has worsened their health status and subsequently led to deaths.

According to health workers, one reason patients expect more from them is because of their inability to distinguish between the different cadres of health worker. Reasons cited for patients refusing referrals, which demotivates health workers, included lack of money to hire vehicles to transport them to urban health facilities, the travelling on bad roads and the costs of treatment. Patients' responses to referral were also affected by the challenges they faced in finding their way around the larger health facilities when health workers could not be spared from the rural health facility to accompany them.

The diverse issues discussed above indicate the need for intensive education in rural communities to inform community members about the job descriptions of the different cadres

of health workers and the need for patients to respond to referrals. The transport challenges show the need for an appropriate ambulance system in health facilities, while enforcement of the National Health Insurance Scheme would help meet patients' medical costs. There are great differences between urban and rural health facilities in Ghana in terms of their structures and modes of operation. Hence it is necessary for patients referred from rural areas to larger health facilities to be accompanied by a health worker to ensure quick access to health care. The health worker would be able to stabilise the referred patient's health until they arrive at the health facility for appropriate treatment. These patient-related changes need to be incorporated into existing health policies.

Patients' expectations and health workers' willingness to do more work provide a good opportunity for the government to upgrade health workers in rural areas and equip facilities with equipment necessary for delivery of health care at a higher level. Issues of specialisation, where health workers are trained in one or more areas to give them the skills to run health facilities, would be necessary but would require a financial commitment from the Ministry of Health. As seen in this study, health managers are concerned about the limited funds allocated to health facilities and this needs to be taken into consideration before they would be able to institute appropriate mechanisms for the successful implementation of task-shifting practice to reduce the impact of rural health worker shortages and to offer appropriate incentive packages to improve staff retention.

Participants in the study spoke of the value of rural training and orientation in preparing them psychologically and physically to work in rural health facilities. Hence the Ministry of Health, Ghana, needs to intensify these activities. This also highlights the need for the establishment of health training schools in rural areas of Ghana. Other push factors such as bad road networks, lack of good schools, lack of entertainment, inadequate security and lack of appropriate markets were shown in this study to have a negative influence on health worker retention in the rural areas and to necessitate inter-sectoral collaboration.

Because some of the issues needed to address health workers' retention go beyond what the health sector can provide, collaboration between other sectors that directly or indirectly have roles to play needs to be strengthened. Adedayo (2010) suggests that inter-sectoral collaboration is necessary for the proper functioning of the health sector especially in providing primary health care, because the health sector cannot solely handle the issues concerning health in totality. In this study, other political sectors need to be involved

appropriately if the Ghanaian health sector is to function efficiently because interference from politicians was a major issue militating against the successful implementation of policies meant to regulate health facilities in rural areas. Don (1998), writing about health promotion, also argues that while embarking on strategies such as dissemination of information and provision of skilled workers is important, these alone are not enough, and it is necessary that the social and physical surroundings are modified in a manner that promotes adequate health delivery. As shown in this study, the suggested incentive packages described by health workers cannot be provided by the health sector without adequate support from other relevant organisations in Ghana.

7.4 Recommendations

The study findings can be used to improve task-shifting practice. This could reduce the impact of health worker shortages in the Upper East region of Ghana and enhance the implementation of incentive packages. Together, these changes may motivate health workers to accept posting to rural areas willingly and remain there to provide quality healthcare delivery. The findings also indicate how existing policy documents governing recruitment and posting of health workers can be improved, along with budgetary considerations. Recommendations to improve task-shifting practice in the study area include adequate training for health workers before additional clinical tasks are handed to them, appropriate supervision to ensure that tasks are carried out properly, education about the need to adhere to medical ethics, and ways of reducing stress and work overload in health workers.

For existing incentive packages to achieve the purpose of motivating health workers and influencing their retention, the study findings indicate that a well-organised allocation of incentives to beneficiaries is needed, with appropriate guidelines in place to ensure that all health workers benefit from the incentive packages and appropriate monitoring systems to ensure that health managers treat all health workers fairly. New incentive packages that are comprehensive and more attractive to workers are needed. There should be a clear distinction between incentive packages for health workers in rural areas and those in the urban areas. Regarding policies on recruitment and posting, clearly defined guidelines should be incorporated into existing policies and adhered to by health managers. This could prevent health managers from exercising their own discretion on allocation of incentives.

