

CHAPTER 1

1. 1 INTRODUCTION

South Africa, like many developing countries, is facing a serious problem of skills/labour migration, especially essential skills such as those of medical doctors. This brain drain is affecting the rural and underserved areas where these skills are mostly needed(Thulare 2003).

The focus in this report will be to look at the factors that are influencing the decision of doctors to relocate from rural areas to urban areas, specifically in the rural district of Dr. Ruth Segomotsi Mompati in the North West Province. The research will present an analysis of the recruitment and retention policy of the Department of Health to identify factors that might lead to the relocation of doctors from rural areas to urban areas that might have been overlooked or were not included in the policy originally, hence the continuation of relocation of doctors from rural areas to urban areas.

The focus will mainly be on operational issues hampering the effective implementation of the recruitment and retention of doctors in the North West Department of Health policy, with the intention reviewing the policy and presenting possible solutions to the perceived policy gaps.

This report starts with an introduction, which includes the background. This is followed by the problem statement, purpose statement, research questions, literature review which will include in its introduction, a definition of terms or concepts, general content and conclusion, research methodology which will include in its introduction, the research approach, research design, data collection which will also include primary data, secondary data, sampling, data analysis, validity and reliability, presentation of results, interpretation of results, conclusion and recommendations.

1.1 BACKGROUND

According to the North West Health Provincial Department's 2005/2006 Annual Report, the Department of Health continues to train quality doctors to serve in the rural areas where the shortage of doctors is experienced the most. The Department of Health has introduced incentives such as rural allowances, furnished accommodation, occupational specific dispensation (OSD) and overtime allowances to retain medical doctors in rural areas(Thulare 2003).

According to the World Health Organization Standards, the ratio of doctors per 100 000 people should at least be 100 doctors. In the United States presently, the ratio of doctors is 247 doctors per 100 000 people, however, in South Africa, there are only 74 doctors per 100 000 people and this includes rural and urban areas in all provinces. According to the South African Government Information Services, the ratio of doctor per 100 000 peoples in the following provinces are as follows: Western Cape is the best resourced with 135 doctors per 100 000 people, Gauteng is at 30 doctors per 100 000 people, Limpopo is at 17 doctors per 100 000 people and finally North West is at 11 doctors per 100 000 people. More than 65% of North West Province inhabitants are based in rural areas, and it is where the shortage of doctors is most acutely experienced due to migration to urban areas(Statistics SA 2010).

Table 1: Ratio of Medical Practitioners per 100 000 population across provinces, 2001 and 2004

Province	2001	2004
Eastern Cape	34	27
Free State	69	54
Gauteng	173	126
KwaZulu Natal	70	52
Limpopo	21	18
Mpumalanga	42	30
North West	30	23
Northern Cape	54	42
Western Cape	182	147

Source: Hall and Erasmus (2003); HPCSA (2004)

Table 1 illustrates the unequal distribution of medical doctors between rural and urban provinces. All nine provinces have medical doctors density ratios higher than the WHO minimum level of 20 per 100 000 population. However it must be noted that these are combined figures for public and private sector health facilities and there was a decrease in the density ratios in all the provinces between 2001 and 2004. Rural provinces such as Eastern Cape, Limpopo, Mpumalanga, Northern Cape and North West have the lowest number of medical doctors per 100 000 people. In contrast, the provinces that have the country's major cities (Gauteng, Western Cape and KwaZulu-Natal) have a higher proportion of medical doctors serving the population. Hamilton and Yau (2004) reported that 46% of the population lived in rural areas but were served by only 12% of doctors. This proves that there is a continuation of mal-distribution of medical doctors between rural and urban areas.

Despite the efforts by the government in offering incentives, such as rural allowances, furnished accommodation and training of doctors to serve in rural areas the problem persists. This is due to the fact that there are no proper retention strategies and policies to keep medical doctors in rural areas.

1.1.1 THE PUBLIC HEALTH SYSTEM IN SOUTH AFRICA

The South African Constitution states that everyone in the country has the right of access to quality health care services. The government, through the public sector, has the responsibility of providing healthcare services to the thirty five million people or 84% of the population that qualify for this service, which is made up predominantly of the indigent, low-income earners and the unemployed (Brink, 2001). To this responsibility must be added the escalating burden of managing HIV/AIDS and tuberculosis (Health Sector Strategic Framework 1999-2004, 1999).

Van Niekerk and Sanders (1997) state that the Department of Health is responsible for determining policies in terms of conditions of employment, compensation and rewards system, and the general macroeconomic and socio-political environment of the delivery of healthcare.

1.1.2 RESOURCE ALLOCATION

Stewardship in healthcare delivery involves, amongst other things, resource allocation (Thulare, 2003). Healthcare delivery is a labour-dependent and labour-intensive industry. The efficiency of healthcare service provision is strongly people dependent. Many factors in the area of human resources will have an impact on how a health system performs (Buch, 2001). One of the most critical and strategic human resource inputs into the health system is that of doctors (Health Sector Strategic Framework 1999-2004, 1999).

1.1.3 PROFESSIONAL MIGRATION

There are various push and pull factors that have resulted in the migration of medical doctors away from areas where the need for service provision is greatest to areas where the need for service provision is less urgent (Buch, 2001). Between 1958 and 1993, 44% to 47% of graduates from the Wits Medical School emigrated with identical percentages settling in the Commonwealth and the USA (Bateman, 2001). Statistics from the South African Medical Association indicate that at least 26% of medical doctors that qualified between 1990 and 1997 have emigrated (Bateman, 2001). Van Rensburg and Van Rensburg (1999) described three forms of professional migration. These are outlined briefly below.

- **Rural to urban migration**

Veitch, Harte, Hays, Pashen and Clarke (1999) state that factors that contribute to urban migration include: limited family support, education and career opportunities, poor local support (such as inadequate housing, and personality clashes with important people in the community), and limited personal and professional development opportunities.

Public to private sector migration

According to Brink (2001), the private sector consumes 60% of total health expenditure and employs 70% of medical doctors in the country whilst serving one fifth of the population. In 2000, only between 50% and 84% of academic posts in medical schools were filled as academics migrated to the private sector or emigrated (Brink, 2001).

- **Migration from South Africa to developed countries**

Wharry (2002) states that countries such as Canada have long relied on a steady supply of doctors from South Africa to supplement its own workforce. “It is common knowledge that the medical school that produces the majority of Canadian rural doctors is the University of Johannesburg” (Romanow Submission, 2001, p.7). It is estimated that in provinces such as Manitoba in Canada, 36.5% of all rural doctors were trained in South Africa. WONCA (2002) states that in 1999 about 600 South African trained doctors were fully registered in New Zealand

1.1.4 Push Factors

- **Remuneration**

Naude (1999) describes low salaries, restrictions on commuted overtime remuneration and poor progress in the development of a comprehensive salary package as factors that contribute to staff turnover and shortages. The over regulation of limited private practice (LPP) and remuneration work outside the public sector has been cited as another contributing factor to attrition (Naude, 1999).

- **Deterioration of Conditions of Service**

Bateman (2001) describes the deteriorating conditions of service in public hospitals. Inadequate services at public hospitals are due to shortages in human and financial resources, inappropriate and inadequate facilities, staffing crises and patient overload. These factors result in a lack of supervision for junior doctors, which in itself, contributes to attrition.

- **Postgraduate Training**

Bateman (2001) describes the shifting of resources to primary healthcare and a spending switch by the Department of Health from highly specialized medicine to primary and secondary healthcare as a push factor.

- **Rural Medicine**

Naude (1999c) describes the on-going lack of, and deterioration in, senior expertise in rural public hospitals, which results in a lack of supervision and mentorship, as a cause for junior doctors' migration to urban hospitals. Community service doctors require the support of capable and motivated senior doctors who currently are not incentivised to practise in rural public hospitals.

- **Regulatory Framework**

The addition of two more years of postgraduate vocational training or community service to the six years of basic training by the Health Professions Council of South Africa has been identified as a push factor for junior doctors (Bateman, 2001).

1.1.5 Pull Factors

According to Bateman (2001) "pull" factors include:

- Attractive salary packages from the private sector and overseas countries;
- Favourable conditions of employment being offered by the private sector and overseas countries; and
- Rewards for working in environments that have fewer financial constraints in the clinical setting and, therefore, offer more therapeutic and technological options for clinicians.

1.1.6 Conclusion

Habte et al(2002) stated that the environment in the public health sector of developing countries has resulted in demoralised, de-motivated, overworked and underpaid health professionals. Current strategies and policies implemented to address retention problems in the public sector have shortcomings.

1.2 PROBLEM STATEMENT

The Department of Health introduced incentives, such as rural allowances, furnished accommodation, occupational specific dispensation (OSD) and overtime allowances for medical practitioners in an attempt to retain doctors in rural areas.

Despite the efforts by government in offering these incentives such as; rural allowances, furnished accommodations and training of doctors to serve in rural areas the problem persist. In the Dr Ruth Segomotsi Mompoti district, 10 to 15 doctors relocate to urban areas annually.

Despite the recruitment and retention strategies and policies that were initiated and implemented by the Department of Health, medical doctors still relocate from rural districts such as Dr Ruth Segomotsi Mompoti to urban areas. The need of the research was to identify factors influencing the relocation of doctors from Dr Ruth Segomotsi Mompoti district to urban areas and what can be done to curb this 'braindrain'. Also the recruitment and retention policy and strategies need to be taken into consideration, and to be critically evaluated to identify the factors that are the root cause of the problem of relocating medical doctors.

The researcher proposes to investigate and identify factors that contribute to the relocation of medical doctors from Dr. Ruth Segomotsi Mompoti District to urban areas and to explore and identify strategies that can be put in place to achieve sustainable recruitment and retention of medical doctors in rural areas.

1.3 PURPOSE STATEMENT / PURPOSE OF THE STUDY

The purpose of this research is to identify the factors influencing medical practitioners to relocate from a rural area, such as, Dr Ruth Segomotsi Mompoti District to urban areas. The study also aims to facilitate a better understanding of factors that will improve the retention of medical doctors in rural areas such as Dr Ruth Segomotsi Mompoti District as it is the most rural district in the province and experiences the relocation of medical doctors to urban areas. This research will be targeting this rural district of the North West Province. The recruitment and retention policy will also be examined, to identify any flaws or gaps in the policy, then the study will seek to identify the solution in order to assist the health sector to close any gaps

in dealing with these factors that influence medical practitioners to relocate from the district. The findings of the study can be used to develop strategies and policies that will assist the public health sector to retain medical doctors in rural districts such as Dr Ruth Segomotsi Mompoti.

1.4 Research Questions

This study's primary question is:

What are the factors that influence medical doctors to relocate from Dr. Ruth Segomotsi Mompoti district to urban areas?

The secondary research question is:

If these factors can be addressed and implemented accordingly will medical doctors be retained in the Dr. Ruth Segomotsi Mompoti district?

1.5 Significance of the study

This study will bring focus and scrutiny on underlying factors that cause medical doctors to relocate from Dr Ruth Segomotsi Mompoti district to rural areas. Findings from this study will contribute constructively to improve the recruitment and retention policy and strategies to keep medical doctors in rural areas. This study may also serve as a reference for other districts in the province that may have the similar problem of the relocation of medical doctors from rural to urban areas. Also, it will establish business best practices to improve retention of qualified medical doctors in the public health sector, especially in rural areas.

