AN INVESTIGATION INTO MOTIVATION OF DEPLOYING MEDICAL DOCTORS IN HEALTH ADMINISTRATIVE POSITIONS IN MALAWI

MASTER OF ARTS (DEVELOPMENT STUDIES)

By

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Thesis submitted to the faculty of Social Science, in partial fulfilment of the requirements for the degree of Master of Arts in Development Studies

UNIVERSITY OF MALAWI
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JUNE 2013

DECLARATION

I, the undersigned, hereby declare that this thesis is my own original work which has not been submitted to any other institution for similar purposes. Where other people's work has been used acknowledgements have been made.

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CERTIFICATE OF APPROVAL

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DEDICATION

To my daughter Lindiwe Nkombezi with love.

ACKNOWLEDGEMENTS

I thank God Almighty for His grace and the wisdom He gave me and all people who supported me in one way or another from the first day I decided to register into Master of Arts in Development Studies degree programme.

I am grateful to Dr. C.D. Chilimampunga and Mrs. T.M. Jamali for their supervision. Many thanks are due to the Ministry of Health Headquarters, Medical Council of Malawi, Kamuzu Central Hospital, Lilongwe DHO, Ntcheu DHO, Balaka DHO and Machinga DHO for allowing me to carry out this study in their premises. Special recognition is given to all the study participants for providing data for the study.

I would also like to recognize the role played by the current MDS Programme Coordinator Mr. Edister S. Jamu and two secretaries-Ms Agnes Mkundiza and Ms Upile Ndege-Mwandali in enabling me to submit my research proposal to the National Health Science Research Committee (NHSRC) by providing me with the required certification in the form of letter of endorsement of my study proposal. In the same vein, I also thank the Medical Council of Malawi, Kamuzu Central Hospital and Lilongwe DHO for providing letters of support to my study proposal as required by the NHSRC. Thank you Ladies and Gentlemen, without your efforts I would not have been able to submit my research proposal to the Committee for review and ethical clearance to carry out the study.

My husband Wiskes Nkombezi, my parents- Davie and Susan Mande, and family members and friends, thank you for the support you rendered to me during the whole period of my study.

I would also like to thank Chancellor College Main Library staff, and also staff in the following Departmental Libraries: Department of Economics, CERT and Centre for Social Research Documentation Unit for their support during my whole period of study.

ABSTRACT

While the Ministry of Health recognizes in its various documents, such as the Malawi Health Sector Strategic Plan 2011 – 2016, that there are inadequate doctors in the country, it is paradoxical to see the ministry deploying these scarce doctors in administrative positions such as District Health Officers (DHO) and Departmental Directors at the Ministry of Health headquarters. This study was carried out to investigate the motivation of deploying the doctors in administrative positions and its impact on the delivery of health care services in Malawi. A sample of 28 participants composed of 4 key informants and 24 respondents was drawn using the purposive sampling technique. Data was collected using interview schedules. The findings show that the main motivation of the ministry of health in deploying doctors in administrative positions was to attract them and retain them in the public health sector. On part of doctors, attraction to these positions is based on their feeling that their qualifications entitle them to assume these positions to endorse the interests of all health workers. The study also brought to light the major feeling widely held by clinical officers that this practice exploit them to the advantage of doctors. The study concludes that the practice ensures retention of medical doctors in the public health sector but does not improve the delivery of health care services because the retained doctors are misallocated and the clinical officers are de-motivated from performing clinical work by the misallocation of doctors. It is hoped that dissemination of the study findings will stimulate further studies in order to come up with alternative strategies that could address these issues.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
CHAM	Christian Health Association in Malawi
COM	College of Medicine
DHO	District Health Office or District Health Officer
DHRMD	Department of Human Resource Management and Development
DHO	District Medical Officer
EHP	Essential Health Package
EHRP	Emergency Human Resources Programme
HIV	Human Immuno-deficiency Virus
HSA	Health Surveillance Assistants
HSS	Health Systems Strengthening
HSSP	Health Sector Strategic Plan
JLI	Joint Learning Initiative
JPoW	Joint Programme of Work
MBBS	Bachelor of Medicine Bachelor of Surgery
MCM	Medical Council of Malawi
MoH	Ministry of Health
MoLGRD	Ministry of Local Government and Rural Development
NMTs	Nurse/Midwife Technicians
OBGYN	Obstetrics and Gynaecological
SWAp	Health Sector Wide Approach
WHO	World Health Organization

Chapter One

Introduction to the Thesis

1.0 Introduction

Malawi health care services are characterized by inadequacy in the numbers of professional health workers emanating from several factors such as inadequate output from training institutions, poor motivation and migration of health professionals from medical to non-medical fields, and to developed countries (WHO Regional Office for Africa, 2004). These shortages are more glaring in the public health sector than in the private health sector because of differences in the conditions of service and equipment to work with. Worse still, doctors often take up administrative positions within the public health sector (Malawi Government, 2011:83). The World Health Organization states that:

> *Deployment of human resources, selection of an appropriate skill mix for the production of health services, distribution of the workforce between different levels of the health service provision system, setting up incentive structures for health personnel and human resources management can be considered elements of the service provision function. ... Improving the performance of the health system ultimately depends on improving the knowledge, skills, motivation and availability of the health workforce* (World Health Organization, 2002:12).

It is assumed that deployment of medical doctors in administrative positions in Malawi coupled with the staff shortages can make it difficult for the Ministry of Health to select

an appropriate skill mix for the production of health service. Actually, the Malawi Government (2011), in its Malawi Health Sector Strategic Plan 2011 – 2016, has stated that shortage and unbalanced skill gaps of the health workforce continue to pose challenges for effective public health care provision. This paper, using the study findings from the sampled health institutions, explains the Ministry of Health's motivation to deploy medical doctors in administrative positions and also gives some reasons why medical doctors take up those positions despite their (medical doctors') numbers in the country being inadequate to provide the required quantity and quality of patient care in the public health institutions.

1.1 Statement of the Problem

There is great recognition that health conditions affect employment, productivity and wages of adults (Malawi Government 2008:1; Todaro and Smith, 2009:409). This signifies the importance of health in development which shows how critical and important health professionals are as an input to improve health outcomes. Many countries fail to achieve an optimum combination of inputs because of inadequate supply of human resources. For instance, 31 countries in Africa, including Malawi, do not meet the 'Health for All' standard of one doctor per 5000 people (Padarath et al., 2003). In the 1980s, the doctor population ratio was 1:10,800 in sub-Saharan Africa compared to 1:1400 in all developing countries (Ibid). Worse still, since the 1980s, the situation in developing countries has deteriorated further. In the 1990s the doctor population ratio was 1: 30,000 in Malawi, Mozambique and Tanzania (Ibid); and by 2004 there were 1.1 doctors per a 100,000 population in Malawi (World Health Organization, 2006). This

downward trend could be attributed to low output from college and emigration of doctors (Malawi Government, 2012:11) against Malawi's growing population.

Human resource projections in Malawi public health sector show that at current output levels it will take many years to come anywhere near the numbers of health staff needed to provide minimum standards of service delivery (Malawi Government, 2011:30; Muula, 2006). In 2008, of the 257 doctors (190 generalist doctors and 67 specialist doctors) who were working in Malawi, only 104 doctors (75 generalist doctors and 29 specialist doctors) were in the public health sector (World Health Organization, 2009:41). The Ministry of Health projected that the public health sector will need 487 doctors (192 Specialist doctors and 295 generalists doctors) by the year 2017 (World Health Organization, 2009:28) to provide direct patient care. Currently, only 200[1] doctors of the available 615 doctors (composed of 439 generalist doctors and 176 specialist doctors) registered by the Medical Council of Malawi work in public health sector serving a population of approximately 14,000,000[2] people. Using the "'Health for All' standard of 1 doctor per 5,000 people" (Padarath et al. 2003), Malawi needs to have 2,800 doctors.

Taking into consideration the shortage of doctors in the country, it is the investigator's belief that the available few doctors, like any cadre of health professionals, ought to be deployed to positions where they are most effective in order for the health sector to achieve its mission. In practice, however, doctors in Malawi are allowed to take up administrative positions within the public health sector.

1. One key informant at the Ministry of Health indicated that there are 200 doctors in the whole public health sector of whom 32 are specialist doctors.
2. In 2008, according to NSO (2011:2), Malawi's total population was 13,077,160 people.

Out of the 200 medical doctors in the public health sector, 70[3] medical doctors hold administrative positions. So far studies have been conducted to curb the shortages of health workers and their focus has been on strategies to motivate and retain health workers in rural areas as well as in the public sector in the developing countries in the face of professional brain drain. The studies that have tackled deployment of medical doctors, have just mentioned it in passing. For example, Phiri's survey in 2007 acknowledged that 90% of surgical operations are done by clinical officers because doctors are busy with administrative work and his focus was on evaluating the surgical training offered to the programme clinical officers. No study, to the investigator's knowledge, has been conducted to investigate why medical doctors are deployed in administrative positions.

This study, therefore, intends to understand the motivation of the Malawi Government through the Ministry of Health in deploying medical doctors in administrative positions; the motivation of doctors in taking up those administrative positions and the impact of this practice on the delivery of health care services in the country in order to propose strategies that would ensure proper utilisation of doctors in the public health sector.

3. There are 28 DHOs in the country, 26 of the 28 District Health Officers are medical doctors. During the study, one DHO told the Investigator that only Salima and Zomba District Health Officers were not medical doctors at that time. In each District Hospital where a DHO is a medical doctor there is another doctor who heads the clinical section who is popularly referred to as the District Medical Officer (DMO). There are 5 Zones headed by a manager who is a medical doctor. 3 of the 4 Central Hospital Directors are medical doctors. At the Ministry of Health Headquarters, one Principal Secretary is a medical doctor; Director and Deputy Director of Clinical Services are medical doctors; Director of HIV/AIDS Unit, Director of Research Unit, Director of Reproductive Health Services, Director of Preventive Health Services, Deputy Director of Health Technical Services (Physical Assets Management) are all medical doctors. Some doctors are in programmes such as TB and malaria control programme. Therefore, there are 52 doctors in the country's DHOs, 3 doctors in the Central Hospitals, 5 doctors in the Health zones and 10 doctors at the Ministry headquarters bringing the total number of medical doctors holding administrative positions in the public health sector to 70. This number constitutes 35% of all doctors in the public health sector.

1.2 Objectives

1.2.1 General Objective

The general objective of this study is to examine the motivation and impact of deploying doctors in administrative positions in the public health sector in Malawi.

1.2.2 Specific Objectives

The study's specific objectives are:

- To identify the factors that informed the Ministry of Health's decision to deploy doctors in health administrative positions.
- To identify the factors that motivated doctors to take up administrative positions.
- To determine the attitudes of health workers towards the deployment of doctors into administrative positions.
- To determine the effects of the doctors' assumption of administrative positions on the delivery of health care services.