Based on the results of this research, the following recommendations are made by the researcher to the different stakeholders of the health sector in Ghana.

7.4.1 District Health Management Team (DHMTs)

District Health Management Teams should ensure that health workers in rural areas are adequately trained before they are allowed to handle additional tasks, especially clinical tasks. They should also ensure that workers are properly supervised by heads of facilities (the in-charges) to ensure that required appropriate medical procedures are followed for quality healthcare delivery. Additionally, there is the need for DHMTs, headed by the district directors of health services, to work in close collaboration with the regional health directorate to ensure that health workers in rural areas are adequately informed about availability of incentives entitlements put in place to motivate them, and to promote fair distribution of incentive packages among the different cadres of health workers. The DHMTs should also sensitise community members on the need to adhere to referrals from health workers in rural areas, and they should encourage health managers and in-charges to show appreciation to health workers by saying 'thank you' and applauding their efforts.

7.4.2 Ministry of Health (MoH) and Ghana Health Service (GHS)

The Ministry of Health and the Ghana Health Service should ensure that health workers are distributed throughout the country according to needs. They must also ensure that appropriate health policies are in place to regulate health facilities in rural areas. These should include mechanisms to ensure that political interference is minimised, if not eliminated, to enable health managers to carry out their duties efficiently in the Upper East region of Ghana. The MoH and GHS should also ensure that adequate funds are allocated to run health facilities efficiently, existing incentive packages are modified to be more attractive to health workers, and new incentives put in place to motivate them. They need to design different incentives for health workers in rural and urban areas and involve health workers in the formulation of their incentive packages.

Appropriate policies on task-shifting practice should be instituted to ensure that correct procedures are followed by health workers and managers. The MoH and GHS are supposed to ensure that health workers' employment contracts are clearly defined and adhered to by their immediate superiors. The MoH and GHS need to work in close collaboration with other relevant sectors in Ghana to provide more comprehensive incentive packages to rural health

workers. They need to conduct regular research to understand health workers' preferences regarding incentive packages to provide more attractive incentives.

7.4.3 Government of Ghana

The government needs to ensure the various development sectors within the country work in close collaboration with various departments within the health sector to provide a program of comprehensive social development in rural areas of the Upper East region instead of stand-alone interventions. Adequate social amenities such as efficient road networks, good schools with well trained teachers, effective security systems and locating spouses close to their partners are important to attract and retain health workers in rural communities. The government should therefore ensure that these social amenities are provided by the appropriate sectors in all rural areas, especially where health centres are situated, to prevent health workers from being pushed out of rural communities and to pull additional workers into these areas. The government needs to put mechanisms in place to prevent politicians and other people who occupy high positions in the seat of government from interfering in the regulation of the health sector.

7.4.4 Recommendations for Further Research

The results and concerns raised in this research study indicate potential avenues for future research. There is need for research to investigate the consequences of task-shifting from patients' perspectives, and to assess the quality of care delivery during task-shifting. A cost–benefit analysis of involving health workers in the formulation of incentive packages could enable health managers and policy makers to ascertain the importance of such involvement.

7.5 Conclusion

In this study, I have assessed the extent of implementation of task-shifting practice aimed at reducing the impact of health worker shortages in the Upper East region of Ghana, and the effectiveness of incentive packages designed to motivate health workers and improve their retention in rural areas. Relevant policies that regulate the recruitment and posting of health workers and budgetary considerations were also assessed. As detailed in this thesis, the formulation, implementation and associated consequences of policies regulating the management of human resources for health are complex issues when viewed from the processes used in them. The success or failure of task-shifting and incentive packages depend on policies that are instituted and the ways in which political influences and the medical

understanding of healthcare provision and services interact to produce conditions that influence the experiences and perceptions of health workers in rural areas.

In practice, task-shifting has the potential of serving the intended purpose of helping to reduce the impact of insufficient numbers of health professionals in the study area, but adequate training is needed to equip health workers with the necessary skills and adequate supervision is essential. Health workers and managers should not only aim at sustaining rural health facilities through task-shifting but should also consider the level of healthcare. Policies need to be formulated to ensure that task-shifting is managed effectively because allowing untrained health workers to perform tasks that require formal clinical training breaches medical and workplace ethics. Appropriate compensation mechanisms in the form of incentive packages should be instituted to motivate health professionals who take up additional tasks.