1.6 Limitations

The study will be limited to medical doctors who are currently employed in the public sector in Dr. Ruth Segomotsi Mompoti District and those who left the district to work in urban areas within the North West. Participants in the sample will be predetermined by the number of doctors working in the district and those who left to work in urban areas. The study is limited to Dr. Ruth Segomotsi Mompoti District of the North West Province as it is the most rural district in the province and experiences relocation of medical doctors to urban areas in the province. Every

financial year the district loses ten (10) to fifteen (15) medical doctors who relocate to urban areas.

1.7 Outline of the Structure of the Report

1.7.1 Chapter One

Chapter one will introduce and give background on the research problem, problem statement, purpose of the research, research questions, significance of the study, its limitations and the conclusion to this chapter.

1.7.2 Chapter Two

This chapter will provide the literature reviewed on the factors that influence medical doctors to relocate from rural to urban areas. It will further look at factors leading to international migration of medical doctors, migration of medical doctors in the African Continent as well as within South African provinces so as to establish the trends and link that to the Dr Ruth Segomotsi Mompati District. Areas such as the doctor as a knowledge worker, factors leading to migration of medical doctors, job satisfaction, South African policies which address migration of medical doctors, push and pull factors leading to migration of medical doctors will be covered.

1.7.3 Chapter Three

Chapter three will give the design of the study, why the particular design was chosen. It will explain the interview process and why this is important in the research, the questionnaire, its importance and why it was chosen, approach of the study, method employed to collect data, primary and secondary data, sampling, data analysis, validity and reliability of the data collected, significance of the study, its limitations and ethical issues.

1.7.4 Chapter Four

This chapter will present the result of the study. It will give perspective on the demographic analysis of respondents and response to the primary and secondary questions of the study.

1.7.5 Chapter Five

This chapter will present an analysis and interpretation of results presented in the previous chapter. The interpretation will be based on confirming similarities to and differences from what was described and discussed in chapter two of the study.

1.7.6 Chapter Six

This chapter will deliberate on the research findings and analysis, thereby drawing its conclusions and making recommendations as well as highlighting the study's limitations and areas for future research.

CHAPTER 2

2. LITERATURE REVIEW

2.1. INTRODUCTION

The focus of this literature review is on the factors that influence medical doctors to relocate from rural areas.

The researcher looked at factors leading to international migration of medical doctors, migration of medical doctors in the African continent as well as within South African provinces so as to establish the trends and link these trends to the Dr. Ruth Segomotsi Mompoti District.

2.2. THE DOCTOR AS A KNOWLEDGE WORKER

A hospital is described as “altogether the most complex human organisation ever devised but also in the past 30 or 40 years, one of the fastest growing types of organizations in all developed countries” (Drucker, 2002, p. 5). Hospitals are based on knowledge work and a specialised homogenous group of knowledge workers.

Skyrme (1999) describes knowledge as encompassing both tacit and explicit components and having to be managed. Knowledge has become the main means of production and a source of competitive advantage. Knowledge work is specialized and deeply splintered (Drucker, 2002).

Knowledge workers are a combination of formal education, skills training, lifetime continuous learning and experiences acquired over a period of time to achieve a certain level of functionality (Drucker, 2002). They own the tools of production and consist of specialised people. The more highly specialised they are, the more effective they become. Drucker (1994) states that knowledge workers tend to work in teams. They are normally employees and prefer to work in organizations that provide basic continuity to ensure effectiveness of their specialisation. If this basic continuity is not provided for, knowledge workers have the potential to quit their jobs (Branch, 1998).

Knowledge capital leverages the productivity of individual workers and results in maximised organisational productivity and organisational success. Drucker (2002) writes that organisational systems must, therefore, serve knowledge workers.

The wealth of most companies is in their intellectual capital and, according to Branch (1998), failure to recognize knowledge, as a tangible asset is still a norm in most organizations. In the knowledge economy, a company's most important asset is the energy, loyalty, and the intellectual capital of its people. According to Branch, (1998) and Butler and Waldron(1999), losing knowledge workers implies that the competition will gain a competitive advantage against the loss incurred by a company. This implies that losing knowledge workers like medical doctors in the Dr Ruth Segomotsi Mompati district to urban areas simply means that urban areas, being competitive in providing quality healthcare to their communities, will be enriched whilst rural areas where these knowledge workers are needed will not be able to perform effectively and deliver on the Department of Health's mandate of "Providing Quality Healthcare services to all individuals in the North West Province". The rural communities will further suffer from the consequences of the relocation of medical doctors to urban areas.

2.3 FACTORS LEADING TO MIGRATION OF MEDICAL DOCTORS

According to Rourke (2010), access to appropriate healthcare in South Africa is often difficult for people living in rural areas because of a widespread shortage of appropriately educated local, rural healthcare workers and the distance, time and cost of travelling to larger urban health centres. This shortage is due to many factors including medical education, practice conditions, health systems, regulatory, community, personal, family and financial considerations. Developing a sufficient and sustainable rural physician workforce requires commitment and co-operation from communities, governments and medical schools.

The Rural Health Advocacy Project in South Africa congratulates the Kwa-Zulu Natal Department of Health for their comprehensive and rural-friendly policy for the allocation of community service officers. In the past the majority of the community service officers were placed in urban areas. With the adoption of this policy, the first of its kind in our country, there are now clear guidelines to ensure the equitable allocation of community service officers to public health facilities in KZN, with

appropriate supervision and a supportive working environment that would enable and encourage community service officers to remain in the public service, particularly in underserved areas. The policy aims to ensure that 90% of community service officer's posts in each professional category are gazetted, and that hospitals and facilities vacancies are filled each year. 100% of community service officers will undergo a structured orientation programme within two weeks of their arrival. Further credit goes to the UKZN Centre for Rural Health which has assisted the Department of Health in drawing up the policy. Some of these rural-friendly components include:

- Rural and underserved areas will be given preference when allocating community service officers of all professional categories,
- Community service officers will be required to provide services in Primary Health Care Settings and may be required to travel to deep rural areas. Rehabilitation and Therapeutic Therapists are required to spend at least 40% of their time at the Primary Health Care Level (this includes clinics, community-based services, non-profit organizations and schools) Rural Health Advocacy Project, (2010).

According to the *Rural Health Advocacy Project (2010)*, the policy further contains detailed guidelines for accommodation, training, supervision and mentorship of community service officers. Research by Rural Health Advocacy Project (2010) has shown that these are important retention tools, to ensure community service officers are keen to stay in the underserved areas after their placements. For the successful implementation of the policy the recruitment and retention of senior health practitioners will be paramount, as they are to provide the required support and supervision.

In 2003, the studies by Preusananond et al (2003) and Thamarangsri (2003) had accessed factors that drove doctors to move away from rural community hospital and public hospitals. The Preusananond et al (2003) studied 958 doctors who moved out of the public sector during 2001-2003, and the results showed that factors negatively associated with decisions to leave public sector were: workload; work close to family; income; organizational policy and administration; overall work satisfaction and organizational commitment. Thamarangsri's (2003) study targeted doctors that had moved from community hospitals and found out those factors affecting their decision making were same as those in Preusananond et al (2003).

The similarity in both studies shows that workload is a significant factor and the South African Health system should put efforts in addressing these factor so as to recruit and retain medical doctors in rural areas. There should be clear policies and strategies in place to address these shortcomings. The implementation part of both these policies and strategies should be based on how best the South African Health system can implement the strategies and policies.

The problem of mal-distribution of health personnel in South Africa is well known and documented. In his article on the arrival of Cuban doctors in South Africa, Lee (1996) claims that the new democratic government's failure to advertise the availability of rural posts adequately is responsible for the lack of health professionals in rural communities. Pick (1996) suggests that the shortage is historical due to the apartheid regime, obsessed with racial discrimination, failed to address the problem of providing health personnel for the rural, largely black population, despite numerous publications illustrating the inequitable distribution of health personnel.

The South African government needs to repopulate these rural areas with quality medical doctors. This needs to be addressed as a matter of urgency as rural communities had been denied their basic right of access to healthcare during apartheid and even in the new democracy.

Sishana (1996), writes that the South African government's restrictive registration process was to ensure that well trained doctors could come to South Africa, largely facilitated by government to government agreements, thus ensuring an organized supply of doctors(Sishana,1996).

In this regard, South Africa should look more at training local medical doctors from rural areas so that they can go back and serve their respective rural communities as their long term strategy to address the shortage or relocation of medical doctors from rural areas. The Department of Health Policy to address the shortage of medical doctors by government to government arrangement seems not to work because those medical doctors work for a short period of time and go back to their home countries.

In South Africa, the government has introduced special financial incentives to encourage medical doctors to remain in rural areas. A project has been launched by the Department of Health to establish a database of South African health professionals living overseas in order to recruit them back to the country. In order to enhance the incomes earned by skilled health professionals, remunerated work outside the public sector has been introduced. Health professionals in the public sector are thus able to earn additional income to supplement their public service salaries. Another mechanism has been the twinning of hospitals with sister institutions in the United Kingdom, which enables the South African hospitals to exchange staff in order to transfer specialist skills(Sishana, 1996).

The use of foreign doctors should be seen only as a short term measure. It may be that this short term measure will be in place for a long time, but it needs to be constantly reviewed by the Department of Health. The long term process of training specifically rural-hospital doctors in South Africa is something that must be strongly advocated and supported in every possible way(Couper,2003). This process requires changes in the way students are selected for medical schools, changes in their undergraduate curricula, different approaches to post graduate training and the development of incentives for rural hospital work. There is a need to plan and implement a clear strategy for the future in order to address the needs of rural hospitals. "I would be happy if South Africa could reach the situation where we do not need foreign doctors in order to staff rural hospitals. Unfortunately that day is long way off"(Couper,2003).

Given all this, what is the way forward? Couper (2003) believes that rural hospitals in South Africa should take the opportunity to recruit doctors from developed countries which now have sufficient doctors. They should be given the necessary permanent residence and even citizenship opportunities so that they are not recruited to work in other countries. In terms of doctors from other countries, Couper (2003) believes recruitment should be on the basis of a government to government agreement between South Africa and those countries which may have an excess of doctors they are then able to offer for export.

Recommendations to increase access to health workers in remote and rural areas through improved retention must be developed within the framework of a country's overall national health plan and guided by the values and principles of primary health care. Rural retention of medical doctors is only one component of strategies to strengthen health systems, address the human resources for health crisis, reduce health inequalities, and attain the Millennium Development Goals (World Health Organization Report, 2009). Rural retention is a complex issue with no easy answers. A host of contextual issues - the current state of health, the health workforce, and the health system, as well as political, socio-economic and cultural factors - need to be considered before effective solutions can be designed. Each country needs to develop its own policies and implementation strategies based on national resources and priorities (World Health Organization Report, 2009).

Cuba trains more doctors than it can use internally. This, and close political ties, resulted in South Africa being the recipient of many Cuban doctors to fill the gaps in underserved areas. Like the migratory gold miners, a hefty chunk of their earnings is repatriated back to the Cuban government (South African Medical Journal 2006).