1.3 Significance of the Study

The motivation of this study was for the researcher to get greater understanding of why medical doctors take up the administrative positions despite the general outcry that there are few doctors on the ground. The study is considered significant because of the potential contribution it will make to the body of knowledge on human resource allocation and management of health professionals and socio-economic development of the country. The findings of this study which are fully discussed in chapter 4 of this paper indicate the factors that influence the deployment of doctors in health administrative positions and also the impact that deploying doctors in administrative positions has on the

health delivery system. The findings of this study will, therefore, stimulate other researchers to carry out further studies in order to come up with alternative strategies to address the issues that the deployment of doctors to administrative positions intended to address.

1.4 Outline of the thesis

The outline of this Thesis is as follows: Chapter One sets the scene of the study as it introduces the study, explains the study problem statement, objectives and significance of the study. Chapter Two presents and discusses the literature and theoretical framework relevant to this study. Chapter Three presents the research design and methodology employed in this study. Chapter Four presents and discusses field findings from the interviews. Lastly Chapter Five concludes the Thesis by summing up the main findings and emerging themes of the study, explaining the implications of the findings and making recommendations.

1.5 Conclusion

This chapter has provided a general background to the study and its focus. It has also given an outline of this paper. The next chapter presents and discusses the relevant literature to this study and the theoretical framework.

Chapter Two

Literature Review and Theoretical Framework

1.0 Introduction

This chapter presents a review of related literature and the proposed theoretical framework within which the motivation of deploying medical doctors will be investigated. The chapter has two sections: the first section discusses the related literature while the second section examines the main theories guiding this thesis to provide a framework for understanding and analysing the findings of the study.

2.1 Literature Review

This section has been divided into three subsections. The first subsection links health and development and also discusses the role that doctors play in health and development. The second subsection discusses professional brain-drain and its effects on the health sector. The third section discusses the literature on the allocation of human resources in formal organizations generally and in the health sector specifically. This section ends with a summary of the literature reviewed.

2.1.1 Health, Development and the role of Doctors in Development

The process of development was traditionally conceived in terms of economic growth. Development meant ‘the capacity of a national economy whose initial economic condition had been static for a long time, to generate and sustain an increase in its gross

national income at rates of 5% to 7% or more which would trickle down to the masses in the form of jobs, and other economic opportunities' (Todaro and Smith, 2009:15). However, the experience of the 1950s and 1960s when many developing countries reached their economic growth targets but the levels of living for the masses of people remained unchanged (Todaro and Smith, 2009:15), led into the emergence of different approaches to the process of development (Conyers and Hills, 1984:32).

The failure of the trickle down approach to development led to redefinition of the goals of development which put much greater emphasis on the non-economic aspects of development - not merely as a means of achieving economic growth but as important objectives themselves. The general understanding of development which incorporated 'human development' accounting was clearly communicated in the first Human Development Report in 1990 which stated that 'people are the real wealth of a nation' and 'the objective of development should be to create an enabling environment for people to enjoy long, healthy and creative lives' (Human Development Report 1990: 9). Human development accounting is important because 'people often value achievements that do not show up at all, or not immediately, in higher measured income or growth figures such as better nutrition and health services' (Human Development Report 1990: 9).

Development is therefore 'a multi-dimensional process and it represents a whole range of changes by which an entire social system, tuned to the diverse basic needs and desires of individuals and social groups within that system moves away from a condition of life widely perceived as unsatisfactory toward a condition of life regarded as better' (Todaro

and Smith, 2009:16). The devastating effects of poor health on child mortality, employment, productivity and wages of adults (Todaro and Smith, 2009:409) attest to the significant and critical role health plays in development (UN Millennium Project, 2005:77).

Availability of adequate and well qualified health professionals is, thus, a prerequisite for development as noted by the Deputy Executive Secretary of the Economic Commission for Africa, Lalla Ben Barka, who predicted at a regional conference on Brain Drain and Capacity Building (February 2000), that 'Africa could claim the 21st century if the issues of human and institutional capacities were placed as top priorities of development' (quoted in Padarath et al., 2003). In addition, Dovlo (2003:3) argues that "the brain drain of professionals, combined with the health crisis together threatens the entire development process on our continent".

Similarly, the Malawi Government recognizes the influence of the professional health workers including doctors on the health outcomes and development as evidenced by this statement in the draft Deployment Policy of the Ministry of Health:

> *The Ministry ... recognizes that the successful accomplishment of its ultimate goal, which is the improvement of the health status of all Malawians to enhance their contribution to sustainable national socio-economic development and poverty reduction, largely depends on the quality and contribution of its human resources* (Malawi Government 2008:iii).

Focus of this study is placed on doctors because they are few in number as compared to other cadres (World Health Organization, 2009:25) which makes them to be considered scarce and they get the longest and most costly training of all professional health workers which implies that the doctors ought to provide the highest quality and most critical patient care.

In recognition of the critical role that health plays in development, the Malawi Government has made a firm commitment to addressing the health needs of the country, through the implementation of an Essential Health Package (EHP) and a 6-year Emergency Human Resources Plan (EHRP) as well as streamlining projects and funding through the Health Sector Wide Approach (SWAp) (World Health Organization, 2009: 28-32; Malawi Government, 2004:3). The EHP is aimed at delivering the minimum essential health package services to communities, free of charge at the point of service delivery. The expectation of the EHP was that, together with the SWAp, it would mobilize additional resources around the Joint Programme of Work (JPoW) which comprises six components including human resources, pharmaceutical and medical supplies; essential basic equipment and infrastructure development; routine operations at the facility level; and central operations, policy and systems development (Malawi Government, 2004).

Prior to implementation of a 6-year Emergency Human Resource Program (EHRP), shortage of the health workforce was described as a crisis requiring an ‘emergency response’ (Muula, 2006). For example in 2000, an estimated 20% of Malawian nurses

and 60% of Malawian doctors worked abroad (Gordon, 2008). Therefore, the EHRP was developed in response to the country's HRH crisis as a targeted response to addressing the crisis on an immediate, medium and long-term basis (World Health Organization, 2009:32). The EHRP was also developed to bring the country's staffing levels of physicians and nurses to the level comparable to that of Tanzania where, in 2004, there were 2.3 physicians and 36.6 nurses per a 100,000 population as shown in the table below.

Table 1: Number of doctors and nurses per a 100,000 population by country in 2004

Cadre	**South Africa**	**Botswana**	**Ghana**	**Zambia**	**Tanzania**	**Malawi**	**USA**	**UK**
Doctors	69.2	28.7	79.0	6.9	2.3	1.1	230	256
Nurses	388.0	241.0	64.0	113.0	36.6	25.5	1212	937

Source: World Health Report 2006

In order to achieve its objectives, the EHRP addressed the following for the 11 priority cadres of professional health workers: rapid scaling up of training infrastructure and staff; 52% top-up of base pay and some allowances; staff housing expansion programme and rural hardship incentive packages; recruitment galas; emergency gap-filling using 90-100 VSO and UNV volunteers per year. The EHRP was nested within six pillars of work in the health SWAp designed to address health system constraints. Documented evidence shows that a lot of progress has been made in increasing the number of professional health workers following the implementation of the EHRP and that by 2010 the number

of professional health workers across the eleven priority cadres had increased by 53%, from 5,453 in 2004 to 8,369 by 2009 (Malawi Government, 2012:11).

2.1.2 Professional brain drain and its effects on the health sector

African countries are confronted with the problem of migration of health professionals to more developed countries. Migration of personnel is defined by WHO Regional Office for Africa (2004a:1) as, *"the voluntary movement of workers from one employment station to another in search of different working arrangements"* while the term 'brain drain' refers to *"a situation where skilled persons move across the national boundaries"* (WHO Regional Office for Africa, 2004a:1). In the past few years, this issue of migration or 'brain drain' has attracted attention and has been described in the medical and health services literature as contributing to shortages of health workers in developing countries. Various 'push', 'pull' and 'grab' factors have been cited as fuelling the brain drain of health professionals from Africa. Push factors describe factors in source countries that force health professionals to emigrate, pull factors describe factors in the recipient countries which encourage health professionals to emigrate and grab factors (also known as stay factors in the recipient countries and stick factors in source country by Padarath et al. 2003) describe push factors both in the source and recipient countries but are mitigated in the recipient country which makes them attractive to immigrants (Dovlo 2004: 3).

The causes and extent of emigration vary from one country to another, but the major "push" factors include low remuneration, poor working conditions and low job

satisfaction (particularly lack of equipment and medication which can significantly reduce job satisfaction) (Dovlo, 2004, WHO Regional for Africa 2004a). "Pull" factors may arise because of increased demand for health professionals in the developed countries which include aging populations in developed countries (Dovlo, 2004: 3) and globalisation related market changes that reduce the transactions and search costs associated with medical migration. While “grab” factors include good working conditions in the developed countries such as higher salaries than those offered in developing countries and availability of drugs and equipment to work with which raises their job satisfaction. The advent of more efficient electronic communication networks has made the movement of health professionals much easier than before as potential migrants are better informed of opportunities in other countries.

The Report of the Special Working Group on the World Health Organization (WHO) Constitution and Brain Drain Problem in Africa (WHO, 1997) recommended that WHO request member countries to evaluate the magnitude of problems associated with the movement of health personnel (WHO Region Office for Africa, 2004a). It was found that the public health sector is the most seriously affected by the migration of health professionals. Actually a 2004 report by the Joint Learning Initiative (JLI, pp 18-19) and Dr. Paul O’Hare of the University of Warwick Medical School speaking in the Medical News Today of March, 2011 claimed that there were probably more Malawian doctors in Manchester than there were in the whole of Malawi in those material years. Padarath et al. (2003) reviewed available literature to present an overview of the distribution and migration patterns of health personnel at national, regional and international levels; the

determinants and causes of such patterns; and the possible policy options for enhancing a shift towards greater equity. They found that African health sectors face significant shortfalls in human resources such that 31 countries do not meet the 'Health for All' standard of one doctor per 5000 people and from the trends in availability of health professionals in the 1980s and 1990s showed that the situation was deteriorating from 1 doctor: 10800 people in the 1980s to 1 doctor: 30000 people in the 1990s.

Concurring with the aforementioned findings in a review conducted by Padarath et al. (2003) that African health sectors face significant shortfalls in human resources and also claims by JLI and Dr. Paul O'Hare of the University of Warwick, the Ministry of Health in Malawi indicated in its Human Resource for Health Strategic Plan 2012-2016 that

> *Current staffing levels do not meet the minimum requirements to support the health care delivery system and shortage is manifested nearly in all cadres of the health workforce. For example, 68% of nurse technician positions, 80% for specialist doctors and 51% for general doctors remain unfilled. This shortage is exacerbated partly by failure to train adequate numbers and partly due to inability to retain those who are already in the system.* (Malawi Government 2012:11).