Further, there is the need to consider contextual issues in the formulation of incentive packages to ensure they are attractive, taking into consideration the preferences of health workers who are the beneficiaries of packages. In this thesis, I have shown that both financial and non-financial incentive packages may influence health worker retention in rural areas, but the level of effectiveness depends on the type of incentives and health workers' preferences. As such, it is important to understand the views of the health workers for whom these incentives are intended, to improve performance and gauge their willingness to remain in rural areas for longer periods. The distribution of available incentives needs to be appropriately organised within the region to ensure fairness in their allocation.

The policy implications of the use of incentives and the associated connections to power and influence over health workers' aspirations, capabilities and attitudes could be addressed by ensuring employment contracts are clearly defined and through effective communication between workers and their managers. There is a need for modification of existing policies regulating human resource issues in rural health facilities, including policies on recruitment, postings and finance, to enable the workers to build trust in the health system. Because most of these health workers are female, their needs should be considered in the formulation of policies to achieve the desired outcome of health workers attraction and retention in rural areas. Married health workers may wish to have their employment locations linked to those of their spouses, while unmarried female staff are concerned about their chances of finding suitable husbands in rural areas.

In this research, I have identified the implications of and offered recommendations for task-shifting practice, incentive packages and policy implementation. The implementation of my recommendations could contribute to improving the success of task-shifting and incentive packages which could subsequently result in improving health worker retention in rural areas for quality health care delivery.

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APPENDICES

Appendix 1: Ethics Approval from Flinders University

FINAL APPROVAL NOTICE

Project No.: **6804**
Project Title: Assessing Policies and Strategies to Reduce the impact of Health Worker Shortages in Primary Health Care Facilities in Ghana.
Principal Researcher: Ms Eunice Okyere

Email: okye0002@flinders.edu.au;euniceadoma@yahoo.co.uk
Approval Date: 21 April 2015 Ethics Approval Expiry Date: **20 April 2019**

The above proposed project has been **approved** on the basis of the information contained in the application, its attachments and the information subsequently provided with the addition of the following comment(s):

Additional information required following commencement of research:

1. Other Ethics Committees
Provision of a copy of the ethics approval notice from the Navrongo Health Research Institute Ethics *on receipt*. Please note that data collection should not commence until the researcher has received the relevant ethics committee approvals (item G1 and Conditional approval response – number 18).

RESPONSIBILITIES OF RESEARCHERS AND SUPERVISORS

1. Participant Documentation
Please note that it is the responsibility of researchers and supervisors, in the case of student projects, to ensure that:

- all participant documents are checked for spelling, grammatical, numbering and formatting errors. The Committee does not accept any responsibility for the above mentioned errors.

- the Flinders University logo is included on all participant documentation (e.g., letters of Introduction, information Sheets, consent forms, debriefing information and questionnaires – with the exception of purchased research tools) and the current Flinders University letterhead is included in the header of all letters of introduction. The Flinders University international logo/letterhead should be used and documentation should contain international dialling codes for all telephone and fax numbers listed for all research to be conducted overseas.

- the SBREC contact details, listed below, are included in the footer of all letters of introduction and information sheets.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 6804). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 82013116, by fax on 82012035 or by email human.researchethics@flinders.edu.au.

2. Annual Progress / Final Reports

In order to comply with the monitoring requirements of the *National Statement on Ethical Conduct in Human Research (March 2007)* an annual progress report must be submitted each

- any complaints regarding the research are received;
- a serious or unexpected adverse event occurs that affects participants;
- an unforeseen event occurs that may affect the ethical acceptability of the project.

Appendix 2: Ethics Approval from Ghana

In case of reply the number and date of this letter should be quoted.

My Ref. App/HWinPHC/07/2015
Your Ref:

Navrongo Health Research Centre
Institutional Review Board
Ghana Health Service
P. O. Box 114
Navrongo, Ghana
Tel/Fax: +233-3821-22348

Email: irb@navrongo.mimcom.org

20th July, 2015.

