EXPLORING PULL AND PUSH FACTORS INFLUENCING HUMAN RESOURCES IN TWO SOUTH AFRICAN HEALTH FACILITIES

By

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DECLARATION

I understand, declare that this dissertation has not been submitted to any university, and that it is my original work conducted under the supervision of Bronwyn Harris. All assistance towards the production of this work has been acknowledged in the Acknowledgements.

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Acronyms and abbreviations

ANC	Antenatal Clinic
CEO	Chief Executive Officer
HCW	Health Care Worker
HPCSA	Health Professional Council of South Africa
HRH	Human Resource for Health
HST	Health Systems Trust
IMCI	Integrated Management of Child Health
IIEP	International Institute for Educational Planning
MDG	Millennium Development Goals
MSA	Municipal Systems Act
NDOH	National Department of Health
NGO	Non Governmental Organisations
NHI	National Health Insurance
OSD	Occupational Specific Dispensation
PHC	Primary Health Care
PMS	Performance Management System
PMTCT	Prevention of Mother to Child Transmission
RuDASA	Rural Doctor's Association of Southern Africa
SDBIP	Service Delivery and Budget Implementation Plan
UDHR	Universal Declaration of Human Rights
WHO	World Health Organization
VCT	Voluntary Counselling and Testing

ABSTRACT

Study Title: Exploring Pull and Push Influencing Human Resources at two South African Health Facilities

Introduction

The magnitude of the health worker shortage in developing countries such as South Africa cannot be overstated and requires an urgent, sustained and coordinated response. In South Africa, the government has introduced many initiatives, such as the rural allowance, to attract more health practitioners in rural areas. However, human resource shortages remain a challenge and therefore looking at ways to better utilize the capacity of human resources could play a significant role in addressing this problem, and could contribute to establishing a well-functioning public health system.

Objectives

This study was aimed at exploring and describing factors that affect human resource capacity in two district hospitals in the Eastern Cape Province: one rural, one urban, and makes appropriate recommendations to health authorities so as to better utilize and retain human resource capacity within the facilities.

Methods

This is a qualitative study, using explorative and descriptive research strategies. The study was conducted in two district hospitals, one urban (hospital B) and one in a rural area (hospital A), both in the Eastern Cape Province. A total of thirty six in-depth interviews were

conducted with allied health professionals and administrative staff – eighteen from each site - to explore their perceptions around "pull and push factors" in their work. Additionally, four interviews were conducted with district team members and key policy documents were reviewed.

Results

The availability of equipment, and quality of infrastructure, as well as relationships between staff differed between the two facilities and were cited as reasons affecting staff intentions to stay or leave. Loosely labelled as "working conditions", these were perceived to be 'better' in the urban-hospital B than rural-hospital A, where staff morale was lower. Geographical differences, including surrounding infrastructure and the availability of services such as schools and recreational facilities, also affected staff decisions and intentions to stay or leave (more pronounced in the rural-hospital A). Opportunities for professional development were also perceived to contribute towards the retention of professional health workers.

Conclusion

Interviewees emphasized wanting more opportunities for professional development and improving their working and living conditions, as well as improving relationships between the hospitals and district structures. It is important to manage any incentivisation-process (financial and non-financial), including rural allowances and professional staff development, with more caution to ensure that they address the intended goals and do not result in unwanted consequences or tensions.

Recommendations

Improving conditions in rural areas is indeed a necessary step. Despite the introduction of rural allowances, for health professionals working in rural areas, rural public health facilities still experience a significant shortage of healthcare professional. Further research is needed to pilot and scale-up existing models aimed at promoting staff retention in these public health facilities.

Chapter 1 – Introduction

According the World Health Organisation, human resource policies that improve health systems performance are important in order to achieve the Millennium Development Goals (MDGs) and to minimize constraints that countries may have in delivering health interventions to their populations to address key health problems such as HIV, TB and malaria (2002: 5). Human resources, when pertaining to health, can be defined as the different kinds of clinical and non-clinical staff responsible for public and individual health interventions (Kabene *et al*. 2006: 1). However, imbalances do exist among the different kinds of clinical and non-clinical staff who make each individual and public health intervention happen (Zurn *et al*. 2004: 1). These are due to a number of factors which include the demand for health personnel, supply of human resource for health, participation in labour market and migration (Zurn *et al*. 2004: 4).