For countries that are battling to address extreme poverty, underdevelopment and large scale health crises, professional brain drain represents a huge and irreplaceable loss of human capital. As more health professionals leave the developing countries for greener pastures, more work is dropped on the shoulders of those health professionals who remain thereby negatively affecting their job satisfaction and their motivation to remain

in the health sector. Considering the critical importance of health in development as health output contributes to human capital of a country, the professional brain drain in the health sector weakens its development efforts. For instance, the JLI reported that:

> *The exodus is often only the beginning of a downward spiral of health system capacity. In health facilities already facing shortages of staff and unfilled vacancies, the migration of existing staff adds to the workload of workers who remain, increasing their case loads and over time, leading to fatigue, a loss of motivation, and eventual burnout. These pressures provide an impetus for remaining workers to themselves migrate out—perpetuating the vicious spiral. The loss of workers also results in leakages of public subsidies invested in educating them.* (JLI p.105).

In his paper, Dovlo (2004), "The Brain Drain in Africa: An Emerging Challenge to Health Professionals' Education" in which the author reviewed professional brain drain using data from Ghana and other African countries noted that training output is limited and retention of health professionals is a challenge. In an attempt to curb professional brain drain, Dovlo argues that there are

> *ways in which educational systems and the health sector can collaborate to mitigate the effects of health professionals' migration and to sustain health services which include (a) new modes of selecting candidates for the professions, (b) establishing new and relevant curricula, (c) profiling new cadres that are better retained, and (d) co-ordinating with the health sector on bonding and community service schemes to facilitate retention* (Dovlo, 2004:1).

In Malawi, in order to cope with the problem of professional brain drain, the government implemented a number of strategies and one of them was salary top-up allowance of 52% of individual's salary under the Emergency Human Resources Programme (EHRP) commencing in April 2005. Donor support was key to introduction of salary top-up in 2005 and the major donors were: Department for International Development (DfID) who contributed approximately $100m, the Global Fund gave $100m, Centre for International Migration, Germany, and UNDP $1m and the Malawi Government allocated an additional $50 million (World Health Organization, 2009:32). The salary top-up allowance was made available to all eleven priority cadres of professional health workers in government health institutions ranging between the grades 'D' and 'M' of the Malawi Civil Service namely physicians, nurses, clinical officers, medical assistants, laboratory technicians, pharmacy technicians, radiography technicians, dental therapists, physiotherapists, environmental health officers, medical engineers (Ibid:33). Those on performance-related contracts were not eligible for the allowance.

While professional brain drain has devastating effects in the health sector and is increasingly being reported in the literature, an investigation on how the available human resources are allocated within the public health sector should be made to check if health workers are deployed to areas where they are most useful and most productive.

2.1.3 Allocation of human resources in general and the health sector

'Our society is an organizational society', observed Presthus (1962) (quoted in Etzioni, 1964:1). We are born in organizations, educated by organizations and spend much of our life working for organizations (Etzioni, 1964:1). Modern society, unlike earlier societies,

has placed a high moral value on rationality, effectiveness, and efficiency. An organization combines its resources and raw materials; and it continuously evaluates how well it is performing and adjusts itself to achieve its goals. In this vein, Etzioni (1964) states:

> *Organizations are characterized by: (1) divisions of labour, power, and communication responsibilities, divisions which are not random or traditionally patterned, but deliberately planned to enhance the realization of specific goals; (2) the presence of one or more power centres which control the concerted efforts of the organization and direct them toward its goals; these power centres also must review continuously the organization's performance and re-pattern its structure, where necessary to increase its efficiency; (3) substitution of personnel, i.e., unsatisfactory persons can be removed and others assigned their tasks. The organization can also recombine its personnel through transfer and promotion.* (Etzioni, 1964:3).

Theorists, such as Etzioni (1964), writing based on Weber's work on bureaucracy assume that an organization has a primary objective which can be reached through establishment of sub-goals and choosing specific means also referred to as strategies to achieve them (Cartwright, 1965:1). This in turn requires a differentiation into specialized tasks which must be carried out dependably in coordinated manner. Tasks are combined into positions (or offices or jobs), and individuals are assigned to these. Much as criticisms have been levelled against this view that this description characterizes an ideally 'rational' organization and that actual ones deviate from it in varying degrees, the view prevails

that every organization has a basic objective and to be viable, it must have some control system to guarantee accomplishment of this objective.

Human resources are assuming increasing significance in modern organizations. Moreover, the activities of different individuals tend to combine in such a way as to result in organizational accomplishments. For example, the health sector 'depends on a precise application of the knowledge and skills of its workforce to ensure patient security and health' (World Health Organization, 2006b) and 'the most crucial performances are carried out by the highly trained physicians' (Etzioni, 1964:30), if these doctors are busy with administration, these crucial performances are left undone because the lower cadres of health workers may not know what to do at that stage. Hence, if the medical doctors are allocated to clinical work where they have more knowledge of the raw materials (human beings), it is assumed that the health system will have good quality health services as these providers will employ effective techniques.

According to the Human Resource for Health Country profile for Malawi compiled by the World Health Organization (2009), 'lack of a clear and equitable deployment policy within the MoH and the health sector in general' was frequently identified as a problem affecting health workforce morale. For example, in a preliminary meeting held by MoH with key health sector stakeholders, critical issues discussed and articulated among others was that health workforce deployment is not uniformly or adequately planned, managed, applied or monitored (World Health Organization, 2009:32). In addition, limited practical guidance on deployment is provided for in the existing Malawi Public Service

Regulations or the Malawi Public Service Act other than a statement that reads "all public officers shall be treated fairly and equally in all aspects of human resource management and development without regard to their political, tribal or religious affiliation, or to their sex, age or origin in Malawi" (Malawi Public Service Regulations).

Lack of deployment policy led to inefficient and inappropriate use of health workers and maldistribution of these scarce human resources was widely noticed in the public health sector. Limited human resources coupled with rising demand for good quality health care services made it imperative for the Ministry of Health to develop a Deployment Policy in 2008 to promote the efficient and equitable deployment and utilisation of available healthworkers at all health facilities (Malawi Government, 2008). The deployment policy sought to ensure clarity, objectivity and fairness in the deployment of health service providers (human resources for health) by planning and managing effective deployment of the limited number of health workers available employed based on standards of best practice in recruitment (Ibid:4).

However, despite the development of the Deployment Policy in 2008, the public health sector still faces the problems that the policy aimed to address. For, example, it is still problematic for the ministry to staff the health facilities in the hard-to-retain-areas and also medical doctors take up administrative positions (Malawi Government, 2012:83).

2.1.4 Summary of Literature Review

The literature reviewed shows that people cannot talk about development of a country without considering the quality of human resources available to deliver the services and

goods. This quality of human resources is determined by the education and health status of the citizenry in the country. A country needs both educated and healthy people in order to develop. The reviewed literature recognizes the significance of human resources for health (in this case doctors) in order to ensure that the citizenry are healthy. The literature indicates that there are shortages in almost all cadres and for doctors it is worse. The shortage of doctors in the country arises from inadequate supply of graduates from training school, emigration of those qualified medical doctors in search of green pastures in other countries; attrition through retirements, resignations, deaths and dismissals; migration from public health sector to the private health sector and non-governmental organizations; and also migration from medical positions to non-medical positions within the public health sector.

According to the literature, strategies have been put in place to curb the shortage. For example, under the EHRP, Malawi College of Medicine has increased the number of student intake into the MBBS programme from 20 in the 1990s to 60 in 2004; and to ensure that health workers remain in the public health service, the Malawi Government, under the EHRP, introduced the salary top-up allowance pegged at 52% of the health worker's basic pay. The literature further shows the importance of allocating employees, in this case doctors, to jobs in which they are well qualified. An analysis of how the available doctors in Malawi are utilized indicates that they are not confined to treating patients, but they are also deployed in administrative positions. 70 of the 200 doctors in the country's public health sector hold administrative positions. This study therefore intends to investigate the motivation of deploying medical doctors in administrative

positions from policy makers and the doctors themselves and also to investigate the impact of such deployment on delivery of health care services.

2.2 Theoretical Framework

In order for investigators to understand a phenomenon being studied, they need a framework hence theories and models popularly known as paradigms (Silverman, 2006:13-14) are used. In agreement with Silverman (2006), Cooper (2008:6-8) argues that *research is inevitably framed by conceptual and theoretical considerations* and that *theoretical frameworks are crucial in shaping the ways in which researchers investigate the world since they highlight particular features of the world as significant; they direct researchers' attention towards certain forms of behaviour; and they suggest certain kinds of research questions*.

An analysis of the literature reviewed in the first section of this chapter shows that there were issues at hand and decisions were made to address those issues. In this study, the Rational Choice Theory and Social Constructionist Paradigm were considered relevant by the investigator to explain issues surrounding the decisions made by the Ministry of Health to deploy medical doctors in administrative positions and the doctors to take up those positions. Furthermore, the theory and the paradigm were also useful in understanding the attitudes of other health workers towards this practice and its impact on the delivery of health care services in Malawi.

2.2.1 Rational Choice Theory

A theory, in simple terms, highlights and explains something that an individual would otherwise not see or would find puzzling (Gilbert, 2008:25). Rational choice theory

focuses on rational choices and calculative decision making. The rational choice theory seeks to explain social behaviour by positing the individual as a strategic and calculating actor who makes choices according to rational criteria (Cooper, 2008:10). This theory draws heavily on the models of action used by economists to explain producer and consumer choices in markets, but its advocates argue that such models can be applied to actions in political, religious, familial, ethnic and other spheres as well as to economic spheres (Filcher and Scott, 2007:55).

This theory views all actions as oriented towards goals and that people choose those means that are likely to be most effective in attaining them. They choose from a range of alternative courses of action by calculating the chances they have of achieving their goals. In doing so, they consider the rewards and costs that are attached to each alternative. Some of these rewards and costs are monetary while others are not. So the knowledge that people acquire is an attempt to understand the world well enough to make practical sense of it and to act effectively. According to this theory, before doctors take up positions, they make an assessment of the jobs, weighing the benefits and costs attached to the positions so that they maximize profits and minimize losses by gaining rewards and avoiding costs.

However, Babbie (2007:40) notes that this assumption of rationality ignores the power of tradition, loyalty, image and other factors that compete with reason and calculation in determining human behaviour. The investigator holds the view that while the decision made by individuals may be influenced in part by the factors mentioned by Babbie

(2007), it does not mean that the decisions made are irrational, it just shows that the decisions are not made in a vacuum but they are made within a certain context. The investigator believes that the individuals still conduct a cost benefits analysis and take a decision which they feel is beneficial to them within the given circumstances. As already mentioned, the costs and rewards do not necessarily need to be monetary, by choosing an option that enforces their traditions they show that they attach higher value to them than the other options left. Other authors call this bounded rationality.