Ms. Eunice Okyere
100 Winston Avenue
Melrose Park 5039
Adelaide, South Australia

ETHICS APPROVAL ID: NHRCIRB204

Dear Ms. Okyere,

Approval of protocol titled *Assessing Policies and Strategies to reduce the impact of Health Worker Shortages in Primary Health Care Facilities in Ghana.*

I write to inform you that following your satisfactory address of the concerns raised by the Navrongo Health Research Centre Institutional Review Board (NHRCIRB) during its full Board review of the above-mentioned protocol, the Board is pleased to grant you approval.

The following documents were reviewed and approved:

- Completed New Protocol submission form
- Summary of Protocol
- Study protocol Version 2 dated 13/07/2015
- Participants' information sheet
- Consent forms – English Version 1 dated 13/07/2015
- Interview guide - Version 1 dated 13/07/2015
- Curriculum Vitae of Investigators

Please note that any amendment to these approved documents must receive ethical clearance from the NHRCIRB before implementation.

Should you require a renewal of your approval, a progress report should be submitted two (2) months before the expiration date. This approval expires on **19th July, 2016**.

The Board wishes you all the best in this study.

Sincerely,

Dr. John Koku Awoonor-Williams
(Chair, NHRCIRB)

Cc: The Director, NHRC

Appendix 3: Letter of Introduction

Dr Lillian Mwanri, PhD
Discipline of Public Health
School of Health Sciences
Faculty of Medicine, Nursing and Health Sciences
Level 2 Health Sciences Building,
Registry Road, Bedford Park South Australia
GPO Box 2100
Adelaide SA 5001
Tel: +61 7221 8417
Fax: +61 7221 8424

LETTER OF INTRODUCTION

Dear……

This letter is to introduce Ms Eunice Okyere who is a PhD student in the School of Health Sciences, faculty of Medicine, Nursing and Health Sciences. She will produce her student card, which carries a photograph, as proof of identity.

She is undertaking research leading to the production of a thesis or other publications on the subject of "Assessing Policies and Strategies to Reduce the Impact of Health Worker Shortages in Primary Health Care Facilities in Ghana" .

I would be most grateful if you would assist in this project, by involving in an in-depth interview which covers certain aspects of this topic. No more than 45 minutes would be required.

Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.

Any enquiries you may have concerning this project should be directed to me at the address given above or by telephone on +6172218417, by fax on +6172218424 or by email lillian.mwanri@flinders.edu.au

Thank you for your participation.

Dr Lillian Mwanri

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number 6804). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au.

Appendix 4: Information Sheet for Health Workers

INFORMATION SHEET

Title: Assessing Policies and Strategies to Reduce the Impact of Health Worker Shortages in Primary Health Care Facilities in Ghana.

Investigators:
Eunice Okyere (Researcher)
Dr. Lillian Mwanri & Professor Paul Ward (Supervisors).
Discipline of Public Health
School of Medicine
Faculty of Medicine, Nursing and Health Science
Flinders University
Ph: +61 8 7221 8453

Description of the study:
This study is a qualitative study that seeks to understand the perceptions and experiences of health care workers and health managers so as to get a deeper insight into the extent to which various policies and strategies are impacting on the retention of health workers in primary health care facilities. Different categories of health workers will be interviewed about the awareness and perception of incentive packages put in place to motivate them. This project is supported by Flinders University Discipline of Public Health.

Purpose of the study:

- To assess the level of implementation of policies and interventions put in place to retain health workers in primary health care facilities in the Upper East Region of Ghana.

What will I be asked to do?
You are invited for an in-depth interview that will ask you a few questions about your awareness and perception of incentive packages, benefits received, factors that attracts or repel you and your routinely and additional performed tasks in this facility. The interview will take about 45 minutes. It will be recorded using a digital voice recorder to help with looking at the results. Once recorded, the interview will be transcribed (typed-up) and stored as a computer file and then destroyed once the results have been

finalised. This is voluntary. You will also be given the opportunity to review and edit your interview transcript if there is the need to do so.

What benefit will I gain from being involved in this study?
The sharing of your views and experiences could inform policies which could contribute to addressing the problem of health worker shortages in rural communities to improve the general well-being of the people.