Health systems in sub-Saharan Africa have been badly damaged by the migration of health professionals to the developed countries, and consequences of losing health workers in most countries have become increasingly recognised due to significant shortages (Naicker *et al.* 2009: 3). Since 1948, more than 2000 doctors have migrated from South Africa to Australia due to a number of reasons related to apartheid - before 1990 – and violent crimes and safety – after 1990 – (Arnold & Lewinsohn: 2010. 2). Most South African doctors who migrated to Australia were impelled to emigrate by South African issues, rather than attracted by Australia (Arnold & Lewinsohn: 2010. 2).

Vujicic et al (2004: 1) conducted a multi-country (Zambia, Sierra Leone, Ghana, Philippines, Sri Lanka, Chad, Mozambique, Malawi, Cote d'voire Trinidad Tobaggo and

South Africa) study conducted aimed at examining the role of wages in migration of healthcare professionals from developing countries to the developing countries (United States, Australia, Canada, United Kingdom and France). The findings are summarised on the table below Vujicic et al (2004: 7);

Factors influencing health care professionals' intent to migrate, reason for migrating and willingness to remain in their home country			
	For what reasons do you intend to leave your home country?	For what reasons did you leave your home country?	What would make you remain in your home country?
Cameroon	Upgrade qualifications (85%)	Recruited (29%)	Salary (68%)
	Gain experience (80%	Gain experience (80%)	Continuing education (67%)
	Lack of promotion (80%)	Better pay (27%)	Working environment (64%)
	Living conditions (80%)	Living conditions (19%)	Health care system management (55%)
Ghana		Gain experience (86%	Salary (81%)
		Lack of promotion (86%)	Working environment (64%)
		Despondency (86%)	Fringe benefits (77%)
		Living conditions, Economic decline (71%)	Resources in health sector (70%)

Senegal	Salary (89%)		Work environment (n/a)
	N/a		Salary (n/a)
	N/a		Better career path (n/a)
	N/a		Benefits (n/a)
South Africa	Gain experience (43%)		Salary (78%)
	Violence and crime (38%)		Working environment (68%)
	Heavy workload (41%)		Fringe benefits (66%)
	Declining health service (38%)		Workload (59%)
Uganda	Salary (72%)	Salary (55%)	Salary (72%)
	Living conditions (41%)	Economic decline (55%)	Fringe benefits (54%)
	Upgrade qualifications (38%)	Save money (54%)	Work environment (36%)
	Gain experience (24%)	Declining health service (53%)	Workload (30%)
Zimbabwe	All factors	All factors	All factors
	Source:[19]		

A study conducted by Willis-Shattuck et al (2008: 3) on motivation and retention of healthcare workers in developing country, identified seven major themes regarding motivational factors for healthcare workers in developing country. These included the following:

- Financial (in terms of salary or allowance)

- Career development (in regard to the possibility to specialise or be promoted)
- Continuing education (having the opportunity to take classes and attend seminars)
- Hospital infrastructure (the physical condition of the health facility, also known as work environment)
- Resource availability (refers to equipment and medical supplies that are necessary for health workers to perform their work)
- Hospital management (refers to having a positive working relationship with the management whom the health workers work with)
- Personal recognition or appreciation (either from manager, colleagues of the community)

About 23, 407 South African doctors are in Australia, New Zealand, Canada, United Kingdom and United States, with 8, 999 in United Kingdom alone, and an excess of 10, 000 South African nurses in the United Kingdom (Naicker *et al.* 2009: 3). The World Health Report of 2006 provided data (shown below) on the number of medical and nursing personnel in South Africa in 2004. As show on the table below, the country seems to experience a general shortage of health workers, in some parts of the country.