Table 2: Levels of Workplace dissatisfaction

Satisfaction with working conditions			
	Dissatisfied %	Satisfied %	Neutral %
Terms of employment			
Taxation	58	14	28
Fringe benefits	56	17	26
Remuneration	53	22	24
Career advancement	41	30	29
Ability to find job	40	31	30
Educations/career opportunities	35	39	26
Training	14	71	15
Workplace conditions			
Work load			
Job security	44	31	26
Workplace morale	37	32	32
Medical infrastructure	34	39	26
Relationship with management	31	50	19
Medical supplies	29	40	31
Relationship with colleagues			
	28	50	22
	5	76	19

Risk factors			
Personal security	34	41	25
Workplace security	30	41	30
Risk contracting MDR TB	30	32	38
Risk contracting HIV	28	35	37
Risk contracting Hep B	26	37	37

Source: International Journal of Migration, Health and Social Care (2010)

Over a quarter of the interviewees expressed dissatisfaction (dissatisfied/very dissatisfied) on 17 of the 19 measures used (Table 2 above). On three of the measures workload, prospects for professional advancement and ability to find the right job, over 40% were dissatisfied. On another three, taxation, fringe benefits and remuneration, over 50% were dissatisfied. On only two of the 19 measures appropriateness of their training for the job and collegial relations were highly rated. It is remarkable that the only working conditions on which a large majority of professionals agreed (76%) is the quality of their relationship with their colleagues (Human Resources for Health SA, 2011).

Previous studies have identified the high degree of personal vulnerability and insecurity felt by South African health professionals in the workplace. Steinman (2003, p.22), for example, found that 34% of public sector health workers and 24% of all workers were very worried about high levels of workplace violence. She also found that 17% of workers in the public sector had been physically attacked in the previous 12 months. This was significantly higher than other countries in a global study that included Thailand (10.5%), Bulgaria (7.5%) Brazil (6.4%), Lebanon (5.8%) and Portugal (3%) (di Martino, 2003, p.16.) A full 70% of public sector and 51% of private sector personnel had experienced at least one incident of workplace violence in their careers. In the previous year, 52% of all workers said they had been subject to verbal abuse, 23% to racial harassment, 24% to bullying and 5% to sexual harassment (Steinman, 2003). Although most of the physical violence is perpetrated by patients, Khalil (2009) found that in Cape Town's public hospitals the threat of violence and harassment also comes from fellow workers. In May 2008, the Association of Surgeons of South Africa also faced unusual personal health risks from treating patients with infectious diseases (Human Resources for Health SA, 2011).

This proves that conditions or factors like crime and fear of contracting infectious diseases when treating patients are also causes of the relocation of medical doctors. They fear for their lives. Our health system should consider how best these factors can be addressed.

South Africa is at the epicentre of the global pandemic of HIV and AIDS. The 2008 Human Science Research Council survey found a national HIV prevalence of 11.9% (equivalent to 5.2 million people living with the virus) (HSRC,2009). AIDS-related mortality is more difficult to quantify, although it is clear that mortality is rising; the Actuarial Society of South Africa estimates that there were 108,000 deaths in 2000 and 47, 000 deaths in 2001. The number rose to 346,000 in 2006 (or 47% of all deaths and 71% of deaths among adults aged 15-49) (ASSA, 2006). South Africa had nearly 460,000 new TB cases in 2007 and an incidence rate of 948 cases per 100,000 populations, an increase from 338 cases per 100,000 in 1998 (WHO, 2009, p145). An estimated 122,000 people died from TB in 2007. Rates of TB-HIV co-infection are high, with an estimated 73% of new TB patients being co-infected with HIV. Hepatitis B is another prevalent infectious disease in South Africa, causing an estimated 14,000 deaths per annum(Human Resources for Health SA,2010).

2.4 JOB SATISFACTION

When job satisfaction decreases, salary becomes more and more important because medical doctors no longer have an interest in what they are doing, they are only concerned to earn a salary in order to survive. Doctors get frustrated because they see people dying and they are helpless to do anything because the equipment and support infrastructure is not there,(July 2009, Vol.99, No. 7 SAMJ).

2.5 SOUTH AFRICAN POLICIES TO ADDRESS MIGRATION OF MEDICAL DOCTORS

Government used the chaotic OSD nurse pay-outs to motivate for proper actuarial probes this time around. Huge mistakes were made around nursing categories and years of experience, (July 2009, Vol.99, No. 7 SAMJ).

South Africa shed 200 000 jobs in the first quarter this year, and the next quarter could see more. Overseas, people are voluntarily cutting salaries to keep their jobs and job sharing to try and curb job losses, (July 2009, Vol.99, No. 7 SAMJ).

He said acceding to doctor demands would mean ignoring the financial health crises in KwaZulu-Natal, Gauteng and the Free State ‘for starters’, being unable to improve doctors’ working conditions or relieve pressure on them by filling more posts, (July 2009, Vol.99, No. 7 SAMJ).

Table 3: Policy initiatives to address mal-distribution of medical doctors between rural and urban public health institutions in South AfricaSource: Ditlopoet *al* (2011)

<i>Year</i>	<i>Policy initiative</i>
1996	Government recruited first group of Cuban doctors and initiated training of medical doctors in Cuba
1997	Government released White Paper for the transformation of the health system, containing recommendations on equitable health professional distribution
1998	Government introduced community service for doctors and for allied health professionals, making it mandatory for these health professionals to work in under-served areas for a 1-year period
2004	Government introduced a: ❖ Rural allowance to attract and retain certain health professionals in rural facilities ❖ Scarce skills allowance to attract and retain certain categories of health professionals in the public sector Government released a policy on the recruitment and employment of foreign health professionals restricting recruitment to persons with verified qualifications and competencies to work in under-served areas Government finalizes a bilateral agreement with Iran to allow Iranian doctors to work in rural South African health facilities
2005	Government promulgated the National Health Act No. 61 of 2003 with a certificate of need provision for health professionals wishing to establish a private practice to decrease the concentration of health professionals in urban areas. This clause has never been enacted
2005	Commonwealth Ministers of Health signed an agreement regarding the ethical recruitment of health workers

- 2006 Government releases a National Human Resources for Health Framework to address the critical shortage of health professionals Activists developed a Draft Rural Health Strategy for South Africa to improve health services in rural areas in the period 2006-2009
- 2007 Government signed an agreement to allow recruitment of Tunisian medical practitioners for temporary employment in rural areas
- 2008 Government released a National Nursing Strategy for South Africa Government introduced community service for nurses, making it mandatory for nurses with 4-year diplomas or degrees to work in the public sector and under-served areas for a 1-year period
- 2008-2010 Government introduced occupation specific dispensation that is salary categories specific to each occupational category in the health sector
- 2010 World Health Organization launched a set of recommendations on increasing access to health workers in remote and rural areas through improved retention in Johannesburg, South Africa

The implementation of the rural allowance was not linked to the remoteness of rural areas. Health professionals working in deep rural areas received no more than those in semi-rural areas. One hospital manager commented: “The problem with the rural allowance is that what a person gets here (deep rural area), is the same amount that a person gets in Vryburg (rural town). The semi-rural areas should have a lower percentage than the extremely rural areas”(Ditlopoet *al*,2011).

Most participants (nurses, doctors, health managers, and policy-makers) indicated that financial incentives alone are insufficient to motivate and retain staff.

“You can give people a million rands but after a year they will go. So the strategy should not only be about money. It is true, money helps but if you have kids that go to school, you won’t come here because there are no good schools. But there are other things that the management can do; they can send people for training. For example, people can be sent to a bigger hospital for six months to enhance their speciality skills”, (Ditlopoet *al*,2011, p5).

A doctor in a Regional Hospital commented that: “I get a rural allowance; it’s about two hundred rands a month. For me to get to town just to get a decent meal at a restaurant, I have to travel about 80km. There are no recreational facilities here. So, you actually spend that money on transport anyway”, (Ditlopoet *al*,2011, p.5).

Previous reviews of retention strategies found that financial incentives can improve recruitment and retention in the short-term, but long-term impact on retention is less certain. Some medical doctors demonstrated that non-financial incentives related to working and housing conditions had a greater potential to influence retention. Others

recognized that health professionals will always move, often for reasons beyond the influence of any workforce retention programme, no matter how well designed. The respondents from Ditlopoet *al* (2011)'s study perceived the rural allowance to have had limited effect on the motivation and retention. This means that policy-makers should obtain better data on the factors that influence health workers' location choices in order to develop more appropriate human resource interventions in future. Although the rural allowance policy document called for annual reviews, government did not develop a framework to monitor potential implementation challenges nor evaluate policy impact. The rural allowance is an expensive intervention to have been left without proper evaluation(Ditlopoet *al*,2011).

2.6 PUSH AND PULL FACTORS LEADING TO MIGRATION OF MEDICAL DOCTORS

Dovlo (1999), Martneau and Decker (2003),Padarathet *al*. (2003) and others have discussed the reasons underlying the brain drain in various papers. They identified a number of push and pull factors, that influence the decisions of health professionals to leave their countries of origin. The push factors refer to events in the country of origin that motivate professionals to leave whilst pull factors are the deliberate and/or unintended actions from recipient countries that attract health professionals to their rural health services. Examples of the push factors include low remuneration, poor working conditions, low job satisfaction, lack of professional development and career opportunities and political and ethnic problems including civil strife and poor security(Dovlo, 2004).

Pull factors are caused by increased demand for health professionals in development prospects and active recruitment by those countries. The common use of English as a *medical lingua franca* and similarities in medical training and systems arising from the colonial experience of African countries are also thought to enhance the pull factors. An individual's threshold decisions to migrate probably arises from a combination of both push and pull factors, and it has been suggested that these are reflected in terms of gradients or tensions in the influence of these factors between source and recipient countries,(Dovlo,2003). The key influences are:

- i. Income gradient or the difference in remuneration and living conditions between the home and recipient countries. For example, Vujicic *et al.* (2004) has calculated that income gradients may range from two times for nurses in South Africa to twenty-two times for nurses from Ghana.
- ii. Job satisfaction gradient. The perception of a good working environment and professional and technical proficiency that allows for international peer recognition is important for tertiary-trained professionals.
- iii. Organisational environment/career opportunity gradient. This factor expresses how fair and accessible opportunities are for career governance, politics and ethnicity as factors in demotivating professionals (Dovlo, 2004).

Remuneration levels are probably the most important factor in retention. A conference of Commonwealth African countries (Commonwealth Secretariat 2003) elicited a variety of local and general incentives tried by countries, though many have not met with significant success. For example, participants from Botswana suggested that significant rises in allowances for nurses did not slow migration. Indeed, at times the perceived unfairness of incentives and disparities between what is paid to different professionals appear to fuel the migration of the cadre at a perceived disadvantage. For example, Ghana introduced additional duty hours allowance (ADHA), which increased incomes significantly for doctors but less so for nurses and other professionals. Consequently, despite a net increase in incomes, such initiatives have apparently resulted in nurses' increased de-motivation and a migration. In South Africa, the Department of Health recently instituted new 'skills and location incentives schemes targeting highly needed skills and deprived areas' aimed at providing incentives to retain certain specific high demand specialities within the country and to retain staff in unpopular work locations according to the National Department of Health Annual Report (2004).