In this vein, Chiotha et al.,(2007) state that the incorporation of indigenous knowledge on different issues is relevant to the achievement of development interventions in Malawi. Similarly, Chambers (1983) in his discussion about how to tackle rural poverty echoes the importance of allowing people experiencing the issue under discussion to express their thoughts about and how to address it. It is necessary, therefore that the actors themselves explain why they behave the way they do, which brings us to the Social Constructionist Paradigm.

2.2.2 Social Constructionist Paradigm

A paradigm is a set of assumptions about how researchers know about the world and what researchers do when carrying out research (Alexander, Thomas, Cronin, Fielding and Moran-Ellis, 2008:137). Social Constructionist paradigm is based on the view that reality is socially constructed. The constructionist stance towards data is that *"social research can never measure a single reality; but it can produce only an interpretation of what researchers themselves see. Research participants provide researchers with interpretations which researchers then re-interpret in the research process."*(Ibid:138).

Furthermore, according to Alexander et al., (2008:138), constructionists argue *"that social research can only produce local, historically-contingent meaning and researchers seek explanation and understanding"*. So, in order for researchers and development practitioners to understand a problem they would like to investigate and address, they need to ask the actors to give them their perspective on the issue.

Based on the social constructionist paradigm, it is necessary for this study to give opportunity to both the policy makers as well as doctors themselves who take up these positions to express their views on this topic for the study to bring to light the motivation behind this arrangement and its impact on the delivery of health care services in the public health sector. Hence this study was framed by both rational choice theory and the social constructionist paradigm in order to get the insights of why doctors assume administrative positions and the effect of the doctor's assumption of the dual role of administration and professional work on the provision of health care services. Using the rational choice theory and the social constructionist paradigm, the study unveiled factors that determine the deployment of doctors in administrative positions and the effects of this deployment on the delivery of health care services.

2.3 Conclusion

This chapter presented the general direction of the study through the review of relevant literature. From the literature reviewed, it is observed that studies have been conducted and strategies employed in an attempt to address the shortages of human resources for health in Malawi but the shortages persist. No study has been carried out to investigate the motivation behind deploying medical doctors in administrative positions in the

country so that appropriate strategies are formulated to address the issues that are unveiled in the study thereby avoiding further experience of the shortages.

The chapter has also discussed the Rational Choice Theory and the Social Constructionist Paradigm that have guided the study. The central message coming from this theoretical framework is that individuals make choices among given options within a framework of sets of expectations about what is reasonable as such development practitioners and investigators can only make sense out of the chosen options when they allow the concerned individuals to explain their behaviour. The next chapter presents and discusses the research design and methodology.

Chapter Three

Research Design and Methodology

3.0 Introduction

This chapter gives the analytical framework of the study. It begins by presenting the conceptualisation of important terms in the study. It also outlines methods and tools used to collect data. Sampling techniques, sample sizes and methods of data analysis follow thereafter.

3.1 Conceptualisation and Measurement

This study is guided by the rational choice theory and social constructionist paradigm. At the centre of rational choice theory is the idea that every action is rational in the eyes of the individual taking it as such rational choice theory suggests that we should look for such reasons and social constructionist paradigm is the idea that meaning attached to an action is socially constructed as such investigators need to ask the actors to explain to the investigators the motive behind their actions. The investigator chose to employ qualitative research approach in this study. The analysis of the findings in this study therefore begins with grouping the transcripts of interviews in order to understand the motivation for deploying medical doctors in administrative positions; attitudes of health workers towards doctors holding administrative positions as well as towards the practice; and its impact on delivery of health care services in Malawi. As already indicated earlier in this paper that 70 of the 200 doctors in the public health sector hold administrative

positions and that no study, to the investigator's knowledge, has been conducted to understand why doctors are allowed to take up administrative positions, the investigator decided to use qualitative research approach in order to explore and get a detailed understanding of the issue which can only be established by talking directly with the people who are affected by this practice and allowing them to tell their stories freely. Qualitative research approach also links well with the theoretical framework that is guiding this study.

3.2 Area of Study

The study sample was composed of respondents from Kamuzu Central Hospital, Bwaila Hospital, Lilongwe DHO, Ntcheu DHO, Balaka DHO, Machinga DHO and key informants from the Ministry of Health, the Medical Council of Malawi and the department of Human Resource Management and Development in Lilongwe district. These institutions are relevant to the research question because of their role in the provision of health care services in Malawi. For example, the hospitals provide the services while the Ministry of Health provides policy direction regarding provision of health services. The Medical Council of Malawi regulates the practice of medicine in the country as such medical practitioners cannot practice in the country without being licensed by the council. The council also accredits training institutions to ensure that they meet the set standards in health education. The DHOs and Kamuzu Central Hospital were sampled for feasibility of the sampling plan in terms of money and time available to access them.

3.3 Sampling Techniques and Sample Size

It is important for an investigator to have a research plan to guide how the study will proceed. Plans for research include consideration of the study population to sample from, sampling techniques to be employed, the research method likely to be most effective to answer the research question among others (Murchison, 2010:44). The key informants and respondents were purposively sampled because of their relevance to the study's objectives. The study recruited medical doctors who assumed administrative positions to understand their motivation for taking up these administrative positions. The clinical officers were also interviewed to get their attitudes towards this dual role of doctors. When doctors are busy with administrative work, the clinical work is done by the clinical officers hence the investigator settled for clinical officers rather than the rest of other cadres to participate in this study.

Two key informants from the Ministry of Health; and one key informant each from Medical Council of Malawi and the Department of Human Resource Management and Development were interviewed. These key informants gave information on the motivation of the government for using medical professionals in administration positions and their perspective of the effect of using doctors in those positions on delivery of health care services in the country.

Sarantakos (2005:170) argues that a *"sample must be as large as necessary, and as small as possible"*. Considering the paradigm that guides the research in this case is qualitative research which does not require very large samples and the nature of the population

which in this case is limited (Ibid: 170), the sample size was 28 composed of 4 key informants and 24 respondents. The study population is limited because, for instance, key informants were chosen based on their positions and it happened that such positions in their organizations were held by one person only. Similarly, in each of the district hospitals targeted, there were two doctors except for one hospital which had four doctors. The respondents interviewed in this study were 1 doctor who holds the position of DHO/Hospital Director and 5 Clinical Officers who refer cases to these doctors in each of the 5 facilities (1 Central Hospital and 4 DHOs) in the study which brought the number of respondents to 24 since one of the doctors indicated that he does not see patients which meant that no clinical officers refer cases to him hence based on the criteria set to identify clinical officers in this study the investigator did not recruit any clinical officers from this health facility.

In total 6 medical doctors who hold administrative positions in public health sector out of a population of 70 participated in this study which gives a sample population ratio of 1 to 12. This sample included doctors in other administrative positions than that of a DHO. For example, the Hospital Director held other administrative positions such as Deputy Head of SWAp after holding DHO position in several hospitals and before becoming the Hospital Director.

3.4 Characteristics of Study Participants

The participants in this study comprised 4 key informants and 24 respondents. It was not possible to get equal numbers for males and females for the study participants because the criterion for inclusion was the position that one held especially for key informants and

medical doctors; for clinical officers, availability at the health facility also contributed to their inclusion. The key informants in the study were all male by gender; two were human resource management professionals while the other two had medical profession backgrounds - one was a medical doctor and another was a clinical officer by professional training.

Among the respondents, there were 5 medical doctors and 19 clinical officers. The five medical doctor respondents comprised 4 males and 1 female and all of them were general practitioners holding Bachelor of Medicine Bachelor of Surgery (MBBS) from College of Medicine. The oldest serving medical doctor of the 5 medical doctor respondents had been in the public health sector for 17 years, the newest medical doctor for 4 years 3 months while the remaining three medical doctors had each served in the public health sector for five years.

Despite the difference in the number of years served in the public health service by the medical doctor respondents, the trend of positions held was similar. Each of them spent 1 year 6 months on internship and another 1 year 6 months as District Medical Officer (DMO) before becoming a District Health Officer (DHO). The longest serving member had also served in other higher administrative positions after serving as DHO. As shown in Table 2, the clinical officer respondents comprised 5 females and 14 males. 10 clinical officer respondents (1 female and 9 male) had served in the public health service for 6 years or more with the longest period of service being 22 years and the shortest period being 1 year 3 months. 17 clinical officer respondents' highest qualification was a

Diploma while 2 clinical officer respondents had Bachelor's Degrees. 5 of these clinical officer respondents had joined the public health service as medical assistants and they had been promoted to become clinical officers after acquiring Diplomas in Clinical Medicine. The focus of the study was on the doctors and clinical officers; hence the key informants' length of service and professional/academic qualifications were not collected which makes it difficult to include them in Table 2 below showing characteristics of respondents.

Table 2: Characteristics of respondents

	N	%
Cadre		
Medical doctor	5	17.86
Clinical officer	19	67.86
Gender by cadre		
Female medical doctor	1	3.57
Male medical doctor	4	14.29
Female clinical officer	5	17.86
Male clinical officer	14	50.00
Year of service by cadre		
Medical doctor served more than 5 years up to 22 years	1	3.57
Medical doctor served 5 years and below	4	14.29
Clinical officer served more than 5 years up to 22 years	10	35. 71
Clinical officer served 5 years and below	9	32.14
Highest professional qualifications by cadre		
Doctors with degrees (MBBS)	5	17.86
Clinical officer with bachelor's degrees	2	7.14
Clinical officer with diplomas	17	60.71

N stands for number of respondents in each given category in the table.

% stands for percentage calculated as number of respondents in a category out of total number of respondents in the study which is 28. The percentage is calculated to the nearest 2 decimal places.

3.5 Data Collection

The investigator chose interview as a method of data collection. According to Silverman, *Often the desire to use multiple methods arises because you want to get at many aspects of a phenomenon. However, this may mean that you have not yet sufficiently narrowed down your topic* (Silverman, 2006:9). Hence the investigator settled to employ one method in this study because the topic is sufficiently narrow. On choice of the research method to be used, the investigator was guided by the study's theoretical framework and also based on the questions that this study intended to answer considered interview as a most suitable research method to effectively provide answers to the research questions in this study. Interviews enable an investigator to obtain detailed explanations as she or he can ask for clarification or follow-up on issues raised by a study participant (Murchison, 2010: 43).