Will I be identifiable by being involved in this study?
You will be anonymous. Once the interview has been typed-up and saved as a file, the voice file will then be destroyed. Any identifying information will be removed and the type-up file stored on a password protected computer that only the researcher (Ms Eunice Okyere) will have access to. Your comments will not be linked directly to you.

Are there any risks or discomforts if I am involved?
There are no risks associated in this research. What I require from you is simple and accurate answers to the questions. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the investigator. To prevent the risk of identification, the information that is collected from you will be used only for the purpose of this study. This form which I will use to take the information from you will be kept under lock and key during and after the study period. The individual response you provide will not be made available to anybody else except the principal investigator. It will be kept in confidence.

Alternative to Participation
You can decide not to take part in this study at any time and your decision will not affect your relationship with the researcher, your employers or any other person.

How do I agree to participate?
Participation is voluntary. You may answer 'no comment' or refuse to answer any questions and you are free to withdraw from the interview any time without effect or consequences. A consent form accompanies this information sheet. If you agree to participate please read and sign the form.

How will I receive feedback?
Outcomes from the project will be summarised and given to you by the investigator if you would like to see them. I will leave my phone number and email address with you to contact me if you would want to see the key finding findings of the research. I will come and present the key findings to you if am still in the field. If I have already left, I will email the key findings to you.

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number .....). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

Appendix 5: Information Sheet for Health Managers

Flinders UNIVERSITY
ADELAIDE • AUSTRALIA

INFORMATION SHEET

Title: Assessing Policies and Strategies to Reduce the Impact of Health Worker Shortages in Primary Health Care Facilities in Ghana.

Investigators:
Eunice Okyere (Researcher)
Dr. Lillian Mwanri & Professor Paul Ward (Supervisors).
Discipline of Public Health
School of Medicine
Faculty of Medicine, Nursing and Health Science
Flinders University
Ph: +61 8 7221 8453

Description of the study:
This study is a qualitative study that seeks to understand the perceptions and experiences of health care workers and health managers so as to get a deeper insight into the extent to which various policies and strategies are impacting on the retention of health workers in primary health care facilities. Different categories of health workers will be interviewed about the awareness and perception of incentive packages put in place to motivate them. This project is supported by Flinders University Discipline of Public Health.

Purpose of the study:

- To assess the level of implementation of policies and interventions put in place to retain health workers in primary health care facilities in the Upper East Region of Ghana.

What will I be asked to do?
You are invited for an in-depth interview that will ask you a few questions about your awareness and perception of incentive packages, benefits received, factors that attracts or repel you and your routinely and additional performed tasks in this facility. The interview will take about 45 minutes. It will be recorded using a digital voice recorder to help with looking at the results. Once recorded, the interview will be transcribed (typed-up) and stored as a computer file and then destroyed once the results have been finalised. This is voluntary. You will also be given the opportunity to review and edit your interview transcript if there is the need to do so.

What benefit will I gain from being involved in this study?
The sharing of your views and experiences could inform policies which could contribute to addressing the problem of health worker shortages in rural communities and could contribute to improving the general well-being of the people.

inspiring achievement

Will I be identifiable by being involved in this study?
Your name and job information will not be explicitly identified. Once the interview has been typed-up and saved as a file, the voice file will then be destroyed. Any identifying information will be removed and the type-up file stored on a password protected computer that only the researcher (Ms Eunice Okyere) will have access to. Your comments will not be linked directly to you.

Are there any risks or discomforts if I am involved?
There are no risks associated in this research. What I require from you is simple and accurate answers to the questions. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the investigator. To prevent the risk of identification, the information that is collected from you will be used only for the purpose of this study. This form which I will use to take the information from you will be kept under lock and key during and after the study period. The individual response you provide will not be made available to anybody else except the principal investigator. It will be kept in confidence.

Alternative to Participation
You can decide not to take part in this study at any time and your decision will not affect your relationship with the researcher, your employers or any other person.

How do I agree to participate?
Participation is voluntary. You may answer 'no comment' or refuse to answer any questions and you are free to withdraw from the interview any time without effect or consequences. A consent form accompanies this information sheet. If you agree to participate please read and sign the form.

How will I receive feedback?
Outcomes from the project will be summarised and given to you by the investigator if you would like to see them. I will leave my phone number and email address with you to contact me if you would want to see the key finding findings of the research. I will come and present the key findings to you if am still in the field. If I have already left, I will email the key findings to you.