The role of incentives and incomes is, however, mixed. A recent WHO African Regional Office study on migration showed that Uganda, which had much lower pay levels than South Africa, appeared to have had better retention success, with many fewer staff members expressing intentions to migrate compared to the wealthier country (Awaseset *et al.*, 2003).

The World Federation of Medical Education recognised that medical migration was increasing worldwide, as were the numbers of medical schools, many of doubtful quality. It therefore developed international medical education standards in 2003 with the objective of quality improvement, noting that 'shared international standards will facilitate exchange of medical students, and ease the acceptance of medical doctors in countries other than those in which they trained'(SAMJ 2011).

Approximately 2000 of the 7000 of South Africa's medical graduates have migrated to Australia. This is equivalent to approximately two year's' output from South Africa's medical schools. Roughly one in every 30 doctors practising in Australia graduated in South Africa. Arnold provides evidence of why this can be considered to be a unique migration. Australia is characteristically a country peopled by migrants. Of the Anglophone immigrants, the professionals were a minority. The migration from South Africa has differed, as high proportions have been professionals, including doctors. Skilled migration generally involves 'journeys of advancement', whereas South African emigration is unique as people did not leave primarily for professional, career or financial advancement.

This migration of professionals commenced on a small scale in the early 1950s, and has progressed in ever-increasing waves, triggered by political upheavals in South Africa. This study, and the other studies, indicate that this large-scale medical immigration is set to continue(SAMJ 2011). There have been four distinct medical migrations from South Africa to Australia. These relate to, among other things, timing, reasons for leaving, reasons for choosing Australia, professional achievement before and after migrating, and family reunion. The earliest migration, with its clear characteristics in all these respects, was heavily Jewish. The latest migration, with its quite different characteristics, is predominantly Afrikaner. Running over all six decades, fluctuating with political upheavals in South Africa, has been the steady flow of non-Jewish, non-Afrikaner whites, and since 1990 there has been a much smaller migration of non-white, mainly Indian doctors. Canada has also experienced a similarly significant immigration of South African professionals(SAMJ 2011).

The vast majority of South African doctors who have emigrated to Australia since 1948, had decided to do so for reasons relating to their individual positions in South Africa's strange racial/ethnic hierarchy. Motivation for this migration has largely been

primarily due to push rather than pull factors. Almost none chose Australia because it offered a better income, unlike the primarily economic inducements that have attracted sub-Saharan, Asian and South American medical graduates to the USA(SAMJ,2011).

South Africa's medical emigration is therefore closely tied to our political environment. An important recurring theme is how we treat our respective ethnic groups and value our professionals. More recently the seriously deteriorating public health facilities and service and high levels of crime have played an increasing role. With close to 40% of its many medical graduates having left the country, South Africa has a higher medical brain drain than any other African country. The health sector has been especially hard hit by the brain drain from South Africa. Unless the push factors are successfully addressed, intense interest in emigration will continue to translate into departure for as long as the demand exists abroad – and there is little sign that this will let up (SAMJ, 2011).

Table 4: Distribution of South African health professionals abroad(Source: NDoH A National Human Resource Plan for Health, 2006)

	Medical Practitioners	Nurses	Other health professionals	TOTAL
Australia	1 114	1 085	1 297	3 496
Canada	1 345	330	685	2 360
New Zealand	555	423	618	1 596
United Kingdom	3 625	2 923	2 451	8 999
United States	2 828	2 083	2 591	6 956
TOTAL	8 921	6 844	7 642	23 407

A range of issues affect the attrition rate of health professionals from South Africa, which is conservatively estimated at an annual rate of 25%. The estimation assumes that each year 25% of the potential workforce does not actively enter the South Africa health sector (not just new graduates). Newly qualified undergraduate and postgraduate health professionals have difficulty finding jobs in the South African public health sector after qualification. The attrition rate of 25% excludes an

additional 6% attrition rate due to retirement, death and change in profession(Human Resource for Health South Africa 2012).

Table 5: Main push and pull factors in migration and international recruitment of health workers(Source: NDoH A National Human Resource Plan for Health, 2006)

Push factors	Pull factors
Low pay (absolute and/or relative)	Higher pay & opportunities for remittances
Poor working conditions	Better working conditions
Lack of resources to work effectively	Better resources health systems
Limited career opportunities	Career opportunities
Limited educational opportunities	Provision of post-basic education
Impact of HIV and AIDS	Political stability
Unstable/dangerous working environment	Travel opportunities
Economic instability	Aid work

Factors affecting attrition and migration are: lack of posts in the public sector, HIV & AIDS, working conditions, workload in the public sector, workplace security, and relationships with management in the public sector, morale in the workplace, risk of contracting TB, personal safety. Lifestyle and income were not the most significant factors. The working environment and management relationships are critical factors affecting why health professionals leave the public sector and South Africa. Table 5 provides a more comprehensive list of push and pull factors affecting health professionals' reasons to migrate. The high level attrition of health professionals from South Africa is creating a shortage of health professionals in the country, despite the number being trained(Human Resource for Health South Africa 2012).

The attrition of Community Service (CS) professionals leads to a notable loss of trained professionals in the health system. 'Community Service' is a requirement which entails one year of practice in the public sector for most health professionals following their graduation. A survey of medical CS professionals in 2009 reported that 17% did not report for CS, and a further 6.1% reported that they would emigrate after completing CS. This amounts to 23.1% planning to leave the country. If the

doctors do not report for CS they cannot practice in South Africa. Even though this is less than the 43% who planned to leave the country in 2001, this is equivalent to the output of one medical school, each year, planning to leave the country. The primary reason given by CS professionals is the working environment in the public sector which does not provide professional support and career opportunities(Human Resource for Health South Africa 2012).

Table 6: Retention Gap for Health Professional Graduates 2002 – 2010

Sources: Department of Higher Education and National Treasury, (2010)

2002 2010				
Profession	Graduate Output	Public Sector post increase	Retention Gap	Retention Gap%
MBChB	11700	4403	7297	62.4%
Dentistry	2140	248	1892	88.4%
Pharmacy	3645	1960	1685	46.2%
Physiotherapy	2934	497	2437	83.1%
OT	1827	410	1417	77.6%
SLP + Audiology	1413	265	1148	81.2%
Dietetics	657	502	155	23.6%

As has been noted earlier in this section, from 2002 to 2010 employment in the public health sector began to grow. However, graduates from Faculties of Health Sciences are not retained in the public health sector. Whilst there is no linear relationship between employment growth and graduate output, what is evident from the data in Table 6 is that graduates are not being absorbed into the public sector. For example, whilst 11,700 doctors graduated between 2002 and 2010, the number of doctors employed in the public sector only went up 4,403. Notable is the Allied Health professionals (physiotherapy and occupational therapy) for which absorption is particularly low due to a lack of public sector posts(Human Resource for Health South Africa 2012).

Rural retention plans include increasing the number of medical students from rural areas. An expanded rural training programme for residents in family medicine and medical specialities is also part of this strategy (Square, 2001). Pretorius (2003) states that recruits from rural areas are more likely to return to practice in rural areas.

Promotion at rural schools of career possibilities in health sciences should be pursued. Reserved allocations/quotas of places at training institutions and financial support for students of rural origin with a work-back commitment should also be encouraged to achieve rural retention (WONCA, 2002).

Appropriate incentives or bursaries should be provided for doctors who are interested in pursuing further studies in rural medicine. Appropriate rural exposure through the curriculum as part of medical training and a decentralised rurally based accessible postgraduate training opportunity should be part of the strategy (WONCA, 2002).

Rural incentive allowances that include extra remuneration, family and educational perks will improve retention. Couper (1999) suggests incentivised and worthwhile packages such as resettlement grants, car and housing allowances, guaranteed locum relief, study leave for continuing medical education, family support.

Rural and scarce skills allowances. This key strategy to recruit and retain health workers was implemented in March 2004. This was in line with recommendations of the World Health Report (2003), which suggests paying differently by reviewing non-financial benefits and also considering opportunities for rotation to rural areas. Whilst these allowances are a step in the right direction, and apparently do lead to changes in career plans, there are other issues that need to be addressed such as job satisfaction, working conditions, further training, and career opportunities (Couper, Sondzaba, & de Villiers (2004).

Socio-cultural integration involves the participation of rural communities in collaborative planning with other stakeholders in healthcare. The aim of this strategy is to integrate local community support to the overall government and professional retention programmes. Rural communities also need to review their attitudes and expectations regarding the type of medical service that will be sustainable in their

areas. This strategy has been implemented successfully in Australia (Veitch *et al*, 1999).

2.7 RURAL RETENTION STRATEGIES

Rural retention plans include increasing the number of medical students from rural areas. An expanded rural training programme for residents in family medicine and medical specialties is also part of this strategy (Square, 2001). Pretorius (2003) states that recruit from rural areas are more likely to return to practice in rural areas. This, according to the researcher, is an important fact that needs to be considered as rural recruits are used to the life in rural areas. Although they might want to leave at a later stage as part of growing and family demands they are likely to stay for a longer time.

Promotion at rural schools of career possibilities in health sciences should be pursued. Reserved allocations/ quotas of places at training institutions and financial support for students of rural origin with a work-back commitment should also be encouraged to achieve rural retention (WONCA, 2002). According to the researcher, the Department of Health is implementing this strategy minimally.

Socio-cultural integration involves the participation of rural communities in collaborative planning with other stakeholders in healthcare. The aim of this strategy is to integrate local community support to the overall government and professional retention programmes. Rural communities also need to review their attitudes and expectations regarding the type of medical service that will be sustainable in their areas. This strategy has been implemented successfully in Australia (Veitch *et al*, 1999). South Africa needs to try this strategy and pilot it to the most rural districts and if it works, then it should be rolled out the whole country.

Appropriate incentives or bursaries should be provided for medical doctors who are interested in pursuing further studies in rural medicine. Appropriate rural exposure in curriculum as part of medical training and a decentralized rurally based accessible postgraduate training should be part of the strategy (WONCA, 2002). This strategy can assist the Department of Health as currently there are limited bursaries for medical doctors, only nurses and administration professionals receives bursaries in the form of full time study leave whilst earning their monthly salaries.

Rural incentive allowance that includes extra remuneration, family and educational perks will improve retention. Couper (1999) suggests incentivised and worthwhile packages such as resettlement grants, car and housing allowances, guaranteed locum relief, study leave for continuing medical education, and family support.

2.3 CONCLUSION

Relocation of medical doctors is an issue that countries throughout the world are grappling with in order to retain them, especially in rural areas. There are various factors influencing relocation of medical doctors from rural areas and there are strategies suggested to deal with the problem. Whilst international migration is an increasing problem, internal migration remains a greater challenge in South Africa. Recruitment and retention strategies must address both these problems in order to effectively address the mal-distribution of medical human resources.

CHAPTER 3

3. RESEARCH METHODOLOGY

3.1 INTRODUCTION

The study conducted was a quantitative design and its purpose was to identify the push and pull factors that influence the relocation of medical doctors from Dr Ruth Segomotsi Mompoti District to urban areas. The design for the study was a descriptive and normative survey, and took the form of face-to-face interviews and a questionnaire. The study also used qualitative research method to collect data and this assisted in understanding the factors influencing medical doctors to relocate from Dr Ruth Segomotsi Mompoti District to urban areas. Questions were posed to participants, and findings were made. According to Neuman (2011, p.151) most quantitative researchers rely on a positivist approach to social science. They apply “reconstructed logic”, and follow a linear research path. Quantitative researchers emphasize precisely measured variables and test hypotheses that are linked to general causal explanations. Neuman (2011, p.151) further states that “**reconstructed logic**” means that the logic of how to do research is highly organised and restated in an idealised, formal, and systematic form. It is reconstructed into logically consistent rules and terms. It is a cleansed model of good research.