Table: 1.1 Healthcare workers in South Africa in 2004 (World Health Organization Report. 2006)

Indicator	Value
Physicians (number)	34,829
Physicians (density per 1 000 population)	0.77
Nurses (number)	184,459
Nurses (density per 1 000 population)	4.08

Source: World Health Organization Report. 2006. Available at www.who.int/whr/2006/en/ Accessed February 2, 2009.

Of the total number of registered medical practitioners in South Africa in 2004, 5277 (16%) were graduates from Zambia, Zimbabwe, Kenya, Ghana, Nigeria, the Indian subcontinent and Eastern Europe.

In 2004, the 57th World Health Assembly passed a resolution on the international migration of health personnel, recognizing that the migration of skilled health workers from poor countries to rich countries represented a serious challenge for health systems in developing countries. In many countries, the tendency of young registered nurses to emigrate for "greener pastures" has become significant, often following structural, policy and organizational changes within the health sector (Scholastika *et al*. 2006: 3). In Namibia, for example, the issue of skilled nurses leaving the country for better opportunities has been such a major concern that a law to prohibit their exodus from the country was suggested, although not adopted (2006: 3)

In 2005, the Regional Network for Equity in Health in East and Southern Africa (EQUINET) conducted a study in Namibia, which focused on the impact of the condition of services and movement of health workers between the public and the private sectors (EQUINET Discussion Paper, 2009: 16). The study established that more than half of the pharmacists, doctors, medical technologists and dentists are in private practice, leaving the public sector with a skeleton service in those categories.

Movement from public to private sectors is a major challenge for the South African public sector too, as it serves over 85% of the total population, especially people from disadvantaged communities where the burden of disease is high, as opposed to the private sector which serves just 14% (Human Resource for Health, 2009: 6). The disparities are even greater in relation to health professionals; each pharmacist in the public sector serves 12 to 30

times more people than in private sector, and each generalist doctor in the public sector serves 7 to 17 times more (Human Resource for Health, 2009: 6).

Another pressing concern internationally and within South Africa is migration which is driven more by broader career concerns such as the quality of opportunities to conduct research, to work with leaders in the profession, where there is political stability as well as lifestyle and family reasons (Gibson & McKenzie: 2012. 11). This trend has negatively affected health care delivery systems, particularly in the most rural areas which are badly affected by shortages of staff. Poor working conditions, inadequate incentive systems, compounded by frustrating out-of-date regulations and management approaches have resulted in serious brain drain of skilled health staff (Bundred & Levitt, 2000: 245). South African government has introduced several policies such as scarce skills allowance and rural allowance for health professionals, which offer financial incentives to staff working in rural areas who have specialized skills (Ried, 2004: 3).

The implementation of rural allowance by the National Department of Health in 2003 was one response to staffing shortages and issues in several impoverished, under-developed districts identified and listed as “rural development nodes” (Bateman, 2007: 24). A study done by Health Systems Trust to monitor the effect of the then new rural allowance for health professionals, reported that the majority of respondents felt it influenced them to work in rural areas (Reid, 2004:5). However, there were other factors which needed to be taken into account beyond this initiative, which include infrastructural and developmental issues. The factors that were reported to influence their choice of where they would work the following year included, in decreasing order of frequency: finances, job satisfaction, career opportunities, security, post-graduate education, family, work relationships, and workload (Reid, 2004:5). About 64% of respondents reported that the previous rural allowance did not

influence them favourably towards working in a rural area in South Africa in the future, and furthermore, that factors other than the rural allowance were more important in considering their place of work the following year. However, 36% said that the previous allowance did influence them.

According to the Human Resource for Health (HRD) Draft HR Strategy (2011: 25) providing health services to rural communities presents complex challenges in every country. The HRD highlights the following (2011: 25);

- That South Africa's rural areas, are home to 43, 6% of the population but are served by only 12% of the doctors and 19% of nurses.
- Of the 1200 medical students graduating in the country annually only about 35 end up working in rural areas in the longer term.
- About 21.3% of households in metropolitan areas have medical insurance compared to 5, 4% of households in rural districts, so access to private care is low.
- However access to primary health care (PHC) needs to be seriously improved in rural areas.