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number .....). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

Appendix 6: Consent Form for Health Workers

CONSENT FORM FOR PARTICIPATION IN RESEARCH
(by interview)

Assessing Policies and Strategies to Reduce the impact of Health Worker Shortages in Primary Health Care Facilities in Ghana.

Introduction

This study is a qualitative study that seeks to understand the perceptions and experiences of health care workers and health managers so as to get a deeper insight into the extent to which various policies and strategies are impacting on the retention of health workers in primary health care facilities. Different categories of health workers will be interviewed about the awareness and perception of incentive packages put in place to motivate them.

Purpose of the study

The purpose of the study is to assess the level of implementation of policies and interventions put in place to retain health workers in primary health care facilities in the Upper East Region of Ghana.

Procedures

You are invited for an in-depth interview that will ask you a few questions about your awareness and perception of incentive packages, benefits received, factors that attracts or repel you and your routinely and additional performed tasks in this facility. The interview will take about 45 minutes. It will be recorded using a digital voice recorder to help with looking at the results. Once recorded, the interview will be transcribed (typed-up) and stored as a computer file and then destroyed once the results have been finalised. This is voluntary. You will also be given the opportunity to review and edit your interview transcript if there is the need to do so.

Appendix 7: Consent Form for Health Managers

CONSENT FORM FOR PARTICIPATION IN RESEARCH
(by interview)

Assessing Policies and Strategies to Reduce the impact of Health Worker Shortages in Primary Health Care Facilities in Ghana.

Introduction
This study is a qualitative study that seeks to understand the perceptions and experiences of health care workers and health managers so as to get a deeper insight into the extent to which various policies and strategies are impacting on the retention of health workers in primary health care facilities. Different categories of health workers will be interviewed about the awareness and perception of incentive packages put in place to motivate them.

Purpose of the study
The purpose of the study is to assess the level of implementation of policies and interventions put in place to retain health workers in primary health care facilities in the Upper East Region of Ghana.

Procedures
You are invited for an in-depth interview that will ask you a few questions about policies put in place to retain health workers in rural Ghana. The interview will take about 45 minutes. It will be recorded using a digital voice recorder to help with looking at the results. Once recorded, the interview will be transcribed (typed-up) and stored as a computer file and then destroyed once the results have been finalised. This is voluntary. You will also be given the opportunity to review and edit your interview transcript if there is the need to do so.

Appendix 8: Health Workers Interview Guide

(Expected time duration – 45 minutes)

Assessing Policies and Strategies to Reduce the impact of Health Worker Shortages in Primary Health Care Facilities in Ghana.

GENERAL FACILITY INFORMATION

1. Name of facility
2. District
3. Type of facility
4. Year established
5. Time interview started
6. Time interview ended

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENT

1. Name of staff (optional):
2. Official designation:
3. Age (completed years)
4. Marital status
5. Tribe
6. Number of children
7. Religion

Interview Comments: where the interview took place, mode of respondent during the interview, interactions and other non-verbal expressions of respondents that will help to understand the context of the interview.

QUESTIONS/PROBES

Decision to accept posting / Push & Pull factors

1. When were you posted to this facility to work?
2. What was your mode of posting?
3. How did you feel and reacted when you were posted here to work? Why?
4. What influenced your decision to accept posting to this community?
5. How long are you willing to work in this facility and why?

Expectations

6. What were your expectations accepting post to this facility
7. Have your expectations accepting post to this facility been met and why?

Incentive Packages

8. Do you know of any Ghana Health Service incentive package for health staff? If yes, what are some of these incentive packages?
9. Have you benefitted from any of these incentive packages? Why?
10. What is your option about these incentive packages? Which do you see as most attractive and why?
11. What other packages should the Ghana Health Service and the Government of Ghana consider providing? Why?
12. What can make you consider staying in this or similar facility for the next 3 years? Why?

Task-shifting

13. What are your routinely performed tasks?
14. Do you perform additional tasks which were originally performed by another staff?
15. If yes, what are those tasks and what amount of your time is allocated to them?
16. What is your general impression about the additional tasks assigned to you?
17. As the head of this facility, how are you managing the staff here?