Maxwell (2005 p2) states that the activities of collecting and analyzing data, developing and modifying theory, elaborating and refocusing the research question, and identifying and addressing validity threats are usually all going on more or the less at the same time, each influencing all of the others. The complexity of the approach does not lend itself to the traditional linear model that is often used in the quantitative research paradigm. The researcher used the combination of both research paradigms in this study to collect as much data as possible.

The study was confined to the North West Province’s district of Dr Ruth Segomotsi Mompoti. The sample was drawn from medical doctors who are currently working in the district and those who have left the district to go and work in urban areas.

3.2 DESCRIPTIVE AND SURVEY RESEARCH METHODS

The term descriptive research refers to the type of research question, design, and data analysis that will be applied to a given topic. Descriptive statistics tell what is, while inferential statistics try to determine cause and effect (Hopkins, 1984).

Descriptive research can be either quantitative or qualitative. It can involve collections of quantitative information that can be tabulated along a continuum in numerical form, such as scores on a test or the number of times a person chooses to use certain feature of a multimedia program, or it can describe categories of information such as gender or patterns of interaction when using technology in a group situation. Descriptive research involves gathering data that describe events and then organizes, tabulates, depicts, and describes the data collection, (Hopkins,1984).

The survey is the most widely used data-gathering technique in the social sciences and related applied fields. In fact, people sometimes say “Do a survey,” to get information when they should be asking, “What is the most appropriate research design?” Despite the popularity of surveys, it is easy to conduct a survey that yields misleading or worthless results. Good surveys require thought and effort. “Surveys, like other scientific and technical tools, can be well made or poorly made and can be used in appropriate or inappropriate ways” (Neuman,2011).

Survey research developed from the positivist approach in social science (Neuman, 2011). As Robert Groves remarked, “Surveys produced information that is inherently statistical in nature”. A survey asks many people (called respondents) about their beliefs, opinions, characteristics, and past or present behaviour,(Neuman,2011).

3.3 IN-DEPTH SEMI-STRUCTURED FACE-TO-FACE INTERVIEWS

According to Leedy &Ormrod (2001),face-to-face interviews have the benefit of achieving the highest response rate and allow for clarification of ambiguous answers. Several distinguishing characteristics of face-to-face interviews are set out below.

- a) The purpose of the interview in a survey research is to draw inferences about a population from the responses of the sample (Leedy &Ormrod 2001)

- b) Pilot tests are conducted to determine the format and duration of interviews. The pilots are used to critique the ambiguity and vagueness associated with the questions.
- c) The interviews allow for flexibility and this enables the researcher to prompt and probe as necessary (Pirow 1990).
- d) The interview adopts a semi-structured format, where a structured question is followed by one or more individually tailored question to get clarity or to probe reasoning (Leedy &Ormrod 2001). This is necessary as circumstances differ for different respondents.
- e) Allowance is given to clarify ambiguous answers or to probe the respondents' reasoning, and to tailor certain questions.
- f) The interviews provide an opportunity to observe non-verbal behaviour that is recorded. This provides an opportunity to elicit other pertinent characteristics of the communication (Pirow 1990).
- g) The sample size is usually small (Leedy &Ormrod 2001).
- h) The interviewer standardises the environment by conducting the interviews in privacy (Pirow (1990); Creswell (1994)).
- i) The interview ensures that the correct respondent answers, so that information is gleaned from the correct participants (Pirow1990).

Although this method of data collection is relatively efficient and is an economical way in which to obtain information, it requires considerable skill and care in its application. The main problems that are associated with this method of information gathering are listed below:

- a) Such interviews take time and therefore, could be impractical if a large sample was interviewed (Leedy &Ormrod, 2001).
- b) The time and expense, especially if participants are from distant locations, could be prohibitive Leedy &Ormrod (2001).
- c) The possibility exists that the interviewers might be biased or that their presence may create bias. Therefore, the researcher uses an interview schedule to overcome this problem (Bailey, (1987); Cresswell (1994); Leedy &Ormrod (2001)).

- d) Sources of error can be as a result of respondents feeling that the information they give could be used to the detriment of the organization or themselves. Assurance of anonymity is used to remedy the situation (Bailey1987).
- e) Respondents could fail to answer because the questions are vague or too general. Interviewers, therefore, should avoid colloquialism and ambiguity (Bailey1987).

3.4 QUESTIONNAIRE

This particular study also used a questionnaire. Leedy &Ormrod (2001) consider questionnaires to be effective tools for information gathering during a research. A questionnaire is effective because:

- It is brief, clear and concise;
- It contains instruction for each phase of the study; and
- It is anonymous.

The questionnaire can also serve as a checklist of behaviours and characteristics, present or absent (Leedy &Ormrod 2001). Some of the drawbacks to the use of a questionnaire are outlined below:

- A large number of people who receive the questionnaire originally do not return them.
- The responses to the questionnaire reflect the conceptual understanding of one or more questions.

3.5 RESEARCH APPROACH

The research approach includes how the research was carried out and the sampling identified is thirty (30), medical doctors currently working in the rural district of Dr Ruth Segomotsi Mompati and ten (10) out of thirty medical doctors who left the district for urban areas were asked questions on migration of medical doctors from rural areas through a designed questionnaire. The questionnaire does relate to key policy issues to be investigated. As this is a quantitative approach, the researcher was granted approval from the District Chief Director Health Services for access to the health facilities such as district hospitals where the medical doctors are based.

After approval the Hospital Chief Executive Officers were informed of the communiqué between the researcher and the District Chief Director, then hospital Chief Executive Officers granted permission of doctors to be interviewed. Medical doctors in all five district hospitals were interviewed as well as five (5) who relocated to Klerksdorp hospital and five (5) in Mafikeng Provincial hospital. The data was analysed thereafter and recommendations given.

3.6 RESEARCH DESIGN

The sample of twenty doctors working in the district and ten who moved to urban areas and they all participated in the study. Quantitative research is mostly based on issue of professional or personal interest according to Neuman (2011). In this case, the quantitative research was also chosen for professional reasons so as to assist the department. The designing of the study is based on the type of sample selected, how to measure relevant factors and what research technique will be employed and in this case the questionnaire is chosen as the research technique. A questionnaire is effective because:

- It is brief, clear and concise;
- It contains instructions for each phase of the study; and
- It is anonymous.

3.7 DATA COLLECTION

The participants were contacted through the permission of the District Chief Director and Hospital Chief Executive Officers to inform them of the purpose of the study, questions to be asked and the duration of the interview. The participants indicated their willingness to participate in the study. The appointment was set and confirmation of place, date, and time were given. Participants were assured of the anonymity and confidentiality of their responses.

The researcher went through the questionnaires with the respondents at the hospitals where they are based on the set date, time and venue. This improved the availability of, and communication from, the respondents. Clarity was given where

respondents did not understand the questions. A few minutes were taken before the filling of questionnaire started, to explain the procedure to the respondents.

3.8 PRIMARY DATA

The researcher used a questionnaire which was designed in three parts. The first part was demographic information. The second part was the first research question with ten (10) sub-questions in a likert scale format and the last research question also with ten (10) sub-questions to tick from and respondents had to choose from whether they Disagree, Strongly disagree, Strongly Agree or Agree. The four scale format was used to avoid neutrality of responses.

The researcher conducted a face-to-face interview using the questionnaire with all 30 participants. "Interviews are an ideal method of dealing with and investigating issues such as feelings and thoughts", (Patton 2002, p.447).

The advantages of face-to-face interviews include the high response rate; the researcher is able to observe the surroundings and use of non-verbal communication and visual aids. The high cost is the biggest disadvantage in face-to-face interviews whilst travel and personnel costs as well as interviewer bias may serve as limitations. Telephone interviews enjoy the same advantages as face-to-face interviews at approximately half the cost, whilst limited interview length tends to be a disadvantage (Neuman, 2011,p. 300-301).

The research questions in this study required the opinions of medical doctors who relocated from Dr. Ruth Segomotsi Mompati District to urban areas between April 2011 to March 2012 and those currently working in the district. Patton (2002, p. 447) argues that interviews are an ideal method of dealing with and investigating issues such as feelings and thoughts. It is therefore in following this view that this study is intended to gain an understanding of pull and push factors influencing the relocation of medical doctors from Dr Ruth Segomotsi Mompati district to urban areas.

3.9 SECONDARY DATA

The secondary data was sourced from books, journals, the internet, theses and studies undertaken on the subject of relocation or migration of medical doctors.

Department of Health policies, strategies and annual reports were used to ascertain the comparative rate of push and pull factors influencing the relocation of medical doctors from rural to urban areas. The total doctors who left the district from April 2011 to March 2012 are 10. Reports and policies from the Department of Health were looked at to gain an insight on the relocation of medical doctors from rural to urban areas. The researcher had access to these by virtue of being an employee of the department.

3.10 SAMPLING

The total sample consisted of thirty (20) medical doctors working in the rural district of Dr Ruth Segomotsi Mompati in the North West Province and 10 that left the district to work in Mafikeng and Klerksdorp respectively. The study focused on medical doctors working in the Dr Ruth Segomotsi District in the North West Provinces which comprises five district hospitals where all medical practitioners in the district hospitals participated. See the table below

Table 7 : Participating medical practitioners by District Hospitals

Institution	Number of Medical doctors
Vryburg District Hospital	5 Medical Doctors
Ganyesa District Hospital	5 Medical Doctors
Taung District Hospital	10 Medical Doctors
Mafikeng Provincial Hospital	5 Medical Doctors
Klerksdorp Hospital	5 Medical Doctors

The sample comprised respondents familiar with what the study was investigating. They have experience in what the study is investigating and were able to respond promptly to the research questions. Others have left the district to work in urban areas like Mafikeng and Klerksdorp. Those who are still working in the district are still working in the same environment. The purposive or judgment sampling method was

used to select respondents for interviews. This selection method is valuable for special situations and is ideal for exploratory research (Neuman, 2006, p.222) as is the case with this study. The use of this method gave the researcher latitude and flexibility to decide on who should participate in the research on the basis of how well informed they are on the subject matter under investigation (Neuman, 2006, p. 222).

3.11 DATA ANALYSIS

Quantitative data analysis was conducted because of the size of the sample and the nature of the data. According to Neuman (2011), quantitative researchers choose from a specialized, standardized set of data analysis techniques. Hypothesis testing and statistical methods are similar across different social research projects or across the natural and social sciences. The quantitative researchers do not begin data analysis until they have collected all of the data and condensed them into numbers. They then manipulate numbers in order to see patterns or relationships. Quantitative researchers manipulate numbers that represent empirical facts in order to test an abstract. In all of the data analysis, a researcher places raw data into categories that he or she manipulates in order to identify patterns. In quantitative analysis, this process is clothed in statistics, hypotheses, and variables. Quantitative researchers assume that social life can be measured by using numbers, then manipulate the numbers with statistics to reveal features of social life. The analysis will be based on the hypothesis of whether there are push and pull factors influencing relocation of medical doctors or no push and pull factors influencing relocation of doctors in rural areas to urban areas. The pattern of relocation and factors influencing relocation will also be taken into consideration (Neuman,2011).