The researcher booked appointments for the interviews. These appointments were made in order to gain access to the study field. Murchison (2010:29) shares the view that gaining access to the research field is very important because once access is denied, the study cannot be carried out since, in most cases and specifically in this study, interviews have to be done where the informants will be found and it happened to be the workplace. Murchison argues that it is important to identify gatekeepers (defined as individuals in positions to grant or deny access to particular field sites) so that a researcher is aware of the people to work with in order to gain access to the field sites (Murchison, 2010:30). Murchison (2010) emphasizes that while their assistance or approval may be invaluable, their rejection can be very detrimental to the research plans.

Letters explaining the objectives of the study were sent through the District Health Offices/office of the Hospital Director who conveyed the message to all sampled respondents and, in the case of key informants, letters were also sent requesting them to participate in the study in order to get informed consent from respondents before conducting the interviews. It is important to obtain an informed consent from participants of the study because *ethical standards prescribe that study participants should not be coerced to take part in the study; rather participation should be free, voluntary and fully informed* (Sarantakos, 2005:20). Similarly Murchison (2010:44) argues that if a researcher expects potential informants to be wary of his or her presence and research agendas, the researcher needs to make the informants gain an understanding of the research goals and some familiarity with him or her. The letters sent to the study participants served the purpose of familiarizing them with the study. The investigator also explained to the study participants the purpose of the study before interviewing them.

Silverman (2006:25) and Simmons (2008:193) argue that in a study using open-ended questions, participants are encouraged to offer their own definitions of particular activities. Sarantakos (2005:245-6) concurs with Silverman and Simmons and adds as follows:

> *Open-ended questions are advisable if the researcher is interested in ample information; the attitudes, ability to communicate and motivation of the study participants are not known; the respondents cannot communicate; and the respondents are not well informed and have not yet formed an opinion. While pre-coded questions can be employed if the researcher is interested in classifying*

> *responses or respondents; the situation of the respondents is known; they can communicate; they are well informed and have formed an opinion* (Sarantakos, 2005:246).

Guided by the rational choice theory and social constructionist paradigm, the investigator settled on open-ended questions hence the study used interview schedules designed by the investigator to collect data. These interview schedules helped the researcher to remain focused on the topics and they also acted as a standard for questions that were administered to all the research respondents. The only difference was the questions that were asked when probing the respondents to elaborate the responses. Notes were taken on issues that were raised in the face-to-face interviews while tape recording was used to fully capture the discussions. Recorded data was transcribed for those who accepted that their interview be audio recorded. For the key informants and respondents who refused audio recording of the interview only field notes were taken.

Due to the nature of the study, where a specified and limited study group was available, a pre-test of tools was not done. The key informants in this study could not be replaced by other people because they were recruited in the study based on their positions and also their roles in relation to the issue at hand, therefore, conducting a pre-test of tools could mean involving the same people twice which could be time consuming and boring to the key informants and expensive to the investigator. Nevertheless, the investigator did not have any problems with the tools during data collection. Field data was collected within a period of three weeks from 18th March 2013 to 3rd April 2013.

3.6 Data Analysis

The transcripts of interviews were summarized using content analysis whereby data was isolated in themes being explored in the study. Themes emerged from the objectives. According to Fielding (2008:335), *Deciding what to code in an interview transcript or field note is a question of deciding what is or isn't important and is usually guided by the purpose of the study*. In this study, data analysis involved a process of coding based on relevant statements acquired from the transcribed data and categorized data based on the objectives of the study. Coding into semantically meaningful units was done on a variety of levels- word, phrase, sentence or paragraph (Fielding, 2008:335). This coding was done to come up with points from the study findings and not converting interview transcripts into numeric data. In this thesis, interview extracts are used to illustrate points the investigator pulled out from the study findings. The points respond to the study objectives.

3.7 Ethical Considerations

When designing a research, a researcher needs to consider ethical principles. According to Bulmer (2008:146)

> *Researchers always have to take account of the effects of their actions upon study participants and act in such a way as to preserve their rights and integrity as human beings. ... Being ethical limits the choices we can make in the pursuit of truth. Ethics say that while truth is good, respect for human dignity is better, even if, in the extreme case, the respect of human dignity leaves one ignorant of human nature. Such ethical considerations impinge upon all scientific research, but they*

impinge particularly sharply upon research in all human sciences, where people are studying other people.

In this study, where information is collected from human beings, the investigator observed the following ethical principles: avoiding harm to subjects and researcher, informed consent, respect for privacy, safeguarding the confidentiality of data, and avoiding deceit and lying.

3.7.1 Avoiding harm to Participants and Researcher

The investigator sought approval from the National Health Sciences Research Committee (NHSRC) to conduct the study. The study proposal and the data collection tools were reviewed by the committee to ensure that the study participants and the researcher are not harmed by their participation in the study and having been satisfied that the study protocol did not pose any harm to the participants and the researcher, approval was granted.

3.7.2 Informed Consent

The principle of informed consent provides that individuals who have been sampled to participate in a study should be free to choose to participate or deny to participate having been informed fully about the nature, purpose, arrangements for maintaining the confidentiality of the data, benefits and risks to which they would personally be exposed (Bulmer, 2008:150).Written consent was sought from all study key informants and respondents to interview them and verbal consent was sought to record the interviews. Appendix 4 is a copy of the informed consent form which was used in this study.

3.7.3 Respect for Privacy

Many definitions, according to Bulmer (2008:152), emphasize the control by an individual of information about her or himself as a key component. This is in some way connected with informed consent. In this study, after getting permission to conduct the study from the NHSRC and head of institutions, the investigator upheld the right to privacy of research participants by first getting informed consent to participate in this study from them and by allowing them to give information that they deemed right for public consumption without being coerced.

3.7.4 Confidentiality of Data

All participants were assured that no names were to be used in reporting of the findings and indeed there are no names in this report. Furthermore, the use of terms 'key informant' and 'respondent' helps to make it impossible to link information with a particular respondent (Sarantakos, 2005:21). Therefore, for the sake of confidentiality of data, this report does not specifically indicate where the medical doctor and clinical officer respondents work to ensure that there is no identity attached to the information because mostly in the case of doctors, only one respondent per facility was included in the study making it impossible to mention the location of the interview without linking it with the respondent.

Study participants were also assured that the responses would be stored by the investigator only and that after analysis would be properly discarded. All transcripts with information were kept by the investigator and no other person had access to them.

Similarly, recorded interviews were saved with passwords so that no-one other than the investigator accesses them. They were also assured that at the end of the study and writing of the study report these transcripts would be destroyed and discarded and the audio tapes would be deleted.

3.7.5 Avoiding Deceit and Lying

The use of deception in research and concealment of one's identity as a researcher to study participants in order to gain access to rare data (popularly known as doing covert research) has been criticised even though it is not possible in other situations to be utterly open to all participants (Bulmer, 2008:153-154). A researcher is obliged to tell the truth to the participants about his or her identity as a researcher as well as the purpose of the study. This can also be linked to avoiding harm to participants and the researcher. The researcher may be harmed by the study participants in an effort to reclaim their privacy if they discover that they were deceived. In this study, data was not collected by any covert means.

3.8 Limitations of the Study

The funding to undertake the research and time was limited which compelled the investigator to sample Central Hospital and DHOs that could easily be accessed. Nonetheless, the study findings can be used to devise strategies to mitigate the effects of deploying medical doctors in administrative work on delivery of health care services in Malawi and also inform other researchers to undertake more-in-depth research.

Chapter Four

Study Findings

4.0 Introduction

This chapter presents and discusses the field findings from the Ministry of Health headquarters; Medical Council of Malawi; Department of Human Resource Management and Development; Kamuzu Central Hospital; Lilongwe DHO; Bwaila Hospital; Ntcheu, Balaka and Machinga DHOs and District Hospitals. The study findings focus on the motivation of deploying medical doctors in administrative positions and its impact on the delivery of health care services in Malawi. This chapter is divided into four subsections. The first subsection presents the factors that informed the Ministry of Health's decision to deploy doctors in administrative positions; the second subsection presents the doctors' motivation for taking up administrative positions; the third subsection presents the attitudes of health workers towards deployment of doctors into administrative positions; and the fourth subsection presents the impact of deploying doctors in administrative positions on their clinical work performance and the delivery of health care services in Malawi.

4.1 Ministry of Health's motivation to deploy doctors in administrative positions

When the key informants were asked about the motivation of the Ministry of Health to deploy medical doctors in administrative positions, three points were raised namely:

the nature of health administration demanded that it be done by the health professionals; the strategy for retaining doctors especially in the districts and also a way of moving the health workers up the hierarchy of the Ministry of Health.

4.1.1 Nature of Health Administration

All key informants argued that administrative positions in health were quasi-administration and were different from generic administration that is done in other organizations, as such health administration needed to be carried out by health professionals to be effective as in this extract:

> *"Administration in health is different from administration in other ministries or organisations. That is why we talk about Human Resources for Health, which means that all administrators need some skills essential in health and also the health workers need to learn administration. Health administration needs to be carried out by health professionals to be effective. For example, a pure administrator cannot handle responsibilities of a DHO or even a Zone Manager; these positions need people with technical know-how to be effective"* (Key Informant 2, Lilongwe, 2013).

Similarly, in his response, Key Informant 1 showed in his reference to what would happen when the health services were fully decentralized that even if it was not a doctor holding administrative positions in health administration but it would be a health professional rather than a generic administrator. In his words he said:

> *"A good doctor with management skills would lead to improvement of services delivered at the district. However it is not possible to gauge from the start that the doctor deployed would be good and also will have the required management*

skills. When the health services will be fully decentralized, the post of DHO will be replaced by the post of District Director of Health and Clinical Services at P4 which will be held by any health professional" (Key Informant 1, Lilongwe, 2013).

Key Informant 4 concurred with Key Informant 1 and put it explicitly this way:

"College of Medicine has introduced a Bachelor's degree in Clinical Management. Medical doctors would be replaced by graduates of these programmes so that the doctors focus on their technical work rather than administration. This cadre of health workers is better placed to run the administration of the hospital rather than lay administrators because they have knowledge of health issues and can set priorities right" (Key Informant 4, Lilongwe, 2013).

While the other Key Informants were expressing their opinions, Key Informant 3 concurred with the other key informants that indeed a health professional is preferable to perform health administration by expressing his experience of deploying medical doctors and health professionals in administrative positions. Here is what he said:

"I have never seen a generic administrator being offered and taking up a DHO position nor have I seen any health professional being offered and taking up administrative positions in any ministry or department other than the Ministry of Health. When health professionals hold administrative positions, they give priority to health or medical issues as is required." (Key Informant 3, Lilongwe, 2013)

The key informants claimed that individuals with medical background were able to set priorities right in order to achieve the mission, goals and objectives of the Ministry of Health and the government as a whole. This, according to them, is why all DHO and Hospital Director positions in the country's district and central hospitals are held by health professionals. Similarly, in the Ministry of Health, technical directorates are staffed by health professionals and one of the two principal secretaries is a health professional. There were even suggestions that both positions of principal secretary should be held by technical people but that did not materialize. These suggestions showed that health workers feel that health administration is unique.