Interventions

18. What interventions do you think when put in place could influence you to stay a bit longer in this facility and why?

THANK YOU SO MUCH FOR YOUR TIME AND SUPPORT.

Appendix 9: Health Managers Interview Guide

(Expected time duration – 45 minutes)

Assessing Policies and Strategies to Reduce the impact of Health Worker Shortages in Primary Health Care Facilities in Ghana.

DEMOGRAPHIC CHARACTERISTICS OF RESPONDENT

1. Name of respondent (optional):
2. Official designation:
3. Age:
4. sex
5. Marital status
6. Tribe
7. Number of years worked

QUESTIONS / PROBES

Policy and strategies

1. Do you have any policies in place for health care workers in rural communities?
2. How were these policies formulated? Who was involved? How were these communicated to people?
3. How were these policies implemented?
4. Where they evaluated? If yes, When & How? Were they revised after evaluation?

Incentive packages

5. Do you specially have in place incentive packages for health care workers in rural areas? If yes what are they? If no why?
6. When is a health worker qualified to benefit from these incentives packages and how are they distributed to them?
7. Do you think the incentives are serving the purpose of retaining health workers in rural areas? If yes/No, why?

Task-shifting – (health managers)

1. How is task-shifting practice in the primary health care facilities?
2. What are the strengths & weaknesses of task-shifting in managing the inadequate health workers in these facilities?

Challenges

8. What are the major challenges you encounter in retaining health workers in rural areas? How are you addressing these?

THANK YOU FOR YOUR TIME AND SUPPORT.

Appendix 10: Study Area Characteristics

Table A 1: Districts and Health Centres involved in the Study

Districts	**Health Centres**
Garu Tempane	Basyonde Health Centre, Bugri Health Centre, Garu Health Centre, Worikambo Health Centre, Woriyanga Health Centre
Pusiga	Pusiga Health Centre
Binduri	Binduri Health Centre
Builsa South	Kanjarga Health Centre
Bawku Municipality	Mognori Health Centre
Bawku West	Binaba Health Centre
Bolgatanga Municipality	Bolga Health Centre, Sokabisi Health Centre, Coronation Health Centre, Sherigu Health Centre, Zuarungu Health Centre, Bongo Soe Health Centre, Namoo Health Centre, Vea Health Centre, Zorko Health Centre.
Kassena Nankana East Municipality	Kologo Health Centre
Kassena Nankana West	Chiana Health Centre, Kandiga Health Centre, Kayoro Health Centre, Nakolo Health Centre,
Builsa North	Chuchuliga Health Centre, St. Lucas Health Centre

Appendix 11: Respondents Characteristics

Table A 2: Respondents involved in the Study

Respondents	Profession	Age	Gender	Tribe	Marital status	Religion
P1	Physician Assistant	33	Male	Frafra	Married	Moslem
P2	Physician Assistant	39	Male	Frafra	Married	Christian
P3	Physician Assistant	35	Female	Frafra	single	Christian
P4	Physician Assistant	50	Female	Ewe	Widow	Moslem
P5	Physician Assistant	30	Female	Bono	Married	Christian
P6	Physician Assistant	31	Male	Kusase	Married	Moslem
P7	Physician Assistant	54	Female	Kusase	Single	Christian
P8	Physician Assistant	48	Male	Kasena	Married	Christian
P9	Physician Assistant	38	Male	Dagomba	Single	Christian
P10	Physician Assistant	45	Male	Ewe	Divorced	Christian
P11	Physician Assistant	52	Male	Frafra	Married	Christian
P12	Physician Assistant	44	Female	Grusi	Single	Moslem
P13	Physician Assistant	36	Male	Dagomba	single	Christian
P14	Physician Assistant	52	Male	Kusase	Divorced	Christian
P14	Physician Assistant	32	Female	Frafra	Single	Christian
P15	Physician Assistant	35	Female	Manprusi	Single	Christian
P16	Physician Assistant	51	Female	Frafra	Married	Moslem
P17	Physician Assistant	48	Female	Guan	Married	Christian
P18	Physician Assistant	53	Female	Bono	Married	Christian
P19	Physician Assistant	39	Female	Kusase	Single	Moslem
P20	Physician Assistant	45	Female	Dagomba	Married	Christian
P21	Physician Assistant	30	Male	Frafra	Single	Christian
CHO 1	Community Health Officer	26	Female	Fante	Single	Christian
CHO 2	Community Health Officer	33	Female	Kusase	Married	Christian
CHO 3	Community Health Officer	35	Male	Bono	Married	Christian
CHO 4	Community Health Officer	26	Female	Kasem	Married	Moslem
CHO 5	Community Health Officer	26	Female	Grusi	Single	Christian
CHO 6	Community Health Officer	27	Male	Dagomba	Single	Christian
CHO 7	Community Health Officer	31	Female	Bono	Married	Christian
CHO 8	Community Health Officer	29	Male	Frafra	Married	Christian
CHO 9	Community Health Officer	26	Female	Kusase	Married	Moslem
CHO 10	Community Health Officer	32	Female	Ewe	Married	Christian
GRN 1	General Registered Nurses	31	Male	Kusase	Married	Christian
GRN 2	General Registered Nurses	32	Male	Kasena	Married	Christian
GRN 3	General Registered Nurses	29	Female	Manprusi	Married	Moslem
GRN 4	General Registered Nurses	28	Male	Frafra	Single	Christian
GRN 5	General Registered Nurses	45	Female	Bono	Single	Christian
GRN 6	General Registered Nurses	31	Female	Dagomba	Married	Christian
GRN 7	General Registered Nurses	50	Female	Frafra	Married	Christian
EN 1	Enrolled Nurse	30	Female	Ewe	Married	Christian
EN 2	Enrolled Nurse	41	Male	Manprusi	Married	Moslem
EN 3	Enrolled Nurse	23	Female	Bono	Single	Christian