Because of the population size of the sample (30) and the nature of the data, a quantitative content analysis was conducted. Each response in the questionnaire and interview was analysed and any patterns or trends that the data reflected were grouped together (Leedy &Ormrod, 2001). Then the frequency distributions of these identifiable characteristics were tabulated (Leedy &Ormrod 2001). The tabulated data informed the researcher of the validity of these characteristics to the respondents. The grouped data was reported in as complete and as balanced a way possible. The results were then linked to the propositions. Linking of results to the propositions either support and confirm existing theory or does not confirm the theory

as presented in the literature(Thulare 2003). This is the procedure that the researcher followed.

Following the data analysis spiral according to Leedy &Ormrod (2001), the following steps were taken to analyze data:

- i. The data was perused to get sense from it.
- ii. Interpretations were recorded.
- iii. Data was classified into categories so as to find the meaning.
- iv. The data was related back to the propositions for discussion of the data.

3.12 VALIDITY AND RELIABILITY

The validity of the research methodology was testing for accuracy of the method and the conclusion drawn. It also evaluated the meaningfulness and credibility of the instrument used, which is the questionnaire. It is vital for all social researchers for their studies to be reliable and valid. Both concepts help to establish the truthfulness and credibility of findings and are central issues in all research measurement. Reliability in social research refers to the consistency and dependability of the research (Neuman, 2011, p. 196). According to Neuman (2006, p.188) validity refers to how well an idea “fits” with actual reality.

Neuman (2006, p.188) further states that reliability is concerned with establishing dependability and consistency of the data gathered. Reliability is necessary, but not a sufficient condition for validity, a measure can be reliable and yet invalid. “A measure can produce the same results over and over (reliability), but what it measures may not match the definition of the construct (validity)” (Neuman, 2011,p. 196). All medical doctors were interviewed face-to-face using a questionnaire to ensure accuracy of information.

Neuman (2011, p. 190) further states that to improve reliability, and it is rare to have perfect reliability, four ways are included: clearly conceptualizing constructs, using a precise level of measurement, using multiple indicators and using pilot tests.

Internal validity was the extent to which the method design and data derived from this method resulted in accurate conclusions about the cause and effect within the data (Leedy &Ormrod, 2001). It attempted to minimise alternative explanations for

the results obtained. It was checked against respondents involved in the research by asking them if they thought the conclusion were accurate and matched reality. This was done by providing the respondents with a copy of the findings and a request for them to comment. The researcher also, as the employee of the Department of Health, sought opinions of peers in health management and health policy to evaluate whether they believed that valid interpretation and conclusions were made.

External validity is the extent to which the results of the method used in research apply to situations beyond the sample of respondents (Leedy &Ormrod, 2001). The validity criterion that was used in the aspect of research was that the findings of the research could be plausible to implement. The external validity was enhanced in that the research took place in a real life setting (Leedy &Ormrod, 2001).

The reliability of this study is the extent to which it is likely that the same study conducted in a different context would have the same conclusion. The researcher improved the chance of replicability by operating in a systematic manner during the interviews and during the synthesis of data to relate the findings of the research to the theoretical framework.

3.13 SIGNIFICANCE OF THE STUDY

The focus of this study was on looking at the push and pull factors influencing relocation of medical personnel from rural areas to urban areas. In particular, it looked at the push and pull factors on medical doctors. From the data, the recommendations will focus on measures that can be put in place to address the problem of relocation of medical doctors from rural areas and discuss existing and possible strategies to retain medical doctors at rural hospitals and also the recruiting of medical doctors to these areas where they are desperately needed.

3.14 LIMITATIONS AND ETHICAL

Only the medical doctors employed by the Department of Health in the Dr Ruth Segomotsi Mompati district of the North West Province were asked to complete the questionnaire. These doctors were accessed through permission from their hospital chief executive officers. A sample of twenty doctors currently working in the district and ten that had left the district to work in Mafikeng and Klerksdorp participated in

the study. The study was limited to Dr. Ruth Segomotsi Mompati District as it is the most rural district in the province and also experiences the relocation of medical doctors to urban areas in the neighbouring districts of the province.

Neuman (2011, p.131) states that “ethical research requires balancing the value of advancing knowledge against the value of non-interference in the lives of others”. Research participants are expected to follow the ethical principles of voluntary consent and informed consent. Principles of voluntary consent occur when people participate in a study only if they feel freely and openly agree to participate. Conversely, informed consent is when the researcher provides participants with a formal statement explaining the essence of the study, before seeking their voluntary agreement to participate (Neuman, 2011, p. 135). A letter giving the background for the study was written and sent to all research participants in advance and a follow up was made to establish if they were willing to participate in the study.

The ethical issues around this study were explained to the participants, specifically that this research was being undertaken as part of the requirement for the degree in Masters of Management at the University of the Witwatersrand. It was also explained that this research was for academic purposes only, and that they will remain anonymous. Before the study was conducted, all participants were advised that they are under no obligation to participate in the study and are free to withdraw if they so wish. Lastly, the researcher explained that permission would be sought from them for any disclosure of information. They were also informed that they can get a copy of the report when it is finished and marked if they were interested in getting it.

CHAPTER 4

4. PRESENTATION OF RESULTS

4.1 INTRODUCTION

The main objective of this study was to establish the push and pull factors influencing the relocation of medical doctors from Dr. Ruth Segomotsi Mompati District to urban areas. The purpose of this chapter is to present the research findings as they emerged after interviews were conducted with twenty (20) medical doctors working in the district and ten (10) others that had left the district to work in urban areas specifically Mafikeng and Klerksdorp. This chapter therefore presents raw data collected during the personal interviews through the completed questionnaires.

4.2 DEMOGRAPHIC ANALYSIS

The table below illustrates the demographics of respondents in the study. The respondents were employed as medical doctors within five district hospitals in Dr. Ruth Segomotsi Mompati District. The respondents were of different age groups, gender and years of service as medical doctors.

Table 8: Demographics

Hospital		Vryburg District Hospital	Ganyesa District Hospital	Taung District Hospital	Mafikeng Provincia IHospital	Klerksdorp Hospital	TOTAL
Respondents		5	5	10	5	5	30
Age	20-30	0	0	0	0	0	0
	31-40	2	3	4	3	3	15
	41-50	2	3	3	1	0	10
	50 & above	1	1	3	0	0	5
Gender	Male	5	5	5	5	5	25
	Female	1	1	1	1	1	5
Years of service	1-5	1	2	0	0	0	3
	5-10	1	2	4	0	0	7
	10-15	3	3	3	3	3	15
	15-20	1	1	1	1	1	5

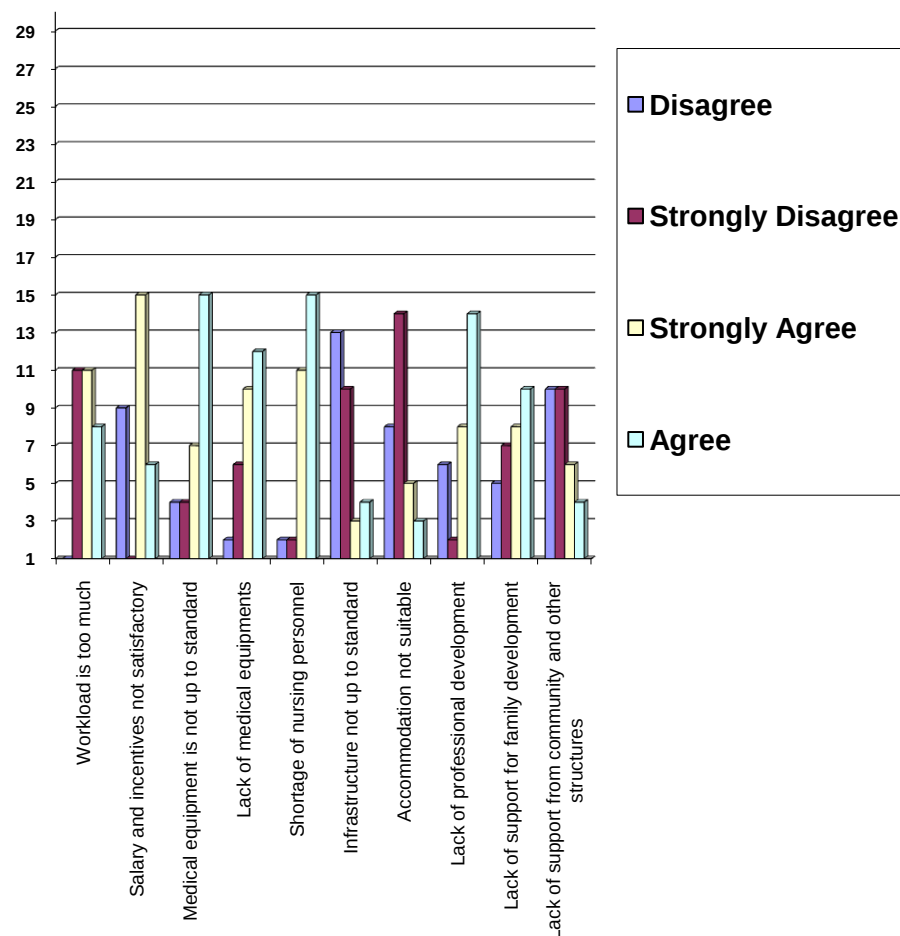
4.3 QUESTIONNAIRE

4.3.1 QUESTION 1 OF THE STUDY

What are the factors that you think influences medical doctors to relocate from Dr. Ruth Segomotsi Mompati district to urban areas?

Factors	Disagree	Strongly Disagree	Strongly agree	Agree
a) Workload is too much	Disagree	Strongly Disagree	Strongly agree	Agree
b) Salary and incentives not satisfactory	Disagree	Strongly Disagree	Strongly agree	Agree
c) Medical equipment is not up to standard	Disagree	Strongly Disagree	Strongly agree	Agree
d) Lack of medical equipment	Disagree	Strongly Disagree	Strongly agree	Agree
e) Shortage of nursing personnel	Disagree	Strongly Disagree	Strongly agree	Agree
f) Infrastructure not up to standard	Disagree	Strongly Disagree	Strongly agree	Agree
g) Accommodation not suitable	Disagree	Strongly Disagree	Strongly agree	Agree
h) Lack of professional development	Disagree	Strongly Disagree	Strongly agree	Agree
i) Lack of support for family development e.g. Child education support, security etc	Disagree	Strongly Disagree	Strongly agree	Agree
J) Lack of support from community and other structures	Disagree	Strongly Disagree	Strongly Agree	Agree

FIGURE 1: What are the factors that influence medical doctors to relocate from Dr Ruth Segomotsi Mompoti District to urban areas?



The findings show that most of the respondents strongly agree that, workload is too much, salary and incentives are not satisfactory, medical equipment is not up to standard, there is lack of medical equipment, a shortage of nursing personnel, infrastructure is not up to standard, accommodations is not suitable, there is lack of professional development, lack of support for family development and lack of support from the community and other structures.