4.1.2 Retention Strategy

According to Key Informant 1, *"deploying doctors to administrative positions such as DHO started after the first crop of doctors graduated from College of Medicine, when they were earmarked to replace expatriate doctors who were DHOs at that time"*. Key Informant 1 elaborated that *"there is nothing else that motivates them to work there other than the knowledge that they will head the institution"* (Key Informant 1, Lilongwe, 2013). The deployment of doctors in district hospitals as DHOs was seen as a retention strategy as doctors received thorough training in medicine as such it was thought that their deployment at the district hospital could improve delivery of health care services at district level and de-congest the central hospitals. This had really been effective in retaining doctors in the districts as young doctors had been attracted to remain in district hospitals after their internship as in this extract *"It is a strategy to attract doctors and it has managed to attract young doctors to the districts because they know that they will become DHOs"* (Key Informant 3, Lilongwe, 2013).

However, when these doctors were deployed in these districts, they did not do their clinical work as they were often occupied with administrative work leaving the clinical work to be done by the clinical officers. In cases where there were more than 2 doctors, one was a District Health Officer (DHO) and another was a District Medical Officer (DMO) who headed the clinical section at the hospital and the rest were medical officers meaning that they were supposed to be in wards just like clinical officers but they tended to stay in the administration block. They did not see the reason why they should be in wards while their colleagues with similar qualifications as theirs were assigned office-based responsibilities. All key informants agreed that the doctors were not being used to their maximum. They felt that the doctors should be left to do clinical work if the country is to improve its delivery of health care services as in the following extracts:

> *"… Utilization of doctors is compromised because of their involvement in administration. … Referrals to central hospitals would be reduced if the doctor at the district hospital was performing clinical work but in most cases they are busy with the administrative part of their job…"* (Key Informant 2, Lilongwe, 2013).

> *"Doctors are not put to best use. If we are to improve the health care delivery service we need to let them carry out clinical work."* (Key Informant 1, Lilongwe, 2013).

> *"College of Medicine has introduced a Bachelor's degree in Clinical Management. Medical doctors would be replaced by graduates of these programmes so that the doctors focus on their technical work rather than administration …"* (Key Informant 4, Lilongwe, 2013).

While the other key informants just explained that the doctors were not utilised at their optimum, Key Informant 3 went further to suggest development of a deployment policy.

> *"They are not used to the maximum. Government should have a policy. Currently, there is no policy on who should be deployed in these administrative positions. It is just an administrative arrangement that has been there for a long time."* (Key Informant 3, Lilongwe, 2013).

Furthermore, Key Informant 1 pointed out that there was a preconceived idea that people with medical background knew health priorities and putting them in those administrative positions would automatically translate to improvement in the quality and standards of services offered at a health facility. The key informant further noted that this belief hindered improvement in management of district health services when these people head the districts because they did not listen and learn from others; they believed that they were better placed to give direction on health issues in the district. Clinical Officer Respondents agreed with the observation by Key Informant 1. Actually, Clinical Officer Respondent 2 stated: *"When we complain to doctors that we need to rest, the doctors do not hear our complaints they favour their own cadre."* However, Key Informant 1 claims that this threat is countered when a good doctor with management skills was deployed to the administrative position.

4.1.3 Way of rising up to the higher positions in the hierarchy

When an organization has vacant positions, it fills them through recruitment from within the organization or from outside the organization (Dessler 2005:162-163; Newell 2005:121 -122; Armstrong, 2009:520). Filling of these vacant positions from within the

organization could be through transfers of individuals from positions of the same grade or promotions of individuals from lower ranks provided that they have the requisite qualifications for the vacant positions in order to achieve the set goals (Etzioni, 1964:3, Malawi Government, 1999). The Ministry of Health, just like any other organization, fills its vacant positions through the promotion of its staff as well as recruiting from outside the organization. For doctors to be promoted to higher positions, they may either choose to specialize in any medical field of their interest or they may be assigned administrative positions to manage the district hospitals. They then move to head health zones and then head the central hospital or any other directorate at the Ministry of Health headquarters.

4.2 Doctors' motivation to take up administrative positions

When the doctor respondents were asked about their motivation to take up administrative position, they raised three points namely: that their education prepared them for such responsibilities; health workers' attitudes towards their leaders and that they were attracted to the benefits attached to those positions.

4.2.1 Doctors' Education

The doctors felt that they deserved to be at this position because of their level of education. They felt that they were more knowledgeable than all other cadres since their training was the most thorough and longest of all trainings offered to health professionals; as such they were better placed to advise or offer the right direction regarding health issues in the districts.

> *"... before holding this position, I too shared the view that deploying doctors in*

administrative positions is a misallocation of scarce human resources but now I know better. This position needs to be held by a more knowledgeable person to be effective because the post-holder is required to give good direction to both the private and public health sector and also non-governmental organizations in the district in order to provide good quality care. Unfortunately there are few doctors- if they were many doctors, this is the best system. People cannot take advantage of them because of their knowledge" (Medical Doctor Respondent 5, 2013).

Medical Doctor Respondent 2 felt that the generic administrator could be taken advantage of because of his or her lack of knowledge on medical issues. He gave an example that pharmacy personnel may request drugs in excess when they knew that the DHO who should approve this request lacked knowledge to determine the actual drugs that would be used in the district for a given period of time unlike when a doctor held that position.

When asked whether the doctors deployed in administrative positions felt that they were deployed at a position that they were most effective, all of them said they were; arguing that health services must be managed by medical professionals as in the extracts below.

"Yes, I am most effective on my current position. Doctors feel comfortable to be managed by a fellow medical doctor. Even though management is difficult for some and it is easy for others, health service must be managed by medical practitioners." (Medical Doctor Respondent 1, 2013).

"Yes, I have succeeded in championing some changes in the DHOs that I have worked as a DHO" (Medical Doctor Respondent 2, 2013).

"Yes, it is a learning environment." (Medical Doctor Respondent 3, 2013).

"Yes, I am giving service to the public." (Medical Doctor Respondent 4, 2013).

"Yes. DHO positions need to be held by health professionals because they know the system. More knowledge is necessary in order to give good direction in the district for the district to give good quality care." (Medical Doctor Respondent 5, 2013).

4.2.2 Health workers' attitudes towards their leaders

In addition to quality and level of education of doctors as a factor that influenced the decision of doctors to assume administrative positions, a related factor or reason given by doctor respondents was that doctors felt more comfortable to be managed by a fellow medical doctor even though it did not guarantee good management as management is difficult for some doctors and it is easy for others.

"It is taking away scarce resources but it is not much of a waste, it is helpful. Leadership requires an individual to be more knowledgeable; health workers would not look up to generic administrators for leadership or guidance; the district requires a well knowledgeable person to advise the DEC. Financial knowledge plus health knowledge makes the doctor able to understand the priorities and better placed for the position of DHO ..."(Medical Doctor Respondent 4, 2013).

Similarly Medical Doctor Respondent 1 made this comment:

"... Doctors are deployed to work as managers but without being prepared to manage. It has weaknesses and strengths, but just like the Army and Police,

health management has to be carried out by health professionals …" (Medical Doctor Respondent 1, 2013).

4.2.3 Benefits attached to the position

The doctors deployed to administrative positions saw their deployment as a promotion.

> *"It was promotion. There were things that I thought should be changed so my position … gave me an opportunity to express my opinion on what I thought was a solution to the problems. I thought administrative issues needed to be sorted out if we are to realize the fruits of the reforms. So they thought of putting me on this administrative position to champion the changes that I was suggesting."* (Medical Doctor Respondent 1, 2013).

Despite most of them (60% of doctors interviewed in this study) being at the same entry grade of salary scale, there are other benefits attached to and prestige associated with the DHO position which the doctors did not enjoy when they were doing clinical work. The following extract illustrates this: *"The benefits attached to this position attracted me to accept the offer to assume this DHO position"* (Medical Doctor Respondent 5, 2013). For example, there was a car, a good office and a secretary who served the office of the DHO.

The DHOs were also controlling officers in their institutions which meant that they controlled funding allocated to their institutions. Even though officially the District Commissioner is the controlling officer of the whole district but the DHO has ultimate authority over all health issues in the district and also resources allocated to the health

sector in the district which makes them controlling officers in their institutions. The District Commissioner cannot use finances or any other resource in the district meant for the health sector without being cleared and approved by the DHO. Being a controlling officer had its own challenges. In this study, the doctors complained that they had been given management positions but there were no resources to manage. For example, funding allocated to the hospitals was too low to allow them procure the much needed drugs and equipment to enable the hospital deliver quality health services. They also complained of shortages of staff which they felt derailed the mission they wanted to achieve.

Too much bureaucracy was also cited as a challenge in the performance of their function. The Ministry of Health had decentralized allocation of financial resources to the districts; as such procurement of drugs and all other items needed at a district hospital had to be approved by an Internal Procurement Committee (IPC) at district assemblies and delays were being experienced in sourcing signatures from assemblies due to unavailability of signatories since they also had other responsibilities. Even when the hospital needed to procure some emergency items, they had to wait for the main IPC to meet and approve such purchases as per the Office of the Director of Public Procurement (ODPP) and Public Procurement Act requirements.

Despite the aforementioned challenges, the doctors held the view that the administrative positions accorded them opportunities that they could not enjoy while performing clinical work alone.*"I was promoted to the position of DHO where I am gaining experience in*

management which can be used elsewhere and also the position of DHO accords me an opportunity to interact with most senior people in the government service and other organizations." (Medical Doctor Respondent 5, 2013).

However, the opportunity cost (foregone opportunity) of holding those administrative positions was that they did not grow professionally compared with their colleagues who performed clinical work along-side specialists at a Central Hospital. The doctors did not grow professionally because administration work took much of the doctor's time such that there were times when it was virtually impossible for them to see patients. One respondent explained that he was not able to attend to patients because his whole day was occupied with administrative issues. In his own words he said *"I do not see patients because there is a long queue of people every day waiting outside my office for their turn to meet me"* (Medical Doctor Respondent 1, 2013). Since doctors are attracted to districts, the government should take advantage of this opportunity to ensure that these doctors perform clinical work so that both the doctors and patients benefit from the deployment of doctors to district hospitals as clinical people.