South Africa has experienced a significant proportion of health workers moving to urban areas to seek better wages and working conditions. As a result, rural communities do not have a choice of multiple public and private facilities nearby. Hence there is a need to generate a better understanding of this distribution, and establishing factors which could assist in addressing the problem.

Inequitable distribution is first and foremost an inter-provincial problem in South Africa. With a total of 9 provinces, some provinces have abundant resident registered professionals while others are seriously deprived. As demonstrated on the table below, the advantaged and attractive provinces are particularly Gauteng, Western Cape and KwaZulu

Natal with regard to health budget. Eastern Cape Northern Cape and Mpumalanga are the disadvantaged and less attractive provinces. Intra-provincial shortages are largely due to mal-distribution of professionals along the rural/urban divide in all provinces. This distribution is highlighted on the **table 1.2** below.

Table: 1.2 Nurses per Population by Province, 2006

Provinces	Population		Nurses		Population per qualified nurse ratios
	Num	%	Num	%	
Eastern Cape	7051500	14.9	20381	10.4	346:1
Free State	2958800	6.2	11467	5.8	258:1
Gauteng	9211200	19.4	51997	26.4	177:1
KwaZulu Natal	9731800	20.5	44349	22.5	219:1
Limpopo	5670800	12.0	17173	8.7	330:1
Mpumalanga	3252500	6.9	9310	4.7	349:1
North West	3858200	8.1	13010	6.6	297:1
Northern Cape	910500	1.9	3376	1.7	270:1
Western Cape	4745500	10.0	25851	13.1	184:1
Total	47390800	100.0	196914	100.0	241:1

Source: SANC (2007)
Note: These figures exclude nurses in training (Students, Pupils and Pupil N/A)

The table shows that Gauteng, KwaZulu Natal and Western Cape Provinces possess a significant proportion of nurses compared to Eastern Cape, Limpopo, Northern Cape and Mpumalanga province which are all in a desperate situation.

It is due to this background, that this study was conducted to explore factors affecting human resource capacity in two health facilities, one rural and secondly urban in Eastern Cape Province. The study looked at factors which influence human resource capacity of health facilities in two district hospitals.

Working Definitions

Human Resource: Is the set of individuals who make up the workforce in an institution. Human resources refer to individuals who make-up the workforce of an organisation or institution.

Human Resource Capacity: This is about ensuring that an institution has enough people with the enough skills to achieve its objectives.

Capacity: Capacity is defined as the ability of individuals, organisations, or systems to perform appropriate functions effectively, efficiently and sustainably (UNESCO, 2006: 1). The UNESCO Guidebook defines capacity building as a process by which individuals, organisations or institutions increase their abilities to (2006: 1);

- Perform core functions, solve problems, define and achieve objectives and,
- Understand and deal with their development needs in a broad context and sustainable manner.

Pull Factors: "Pull factors" attract health professionals to employment as the opposite of the "push factors", i.e. better paid salaries, job satisfaction, security and career development opportunities. These factors reflect the fact that conditions of service in general are strong determinants of the movement of health professionals. According to Ali Shah *et al.* (2010: 170), push factors are aspects that push employees towards the exit door. Ali Shah *et al.* (2010: 170) refers to these as controlled factors because they are internal and can be controlled by an organisation.

Push Factors: Push factors influence existing staff to consider leaving their current workplace

due to a number of factors highlighted above, which are unfavourable to them such as low salaries, poor governance or even discrimination. If staff move as a result of these factors, the capacity of human resource decreases. As a result, this can affect delivery of services to the affected community.

Rural areas: Literature shows that defining "rural areas" have always been particularly challenging (WHO, 2009: 6). According to the WHO paper on "increasing access to health workers in remote and rural areas through improved retention", the term invokes images of farms, villages, small towns, and open spaces (2009: 4). The paper also highlights that there has been no consensus on specific definitions of these areas, making clear-cut distinctions between the two difficult.