EN 4	Enrolled Nurse	28	Female	Kasena	Married	Christian
EN 5	Enrolled Nurse	45	Male	Frafra	Married	Christian
EN 6	Enrolled Nurse	40	Male	Ewe	Married	Moslem
EN 7	Enrolled Nurse	38	Female	Bono	Married	Christian
DCO 1	Disease Control Officer	25	Female	Kasena	Single	Christian
DCO 2	Disease Control Officer	26	Male	Ashanti	Single	Christian
DCO 3	Disease Control Officer	28	Male	Frafra	Married	Christian
DCO 4	Disease Control Officer	29	Male	Ashanti	Married	Christian
DCO 5	Disease Control Officer	37	Female	Grusi	Single	Christian
DCO 6	Disease Control Officer	42	Male	Frafra	Single	Christian
DCO 7	Disease Control Officer	34	Female	Dagomba	Married	Moslem
HA 1	Health Aid Nurse.	29	Female	Frafra	Married	Moslem
HA 2	Health Aid Nurse	40	Female	Kasena	Married	Christian
HA 3	Health Aid Nurse	33	Male	Bono	Single	Moslem
HA 4	Health Aid Nurse	25	Female	Kasem	Single	Christian
HA 5	Health Aid Nurse	38	Female	Dagomba	Single	Christian
PN 1	Psychiatric Nurse	33	Male	Frafra	Single	Christian
PN 2	Psychiatric Nurse	35	Male	Manprusi	Single	Moslem
Midwife 1	Midwife	31	Female	Kasen	Married	Christian
Midwife 2	Midwife	58	Female	Ashanti	Divorced	Christian
Midwife 3	Midwife	28	Female	Guan	single	Christian
Midwife 4	Midwife	57	Female	Kasena	Divorced	Christian
Midwife 5	Midwife	34	Female	Fante	Single	Christian
Midwife 6	Midwife	35	Female	Manprusi	Married	Christian
Midwife 7	Midwife	44	Female	Dagomba	Married	Christian
Midwife 8	Midwife	55	Female	Frafra	Married	Christian
Midwife 9	Midwife	26	Female	Ewe	Single	Christian
Midwife 10	Midwife	36	Female	Frafra	Married	Moslem
Optometrist 1	Optometrist	53	Male	Frafra	Married	Christian
Key Person 1	Human Resource Manager	36	Male	Ewe	Married	Christian
Key Person 2	Health Services Administrator	37	Male	Kasena	Married	Christian
Key Person 3	Health Services Administrator	40	Male	Grusi	Married	Christian
Key Person 4	Medical Superintendent	42	Male	Kasena	Married	Christian