4.3 Attitudes of health workers towards deployment of doctors in administrative positions

The study accorded the respondents an opportunity to express their attitudes towards this practice of deploying medical doctors to administrative positions. In this study, the investigator adopted Simmons' definition of attitudes. Simmons (2008:190) noted that *"Attitudes imply evaluation and are concerned with how people feel about an issue."* Questions about attitudes in a data collection tool usually employ scales; a statement is

made and individuals are asked to indicate their level of agreement in a positive or negative direction (Ibid). In this study, a scale was not employed, instead the study participants were asked to describe freely their feelings about the deployment of doctors in administrative positions and its impact on the delivery of health care services in the public health sector in Malawi. The scale was not used because the investigator felt its use would limit the respondents from explaining their feelings fully which is against the Social Constructionist Paradigm that guided this study.

Just as people view everyday matters that they choose to discuss or debate from different angles, the same was observed on this issue. Some clinical officers felt that doctors were victims of circumstances they had no choice over; that medical doctors just found themselves in those administrative positions; others felt that doctors' training prepared them to be leaders in their workplace just as clinical officers were, the only difference was that doctors held a higher qualification (that is, a degree) than most clinical officers who held diplomas but in cases where there were other clinical officers with degrees then the choice of a doctor over a clinical officer to be a DHO was not justified. Other clinical officers saw doctors who held administrative positions as having low interest in clinical work yet they were trained to do it.

4.3.1 Doctors have no choice

Some clinical officers felt that administrative positions were, in most cases, senior positions with privileges attached to them hence their attractiveness as in these extracts.

"It is a senior position so benefits attached to these positions attract them." (Clinical Officer Respondent 5, 2013).

"Doctors are attracted to the privileges attached to those positions" (Clinical Officer Respondent 7, 2013).

"The doctors want to improve the standards of health service delivery in the country; and these positions easily influence the necessary changes. The doctors do not want to be in direct contact with patients but they want to assist these patients in another way through managing health services. In addition, those positions elevate one's social status, as evidenced by the respect that a holder of a management post receives from the general community and also fellow health workers, which motivates many health workers to take them up." (Clinical Officer Respondent 19, 2013).

Even though those positions are attractive, and despite an individual's interest to hold any of those administrative positions, they cannot put themselves in such positions or indeed any other position in the formal organization. They are assigned those positions by people with authority for the assignment to be recognized by the rest of the members of the organization (Etzioni, 1964; Malawi Government, 1999). The individual is formally communicated of the assignment giving him or her mandate to perform the duties reserved for the post holder as well as mandating her or him to enjoy the benefits and privileges attached to the assigned position in exchange of the services provided.

Therefore, according to some clinical officers, since an individual assumes responsibility of the position that he or she has been assigned, more especially in the nature of organization like the Public Service in Malawi, it follows that, doctors had no choice but to accept their appointments into administrative positions as deemed fit by their employer, the Ministry of Health. The following extract illustrates the point: *"I do not know if they have a choice. I think they are just posted to these positions"* (Clinical Officer Respondent 15, 2013).

4.3.2 Doctors deserve the administrative positions

Some clinical officers in the study held the view that the doctors and clinical officers were trained to be managers or to lead, that is why in health facilities where there were no doctors, the clinical officer took charge of the operations of the health facility. When asked to explain why some doctors took up administrative positions, clinical officer respondent 1 said:

> *"It was the nature of their training. They were trained to be both clinicians and administrators. They know what is required at that position so their deployment to these administrative positions is a natural thing. There is therefore, need to train many clinical officers because they are the ones that perform clinical work".* (Clinical Officer Respondent 1, 2013).

Clinical officer respondent 4 also felt that the doctors' qualification entitled them to assume those administrative positions. In her own words she said: *"...assignment of individuals to positions goes with educational level, when you have a master's degree you cannot be treated as a clinical officer ..."* (Clinical Officer Respondent 4, 2013).

4.3.3 Doctors do not want to perform clinical work

Most of the clinical officer respondents expressed dissatisfaction with the way medical doctors were used in the public health sector. They felt that the doctors did not want to perform clinical work and that is why they accepted the administrative positions hoping to have access to money for the running of the district health service. When asked to explain why health workers accepted administrative positions such as DHO and Directorship, clinical officer respondent 2 said:

> *"It is good to have a health worker at that position but in practice when the health workers are at that position they forget what they were facing in wards. They only consider themselves when they take up those positions and forget motivation of other health workers; resources are not available even if DHOs are doctors. Let doctors work in hospitals. Currently, they do not avail themselves for consultation. Human skills are misused as sometimes MBBS is not put to use. I do not know. It is a promotion but they are exposed to so many things such as money and procurement. Interns from College of Medicine do not have interest to work in hospital as they actually say that if they are not DHOs then they will have to leave the public health sector so I think their motivation is money. Government should raise their salaries to retain them because they are well qualified theoretically, practically they are not good because they lose interest in clinical work"* (Clinical Officer Respondent 2, 2013).

Similarly, Muula (2009:509) observes that medical students that he interacts with at the College of Medicine where he lectures, just like students in any other fields, are concerned about their career prospects as medical doctors and the possibility of earning

enough money for them to live comfortably. Therefore, it is not surprising to see that doctors leave the public health sector when their expectations are not met.

4.4 Impact of deploying doctors in administrative positions

The deployment of doctors into administrative positions affects the health system in three aspects namely: on the doctors themselves, on the clinical officers and on the delivery of the health care services as discussed below.

4.4.1 Effects on doctors

Those administrative positions exposed the doctors to a lot of things and in the end shaped the way they viewed their profession and also took away their interests from clinical work. Many doctors in those administrative positions realised that their posts gave them access to so many opportunities and financial rewards without necessarily having to attend to patients. Out of the five doctors interviewed, two (40%) said that they would gladly revert to clinical work if given an opportunity; two (40%) would not accept to go back to technical work while one (20%) said that he would only revert to clinical work if he got a scholarship for specialist training and/or becomes a researcher.

The two medical doctor respondents who said that they would not accept to be put in clinical work elaborated as follows:

> *"I am a qualified general practitioner, but my current grade is equivalent to that of a specialist, so for me to go back to technical work I will need to go for specialist training in order to be at this same grade (P2). I am too old to go for*

specialist training. After all I am remaining with 3 years to retire. The best for me is not to see patients but to share the experience, with other professionals on how changes could be implemented." (Medical Doctor Respondent, 2013).

Concurring with the statement above, another medical doctor respondent said:

"Doctors should be left to do what they like most in order to gain their commitment so that they become efficient and effective. They should not be forced to be in wards because they have an MBBS - as they may not be effective at the positions that provide direct patient care. Furthermore, conditions of service are terrible." (Medical Doctor Respondent, 2013).

The two doctors who said that they would revert to clinical work if given that opportunity explained that there was no motivation in taking up the position of DHO; and one of them attributed this lack of motivation to injustice as he said that their salaries did not reflect the amount of work that DHOs performed. In his own words he said: *"There is no justice, I get paid as a fellow doctor at a central hospital yet I work more than them..."* (Medical Doctor Respondent, 2013).

4.4.2 Effects on clinical officers

Apart from the erosion of interest of doctors from clinical work, deployment of doctors into administrative positions also affects clinical officers. 16 out of the 19 clinical officers interviewed said that their work is negatively affected by this practice. Some clinical

officers said this practice de-motivates them as they felt that the doctors were getting paid a lot of money for not working. Clinical officer respondent 2 said:

> *"... I do some work which was supposed to be done by a doctor such as major surgical procedures. Doctors are given more money but they work less. Few doctors are committed to work on a bedside; most of them are doing office work. The impact of College of Medicine is not known; the objective of College of Medicine is not known. Government should facilitate upgrading of clinical officers to empower them as currently clinical officers are undermined and overlooked."* (Clinical Officer Respondent 2, 2013).

As clinical officer respondents put it, even in hospitals where there were more than two doctors, all of them were normally not available for consultations and their work was left on the clinical officers' shoulders thereby increasing their workload yet their salary remained the same. One doctor observed that *"when the DHO was away from the hospital to such assignments as meetings, clinical officers relaxed in the way they rendered their services but when the DHO was around the clinical officers worked so hard"* (Medical doctor respondent 5, 2013). This observation could be explained by what the clinical officers said that they felt the doctors take up administrative positions because such positions gave them (the doctors) many opportunities to access financial rewards such as attending workshops and seminars where they could get allowances. As such, when the doctors left their duty stations for such meetings, the doctors' absence from the hospitals confirmed their suspicion that they went out to workshops and meetings to get allowances hence the clinical officers would react by going slow.

4.4.3 Effects on the delivery of health care services

In addition to the aforementioned effects, knowledge transfer between doctors and clinical officers is negatively affected when doctors are deployed in administrative work. The clinical officers feel that doctors have lots of skills and knowledge which they need to share with them and this can only be done when they work on patients. This is one of the major reasons why clinical officers felt that doctors should concentrate on clinical work. According to one clinical officer respondent, deployment of doctors to administrative positions *"They have lots of skills which they need to share with others and this can only be done when they work on patients hence doctors should concentrate on clinical work"* (Clinical Officer Respondent 10, 2013).

The delivery of health care services is also adversely affected by the impact of deploying medical doctors in administrative positions as it has been explained above that the loss of doctors' interest in clinical work and the de-motivation of clinical officers mean that the number of staff dedicated to provision of direct patient care is reduced further. The following extracts illustrate this point:

> *"It means shortages of staff on the ground. The vision of government in providing enough doctors will not be achieved because most doctors will be in office performing administrative work; government should find other means by which they would be utilized efficiently*." (Clinical Officer Respondent 19, 2013).

> *"This practice is crippling the delivery of health care services; doctors gain a lot of knowledge but they do not use it on patients - it is a waste of money spent on*

their training as well as a waste of skills gained; the standards would reach high level had they performed clinical work but now the standards are pathetic." (Clinical Officer Respondent 7, 2013).

"Doctors focus on administration neglecting clinical work hence part of clinical work suffers. Patients suffer." (Clinical Officer Respondent 12, 2013).

"We have two doctors who hold administrative positions; their clinical work is left on our shoulders which increases our workload. Core business of a hospital is never achieved. However, it is difficult to eliminate this arrangement as doctors are many in administrative and decision making positions as such they would block any change that would put them at a disadvantage." (Clinical Officer Respondent 13, 2013).

"It de-motivates me. Doctors do not do their work. The way some doctors talk make other health workers shun meetings with them such as morning report. They should be trained on how to manage people" (Clinical Officer Respondent 14, 2013).

"All administrative positions are held by doctors. This de-motivates other health workers who feel that they work but money goes to these doctors. Doctors should work for some time before assuming administrative positions." (Clinical Officer Respondent 17, 2013).

> *"Patients are suffering, doctors concentrate on administration."* (Clinical Officer Respondent 15, 2013).

Even medical doctors who hold administrative positions also recognize that this practice deprives the public health sector of their services as in the following extracts: *"It is taking away scarce resources but it is not much of a waste, it is helpful."* (Medical Doctor Respondent 4, 2013).