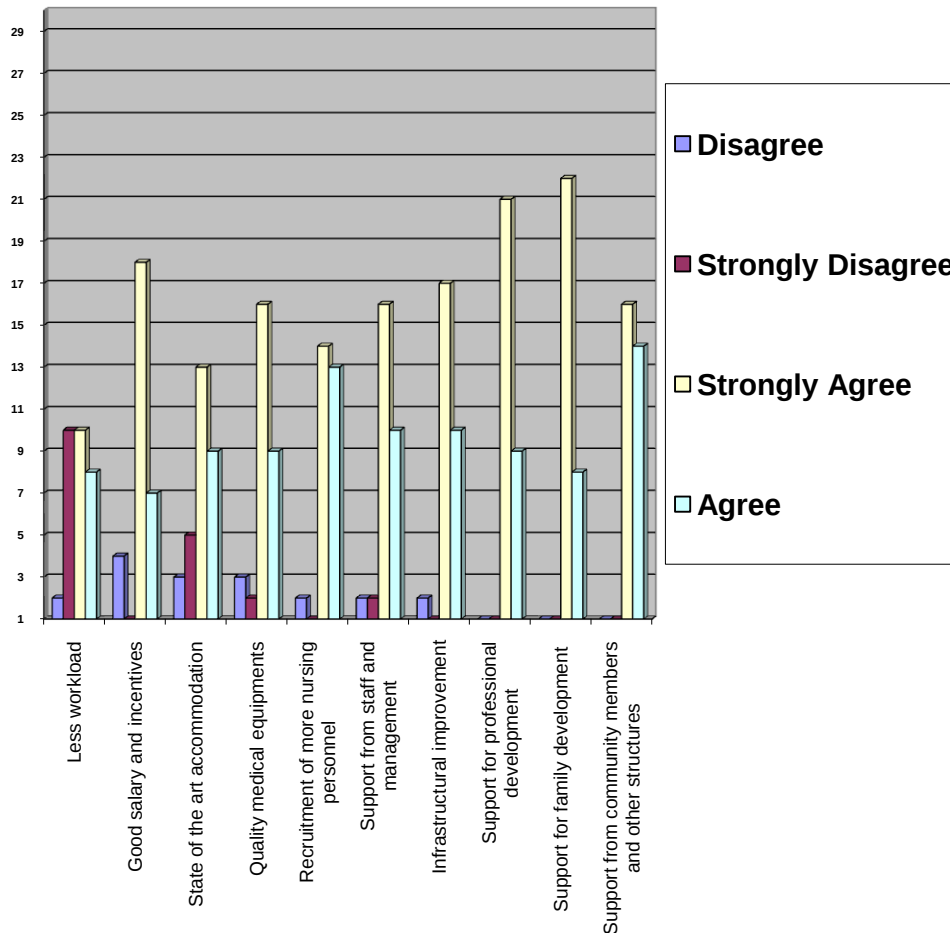
All the above factors are in essence the push factors that influence the medical doctors to relocate from Dr. Ruth Segomotsi Mompoti District to urban areas like Mafikeng and Klerksdorp within the North West province.

4.3.2 Question 2 of the study

Do you think if these factors can be addressed and implemented accordingly, medical doctors will be retained in the Dr. Ruth Segomotsi Mompati district?

Factors	Disagree	Strongly Disagree	Strongly agree	Agree
a) Less workload	Disagree	Strongly Disagree	Strongly agree	Agree
b) Good salary and incentives	Disagree	Strongly Disagree	Strongly agree	Agree
c) State of the art accommodation	Disagree	Strongly Disagree	Strongly agree	Agree
d) Quality medical equipment	Disagree	Strongly Disagree	Strongly agree	Agree
e) Recruitment of more nursing personnel	Disagree	Strongly Disagree	Strongly agree	Agree
f) Support from staff and management	Disagree	Strongly Disagree	Strongly agree	Agree
g) Infrastructural improvement	Disagree	Strongly Disagree	Strongly agree	Agree
h) Support for professional development	Disagree	Strongly Disagree	Strongly agree	Agree
i) Support for family development e.g. Child education, security	Disagree	Strongly Disagree	Strongly agree	Agree
j) Support from community members and other structures	Disagree	Strongly Disagree	Strongly agree	Agree

FIGURE 2: Do you think if these factors can be addressed and implemented accordingly, medical doctors will be retained in the Dr. Ruth Segomotsi Mompoti district?



The findings prove that medical practitioners will stay in rural areas (specifically, Dr. Ruth Segomotsi Mompoti District), if the following can be included in recruitment and retention policies. The conditions stated in Figure 2; less workload, good salary and incentives, state of the art accommodation, quality medical equipment, recruitment of more nursing personnel, support from staff and management, infrastructural improvement, support for professional development, support for family development, support from community members and other structures.

The Department of Health needs to intensify their strategies and policies in a sense that they address this pull factors for effective recruitment and retaining medical doctors in the rural district, namely Dr. Ruth Segomotsi Mompoti.

In the interviews where medical doctors were asked to explain in detail what they have responded to in the questionnaire about factors influencing the relocation of medical doctors from rural to urban areas, most of them responded as follows:

- Majority of the respondents stated that too much workload and shortage of medical doctors and nursing personnel makes them work irregular hours, senior medical doctors do not have ample time to supervise junior medical doctors who are on community service level and that they again perform nursing personnel duties and that is the leading factor in relocation of medical doctors from rural to urban areas.
- The issues of postgraduate training, family support, crime and security also came as the concern for medical doctors. They further stated that nursing personnel are given study leaves to improve their qualifications and also the specialties' they want to pursue and that is not done to medical doctors. Respondents reiterate that technology is growing fast and most of the equipments they are using are technologically advanced and they have to learn how to operate those themselves. The HIV/AIDS training for medical doctors is also limited. On the family support factor respondents stated that they have to transport their kids to schools more than 70km's where they are working. There is no family support where the Department can arrange a scholar transport for their kids as they want them to get quality education and that leads them to go to urban areas where there is ease of access to quality education for their children.
- Respondents stated that medical equipment is not up to standard and support from management is limited. This is due to lack of healthcare knowledge of Hospital Chief Executive Officers. Respondents further mentioned that most of their managers do not have health related qualifications or background and that lead to them and management not having common goals and objectives to improve the working conditions of the medical doctors.
- Respondents mentioned that if all of these factors can be addressed by the Department, medical doctors will not hesitate to work in rural areas where they are mostly needed.

CHAPTER 5

5. INTERPRETATION OF THE RESULTS

5.1 INTRODUCTION

This chapter presents an analysis and interpretation of results presented in the previous chapter. The interpretation is based on confirming similarities to and differences from what was described and discussed in the literature review in Chapter 2. The conclusion drawn in the literature review states that the relocation of medical doctors is an issue those countries throughout the world are grappling with to retain medical doctors in rural areas. There are various factors influencing relocation of medical doctors from rural to urban areas and there are strategies suggested to deal with the problem. Recruitment and retention strategies must address both these problems in order to effectively address the mal-distribution of medical human resources.

This analysis and assessment is based on the need to investigate the factors that may have influenced the relocation of medical doctors from Dr. Ruth Segomotsi Mompati District to urban areas such as Mafikeng and Klerksdorp with a view to propose remedial actions to help contribute to finding solutions to the problem. The push and pull factors were influencing the relocation of medical doctors from rural to urban areas were presented in the literature review and also expressed by the respondents in the data collection process.

5.2 THE FACTORS THAT INFLUENCED MEDICAL DOCTORS TO RELOCATE FROM DR. RUTH SEGOMOTSI MOMPATI TO URBAN AREAS

5.2.1 Too much workload.

All respondents in the study strongly agreed to workload as one of the push factors influencing relocation of medical doctors from Dr Ruth Segomotsi Mompati District to urban areas. They further indicated the shortage of nursing personnel as aggravating the situation as they also do the work that was supposed to be done by professional nurses. The other factor is that there is a huge shortage of medical doctors and this leads to them working abnormal shifts that are tiring. They have limited time to rest and even when they want to take annual leave, they have to wait for one another or

take turns so that the work can be done. Bateman (2001) states that the deteriorating conditions of service in public hospital are due to shortages in human and financial resources, inappropriate and inadequate facilities, staffing crises and patient overload. These result in a lack of supervision for junior doctors, which in itself, contributes to migration of medical doctors.

5.2.1 Salary and incentives not satisfactory

Respondents agreed that salary and incentives are not satisfactory in the sense that they use the incentive money to travel to town, which is about seventy kilometres away, to get groceries and to pay accounts. Most of the money is used on transport. Couper (1999) states that rural incentive allowances that include extra remuneration, family and educational perks will improve retention. According to Couper (1999), incentivised and worthwhile packages such as resettlement grants, car and housing allowances, guaranteed locum relief, study leave for continuing medical education and family support will help retain doctors.

5.2.3 Medical equipment not up to standard

Respondents agreed to this push factor that in their respective hospitals there is minimal technologically advanced equipment and while technology is very high, they are still using old equipment.

5.2.4 Lack of medical equipment

Few respondents agreed that there is lack of medical equipment. To be specific only 2 out of 30 agreed that there is lack of medical equipment.

5.2.5 Shortage of nursing personnel

All respondents strongly agreed to this push factor that influences relocation of medical doctors from rural to urban areas. They stated that they work long hours and sometimes they do work for the nursing personnel due to the shortage of nursing personnel.

5.2.6 Infrastructure not up to standard

Majority of the respondents disagreed that infrastructure is not up to standard. Only four agreed that infrastructure is not up to standard.

5.2.7 Accommodation not suitable

Out of 30 respondents 14 strongly disagreed that accommodation is not suitable. Three (3) agreed that accommodation is not suitable; while five (5) strongly agreed that accommodation is not suitable

5.2.8 Lack of professional development

More than thirteen (13) respondents agreed that there is a lack of professional development in medical education in the Dr. Ruth Segomotsi Mompati district. More than five (5) strongly agreed and only two (2) strongly disagreed that there is lack of professional development in the district. WONCA (2002) states that appropriate incentives or bursaries should be provided for medical doctors who are interested in pursuing further studies in rural medicine. Appropriate rural exposure through the curriculum as part of medical training and a decentralised rurally based accessible postgraduate training should be part of the strategy (WONCA, 2002).

5.2.9 Lack of support for family development

In this push factor, five (5) respondents disagreed, Seven (7) strongly disagreed, Eight (8) strongly agreed and ten (10) disagreed. Hartwig (2000) and Bateman (2001) reiterate this factor and describes rampant crime, the threat to personal safety, uncertainty about children's future and violence as aggravating the poor conditions under which public sector doctors' work, and as contributory factors to emigration.

5.2.10 Lack of support from community and other structures

Respondents in this push factor strongly disagreed that there is lack of community support other structures whilst few strongly agreed. The researcher noted that the respondents were warmly welcomed in the community and only few feel unwelcomed and that might be according to cultural difference and individual perceptions respondents hold.

5.3 THE PULL FACTORS THAT WILL INFLUENCE MEDICAL DOCTORS TO STAY IN THE RURAL DISTRICT OF DR. RUTH SEGOMOTSI MOMPATI

5.3.1 Less workload

Most of the respondents strongly agreed, and agreed to this pull factor with a few disagreeing. This shows that workload has an influence in medical doctors relocating from the district.

5.3.2 Good salary and incentives

More than seventeen (17) of the respondent strongly agreed, with seven agreeing and six disagreeing. The researcher notes that salary and incentives plays a vital role in the retention of medical doctors in rural areas. Gering & Conner (2002) supports this view and states that a competitive pay package is important for retention. Medical doctors needs market related inflation-linked salaries that are congruent with levels of their professional qualifications.

5.3.3 State of the art accommodation

The majority of the respondents agreed to this pull factor as there are eighteen (18) respondents that strongly agreed to the state of the art accommodation for medical doctors. The researched notes this with concern because in the push factor majority of the respondents disagreed that there is a need for accommodation to be upgraded. This will need further research.

5.3.4 Quality medical equipment

Respondents strongly agreed that there is a need of quality and technologically advanced medical equipment as most hospitals in the district still use old machinery or medical equipment. Gering & Conner (2002) assert that availability of technology, equipment, resources, tolls and the general state of the work environment are significant contributors to motivation and commitment.

5.3.5 Recruitment of more nursing personnel

The majority of the respondent strongly agreed and agreed to this pull factor. This will ease the burden on doctors performing nursing duties due to shortages. It will also influence doctors to stay in the district hospitals.

5.3.6 Support from staff and management

Most of the respondents strongly agreed and agreed to this pull factor that if it can be properly implemented it will lead to increased turnover of medical doctors. The Harvard Management Update (2000) stated that information sharing and ordinary human virtues such as courtesy, respect and the recognition that workplaces are the kind of social settings that create friendly relations, will improve the work environment. Barney (2002) stated that work and collegiality amongst co-workers are the prime motivators that influence employee turnover. The essence of management is to make knowledge productive through defining values, culture, rewards and discipline within the organisation. The Harvard Management Update (2000) stated that managers contribute significantly to attrition and retention by influencing employees' commitment level. According to Prewitt (1994, p.4) and Dobbs (2001, p.2) "People do not leave organisations. They usually leave bosses".

Many talented professionals leave an organization because senior managers fail to understand the psychology of work satisfaction and assume that people who excel at their work are happy (Butler &Waldroop, 1999).

5.3.7 Infrastructure improvement

About seventeen (17) respondents strongly agreed that there is a need for infrastructure improvement. Ten (10) respondents agreed whilst three disagreed. Infrastructure development in the healthcare system is very important.

5.3.8 Support for professional development

The majority of the respondents strongly agreed to this pull factor. Sturges and Guest (2001) state that career growth, learning, development and mentoring are among the top reasons why employees stay with their current employer. Butler

&Waldroop (1999) confirm this factor by stating that career malaise has been identified as a factor in professional migration.

5.3.9 Support for family development

More than twenty one (21) respondents strongly agreed to this pull factor with the remaining agreeing to it also. Hartwig (2000) and Bateman (2001) describe rampant crime, the threat to personal safety, uncertainty about children's future and violence as aggravating the poor conditions under which the public-sector doctors' work, and as contributory factor to emigration.

5.3.10 Support from community members and other structures

Most respondents strongly agreed and agreed to this pull factor. However, the researcher notes this with concern because the response given in this factor as a push factor was very positive that most respondents are welcomed by the community members and other structure. This factor will need a further research.

5.4 Conclusion

The involvement of stakeholders is crucial in policy making which will have fruitful implementation through the inputs of stakeholders and effective mobilisation of resources as they are involved and are part of the implementation of policy. The Department of Health has good Human Resources for Health Policy and Recruitment and Retention strategies for Health Practitioners. If this can be applied, medical doctors will be encouraged to be retained to practice in rural areas and access to primary healthcare services in rural areas will be improved. Most scholars concur that if these pull factors can be improved, medical doctors will be retained in rural areas and provision of healthcare services will also be improve.

CHAPTER 6

6. CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The relocation of medical doctors from rural to urban areas is one of the most widely researched areas in the existing body of knowledge; there are few studies that have conducted this study specifically in the North West Province and up to the district levels of our provinces. The aim of the research was to investigate the push and pull factors influencing the relocation of medical doctors from Dr. Ruth Segomotsi Mompati District to urban areas.

The study sought to establish the underlying push and pulls factors influencing the relocation of medical doctors to relocate from the district to urban areas, with a view to identify corrective measures or remedial steps and recommendations to inform better retention practices in the Department of Health.

This chapter deliberated on the research findings and analysis, thereby drawing its conclusions and making recommendations as well as highlighting the study's limitations and areas for future research.

6.2 Conclusion

The Department of Health has the responsibility of providing quality healthcare services to citizens of South Africa. The healthcare sector currently has the challenge of the relocation of medical doctors from rural areas to urban areas and even outside the country and abroad. The provision of quality healthcare service cannot be done if the Department of Health does not implement the human resources for health and the recruitment and retention of health professional strategies effectively to recruit and retain committed medical doctors more especially in rural areas such as Dr. Ruth Segomotsi Mompati District in the North West Province.

The healthcare professionals are knowledge based and are affected by the push and pull factors of globalization. These factors encourage the movement of employees away from areas of great need to areas of maximum job satisfaction. This is what is happening in the rural district of Dr. Ruth Segomotsi Mompati in the North West Province where medical doctors relocate to urban areas where they are less needed than in rural areas.

In terms of pull factors, job satisfaction is affected by factors such as work environment, opportunities for career advancement, incentives and compensation as well as allocation of resources to perform to the best of their abilities. Security is also another factor that leads to medical doctors relocating in the district.

In conclusion the researcher states that relocation of medical doctors is an issue that countries throughout the world are grappling with in order to retain medical doctors, especially in rural areas. There are various push and pull factors influencing the relocation of medical doctors from rural to urban areas and there are strategies suggested to deal with the problem. Whilst international migration is an increasing problem related to globalization, the problem of internal migration remains a greater challenge in South Africa. The recruitment and retention strategies must address both these problems in order to effectively address the mal-distribution of medical human resource.

6.3 Recommendations

Organizations that intend remaining competitive have to be serious about how they manage their knowledge workers. A successful retention programme is based on organisations improving employee commitment, by making employees feel valued, appreciated and trusted. Organizations have to continually evaluate employee expectations by conducting regular research on what it is that their employees value (Thulare, 2003).

Although the public healthcare sector has challenges in mobilising and allocating resources to improve healthcare services, specifically in rural areas, the provincial government should ensure that it supports the North West Department of Health in improving health and infrastructure as the premier reiterated in her State of the Province address. If this can be implemented, the push factors stated below can be

achieved and medical doctors in rural areas will be retained. The study has revealed that medical doctors regard several important factors that would make them stay in rural areas: It is recommended that

- 1) More medical doctors and nursing personnel be recruited as doctors end up doing nursing work and working irregular hours due to the shortage of medical doctors and nurses.
- 2) Good salary incentives, quality medical equipment, infrastructure improvement and state of the art accommodation for medical doctors should be implemented to be pull factors so doctors stay in the district. The use of old and not up to standard medical equipment frustrates medical doctors.
- 3) Support for professional development as most scholars state that this is very critical for doctors who want to pursue further studies in medical education, especially in rural medicine.
- 4) Security and support for family development is also one of the key push factors that leads to the relocation of medical doctors from rural to urban areas. As Hartwig (2000) and Bateman (2001) describe rampant crime, the threat to personal safety, uncertainty about children's' future and violence are aggravating the poor conditions under which public-sector doctors' work and are a contributory factor to emigration.

The literature review and previous studies that had been conducted on similar topics substantiates the fact that if all the above mentioned factors can be effectively implemented, the country will experience fruitful recruitment and retention of committed and dedicated medical doctors in rural areas and also in the public health system. The North West Province Department of Health also needs to ensure that all the above mentioned factors are effectively implemented in their strategies and its quest for provision of quality healthcare to communities in Dr Ruth Segomotsi Mompati District will be achieved.

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LIST OF APPENDICES

APPENDIX 1

1. The demograhpics part of the questionnaire.

BIOGRAPHICAL INFORMATION

Gender	Male		Female	
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Age	20-30		31- 40		41- 50		50 and above	
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Years of service in this area								
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APPENDIX 2

The first research question with ten (10) sub questions where respondents had to choose.

SURVEY QUESTIONS

What are the factors that you think influences medical doctors to relocate from Dr. Ruth Segomotsi Mompoti district to urban areas?

Factors	Disagree	Strongly Disagree	Strongly agree	Agree
a) Workload is too much	Disagree	Strongly Disagree	Strongly agree	Agree
b) Salary and incentives not satisfactory	Disagree	Strongly Disagree	Strongly agree	Agree
c) Medical equipment is not up to standard	Disagree	Strongly Disagree	Strongly agree	Agree
d) Lack of medical equipments	Disagree	Strongly Disagree	Strongly agree	Agree
e) Shortage of nursing personnel	Disagree	Strongly Disagree	Strongly agree	Agree
f) Infrastructure not up to standard	Disagree	Strongly Disagree	Strongly agree	Agree
g) Accommodation not suitable	Disagree	Strongly Disagree	Strongly agree	Agree
h) Lack of professional development	Disagree	Strongly Disagree	Strongly agree	Agree
i) Lack of support for family development e.g Child education support, security etc	Disagree	Strongly Disagree	Strongly agree	Agree
j) Lack of support from community and other structures	Disagree	Strongly Disagree	Strongly agree	Agree

APPENDIX 3

The secondary research question with ten (10) sub questions where respondents had to choose.

Do you think if these factors can be addressed and implemented accordingly medical doctors will be retained in the Dr. Ruth Segomotsi Mompati district?

Factors	Disagree	Strongly Disagree	Strongly agree	Agree
a) Less workload	Disagree	Strongly Disagree	Strongly agree	Agree
b) Good salary and incentives	Disagree	Strongly Disagree	Strongly agree	Agree
c) State of the art accommodation	Disagree	Strongly Disagree	Strongly agree	Agree
d) Quality medical equipments	Disagree	Strongly Disagree	Strongly agree	Agree
e) Recruitment of more nursing personnel	Disagree	Strongly Disagree	Strongly agree	Agree
f) Support from staff and management	Disagree	Strongly Disagree	Strongly agree	Agree
g) Infrastructural improvement	Disagree	Strongly Disagree	Strongly agree	Agree
h) Support for professional development	Disagree	Strongly Disagree	Strongly agree	Agree
i) Support for family development e.g Child education, security	Disagree	Strongly Disagree	Strongly agree	Agree
j) Support from community members and other structures	Disagree	Strongly Disagree	Strongly agree	Agree

Appendix 4

P.O.Box 240

Taung Station

8580

11 May 2012

Dear Sir/Madam

Request for an interview

I am a student at the University of the Witwatersrand pursuing a degree in Masters of Management in the field of Public and Development Management. I am conducting a research about the push and pull factors influencing the relocation of medical doctors from Dr Ruth Segomotsi Mompati District to urban areas.

I am therefore requesting to make an appointment for an interview during May or June at a time mutually agreed upon. I can be contacted on 071 985 7755 at all time. Kindly indicate your availability as soon as you can.

As indicated the interview is being undertaken purely for academic purpose and confidentiality and anonymity is guaranteed. No information will be divulged unless with prior written consent from yourself.

Looking forward to your favourable responses.

Yours sincerely

Raetlaka Solly Manoto