> *"The service provision is affected but not significantly because we work as a team so when one member is away, the other clinicians take over. However, the absence of a DHO from the hospital makes other health workers to relax. For example, when the DHO has gone to attend a meeting say in Lilongwe the clinical officers relax in the way they perform their job. They can leave patients waiting for them and attend to their personal issues during working hours but when the DHO is around they become serious with their job."* (Medical Doctor Respondent 5, 2013).

The shortage of doctors and clinical officers coupled with shortages of drugs and other essential supplies, broken equipment, inadequate human logistical support and management worsen the situation in the country's hospitals. The patients do not get the medical attention that they could otherwise receive if all the available health professionals who specialized in provision of direct patients' care and qualified health managers are recruited and dedicated all their time on provision of services in their field of specialty and medical supplies, drugs and medical equipment to work with were available.

4.5 Conclusion

Study findings show that considering the nature of health administration and the urge to remain attractive in order to retain medical doctors in the public health sector, the Ministry of Health deploys medical doctors in administrative positions through promotions to these positions as well as first appointments. This has, however, been noted by the key informants and study respondents as being costly. The doctors have been retained in numbers yet performance indicates the shortages of the skills to effectively provide direct health care as these retained medical doctors have completely switched their attention to administrative work. Furthermore, this practice has created a feeling widespread among clinical officers that they are doing part of the job that was supposed to be done by medical doctors consequently it has negative effects on the clinical officers' performance and the health system in general.

Even though the study sample did not come from all institutions in the public health sector, it was found in all the 4 district hospitals visited that each of them had 2 doctors except one hospital which had 4 doctors and the trend was the same that all doctors concentrated on administrative work, indicating a consequent depletion of the number of doctors providing direct patient care. The key informants indicated that this was a trend in all the district hospitals in Malawi.

This chapter has presented the findings of the study. The next chapter presents conclusions drawn from the study, implication of the findings, suggested areas for further research and recommendations by the investigator based on the study findings.

Chapter Five

Conclusion, Implication, Area for Further Research and Recommendations

5.1 Conclusion

From the study findings, the practice of deploying medical doctors in administrative positions helps to retain medical doctors in the public health sector. However, this deployment is a misallocation of human resources. This negatively impacts on the delivery of health care services since both doctors and clinical officers do not perform to the best of their ability because the doctors lose interest in clinical work and clinical officers are de-motivated to see that doctors are not performing the work they were trained for and yet nothing is done to correct this problem. From the Rational Choice Theory point of view, the deployment of medical doctors to administrative positions as a means of improving health services is not a rational decision.

5.2 Implication of the Study

The implication drawn from the findings is that higher level direct patient care in the district hospitals is suspended or is being offered by clinical officers who are less qualified than the doctors. This may result in frequent referrals to the central hospital or even low quality patient care.

5.3 Suggested area for further research

A study should be done to find out whether migration of clinical officers and medical doctors is one of the consequences of the deployment of medical doctors in administrative positions.

5.4 Recommendations

The investigator makes the following recommendations:

Firstly, the Ministry of Health should consider reviewing this practice by reviewing the Deployment Policy to ensure that qualified health managers and professional health workers with skills in direct patient care are placed in right positions. This would improve the delivery of health care services and lead to more specialization for those trained in the medical profession and those trained in health management.

Secondly, the Ministry of Health should make sure that both clinical officers and DHOs have proper and clear job descriptions that should act as a benchmark upon which they can make reference to check if they are performing accordingly and, if they are not, also hold them accountable for underperformance. In relation to this, the Ministry of Health should introduce an effective performance management system in its health facilities.

Thirdly, there is need to motivate clinical officers through better remuneration packages and career advancement. The study found that because DHOs are busy with administrative work, a lot of clinical work including surgical operations at district level is

done by clinical officers. This signifies the need to recognize clinical officers and employ incentives that would motivate them to remain in the service. With a proper performance management, the Ministry of Health would devise a good remuneration package that rewards hard workers through promotions, scholarship and/or extend the retention policy to clinical officers through introduction of a "Hardship Allowance" as is done with rural teachers under the Ministry of Education, Science and Technology.

Lastly, the Ministry of Health should develop an effective communications strategy to its employees and the general public. Some of the de-motivation among certain cadres of the health workers is due to ineffective communication of various policies in the health sector. The Ministry may develop a wonderful policy but if such a policy is not properly communicated across the rank and file of the whole health care system, demoralization and slowdowns resulting from lack of correct information will continue plaguing the health sector with adverse effects on delivery of health care services.

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APPENDICES

APPENDIX 1: Interview Schedule for DHO and Central Hospital Director

1. What is your profession?
2. What qualifications do you have?
3. What attracted you to this profession?
4. How long have you been working in the government health service (starting from your first position to the current position – stating the number of years at each position)?
5. When you joined the Ministry of Health, what was your experience in performing your job (citing opportunities and challenges etc)?
6. What are suggested solutions to these challenges if any?
7. What motivated you to assume this position of DHO or Directorship?
8. May you please give me a brief description of your current job (position)?
9. If his/her job involves both clinical and administrative work, how is time allocated to each type of work?
10. How is the deployment of doctors to administrative work affecting the referral system in terms of the numbers and types of cases referred?
11. In your opinion, are you deployed or placed at a position that you are most effective?
12. Given an opportunity to revert to your technical work at the same grade you are now, would you accept the offer?
13. Explain why you would accept (or not accept) the offer.

APPENDIX 2: Interview Schedule for clinical officers

1. What is your profession?
2. What attracted you to join this profession?
3. How long have you been working in the public health service?
4. May you please give me a brief description of your job?
5. What are the challenges that you face in performing your job?
6. What are suggested solutions to these challenges?
7. After training, and your entry into the public health sector, are you still interested in your profession?
8. What could have been done or not done to ensure that you remain active (practicing) in your profession?
9. Why do you think health workers accept administrative positions such as DHO or Directorship?
10. Is your work affected by this assumption of administrative positions by doctors and other clinical officers in any way? If yes, how is it affected? If no, may you explain why you think it is not affected?

APPENDIX 3: Interview Schedules for the Key Informants.
For Ministry of Health

1. What is the mandate of the Ministry of Health?
2. How many doctors are available in Malawi?
3. How many of the available doctors are performing clinical work?
4. How many, of the available doctors, hold health administrative positions?
5. In your opinion, is the number of doctors carrying out clinical work adequate to deliver the required quantity and quality of health care services in Malawi considering the country's population and burden of disease? Please explain your answer.
6. Are the doctors assigned to administrative work adequately prepared for the non-clinical work? Please explain how they are prepared.
7. To what degree does deployment of doctors to administrative positions help the Ministry of Health in achieving its mission, goals and objectives (please explain)?
8. What is the government's policy on using health professionals in health administrative positions?
9. What informed the formulation and adoption of this policy?
10. What is the motivation of the ministry of Health for using health professionals in health administrative positions?
11. What was the context within which the policy of using health workers emerged in Malawi?
12. How appropriate is the choice of cadre of health professionals to assume administrative positions, considering the quantity and quality of health professionals required at each level of care (please explain)?

13. How well does the deployment of doctors to administrative positions fit with the human resource requirements in the public health facilities?
14. What are the strengths and weaknesses of deploying doctors to administrative positions?
15. In your opinion, why are doctors still deployed in administrative positions despite the weaknesses that you have outlined?
16. How is the deployment of doctors to administrative work affecting the referral system in terms of the numbers and types of cases referred?
17. How does performance of a professional administrator differ from that of administrator with medical profession background?
18. What is your comment on the utilization of doctors in the country?

For Regulatory body

1. What is your mandate?
2. How many doctors and clinical officers are registered with your organization as of now?
3. How many of the registered doctors and clinical officers are performing clinical work?
4. How many of the registered doctors and clinical officers are performing non-clinical work (administrative work)?
5. Are these medical practitioners performing administrative work adequately trained to take up the administrative work?

6. In the event that they are performing administrative functions rather than clinical work, how do you regulate their performance?
7. In your opinion, what number of doctors and clinical officers can be deemed adequate to deliver health care services in Malawi? Explain why?
8. What is your role in addressing the shortages of human resources for health in the country?
9. What do you think can be done to address this shortage?
10. What challenges do you face when carrying out your mandate?
11. What can be done to address these challenges?

For the Department of Human Resource Management and Development

1. What is the government policy on using health professionals on health administrative positions?
2. What informed the formulation and adoption of this policy?
3. How is the policy contributing to the improved health care delivery service?
4. How does a case of a professional administrator differ from the case of administrator with medical profession background?
5. What are the strengths and weaknesses of deploying doctors to health administrative positions?
6. In your opinion, why are doctors still deployed in administrative positions despite these weaknesses that you have stated?
7. What are your comments about utilization of doctors in the country?

APPENDIX 4: Informed Consent Form

Informed Consent Form

Consent Form for Study Participation

Study Title: An investigation into the impact of deploying doctors in health administrative positions on delivery of health care services in Malawi

Principal Investigator: Ruth Elizabeth Nkombezi (nee Phiri)

E-mail address: ruthnkombezi@gmail.com

Contact number: 0888 300 177

Institution: University of Malawi, Chancellor College

Introduction

You are requested to take part in this study being conducted by Mrs. Ruth. E. Nkombezi, a student pursuing a Master of Arts degree in Development Studies at Chancellor College of the University of Malawi, as part of the course requirement.

Purpose

The purpose of the study is to investigate the impact of deploying medical doctors in health administrative positions on the delivery of health care services in Malawi.

Procedure

Participation in this study is entirely voluntary. You are free to take part or not or withdraw from the study at any point. If you accept to take part in this study, you will be required to answer some questions about yourself and your assessment of the impact of the assumption of administrative positions by medical doctors on the delivery of health care services.

Benefits

You will not be compensated for taking part in this study; however, you will have the opportunity to express your views on:

- The choice of cadres of health workers that assume administrative positions.
- The motivation of the ministry of health to deploy doctors to administrative positions.
- The motivation of the doctors to accept administrative positions.
- How using doctors in administrative positions is affecting the delivery of health care services (both positive and negative effects).
- What you think can be done to ease any negative effects of this arrangement.

Risks

There is no harm for taking part in this study.

Confidentiality

Your name will not be shown on the sheet for your responses nor in the report. Access to the study information is solely limited to the investigator.

Study Approval

The study is approved by the College Research Committee and the National Health Sciences Research Committee (NHSRC). If you need any clarification, you can contact the head of Research Unit, Dr. D.D. Kathyola through the following phone number 0888344443.

Consent and Signature

Make sure you have read and understood the contents of this form before signing.

Are you ready to take part in this study?

YES ☐ NO ☐

Respondent's full name……

Respondent's Signature……. Date……

Investigator's Signature……. Date…….