Urban Areas: Sociologists define rural as those areas which are not urban in nature. Hewitt (1989: 3) mentions that it is difficult to quantify rural health problems and to make informed policy decisions without knowing which areas are rural. She characterises the rural area as having a small population, sparse settlement and remoteness (1989: 3). Rural areas face particular challenges which make them different from urban, beyond the deficiencies of workforce (Couper, 2003: 2). Some of these challenges include lack of medical equipment, infrastructure and personnel.

Problem Statement

Poor human resource capacity in public health facilities can compromise effective delivery of health services to the majority of South African population. A significant proportion of the population, from both urban and rural areas, access health services at public

health facilities. With an increase in burden of disease due to HIV and other disease, it then becomes important to address this problem.

Also, migration of professional staff to urban areas due to a number of factors, such as quality of opportunities and lifestyle, continues to be the greatest threat for human resource capacity in rural health facilities, some of which are confronted by a serious public health challenges and an increased burden of disease. The extent of the problem has increased, such that even the newly qualified, choose to serve in urban areas. There has been an assumption on a related-perception that urban areas are better resourced and provide better health services than rural areas. To a certain extent, this has influenced professional health workers to perceive urban areas as most desirable areas to work in, making it extremely difficult for rural health facilities to retain or attract new staff.

Some of the greatest challenges related to human resource capacity experienced by health facilities in rural areas include recruitment and retention of professional health workers in rural areas to improve service-delivery and capacity. The issues highlighted above demonstrate how important it is to do more research and recommend interventions to address human resource capacity challenges. It is therefore a problem that human resource capacity lacks in public health facilities as this lack has a direct influence towards the delivery of services. Hence, this study sought to establish factors which influence human resource capacity in two district hospitals, and make appropriate recommendations to address the problem.

Rationale

In South Africa, the government has introduced many initiatives, such as the rural allowance, to attract more health practitioners in rural areas. However, human resource shortages remain a challenge and therefore looking at ways to better utilize the capacity of

human resources could play a significant role in addressing this problem, and could contribute to establishing a well-functioning public health system. A study by WHO established that qualified and motivated human resources are essential for adequate service provision, and that shortages have reached critical levels in many resource-poor-settings especially rural areas (Dieleman & Harnmeijer, 2006: 9).

There is a need to develop a better understanding of the critical factors influencing human resource capacity to deliver equitable, effective health care efficiently at a district level. The study identified district level hospitals as research sites because, for many South Africans, district hospitals are expected to provide a more comprehensive package of health services. The district hospitals play an important role in supporting primary health care and at the same time being a gateway to more specialist care, with 30 to 200 beds, a 24 hour emergency service and an operating theatre (District Hospital Service Package for South Africa. 2002. 3). The identification of constraints to human resource planning and management at the district level, as well as the key factors influencing staff retention and attrition which affect human resource capacity, will contribute to the development of more effective human resource strategies that ultimately have the potential to strengthen health systems at the district level. Though the study has primarily focused on retention issues, the data collected could also feed into identifying critical factors influencing human resource capacity and performance at the district level and feed into policy development. Additionally, this study will contribute to existing literature, strengthen health systems to achieve MDGs and policy improvement.

Objectives

This study is aimed at exploring and describing factors that affect human resource capacity in a rural and urban district hospitals in the Eastern Cape Province thereby making recommendations for health systems improvements.

The specific objectives were to:

- Describe the perceptions of health professionals regarding human resource capacity in health facilities
- Describe the perceptions of participants around "pull and push" factors
- Describe current strategies employed by district health managers to motivate and retain staff.
- Describe their suggestions to improve current working conditions and services delivery.
- Compare experiences between a rural and urban district health facility.
- Make recommendations directed at improving the capacity of human resources.

The study addressed the following research questions;

- What do you think about human resource capacity at your health facilitiy?
- What are the "pull and push" factors?
- Are you satisfied/ happy with the current working conditions at your health facility?
- What does the district health management team do to retain you at your health facility?
- What do you think are the alternative sources that attract health professionals to seek other jobs?

- What do you think should be done to improve the current working conditions on your health facility?
- Do you think that the current policy helps to achieve this objective?

Chapter 2 – Literature Review

Background

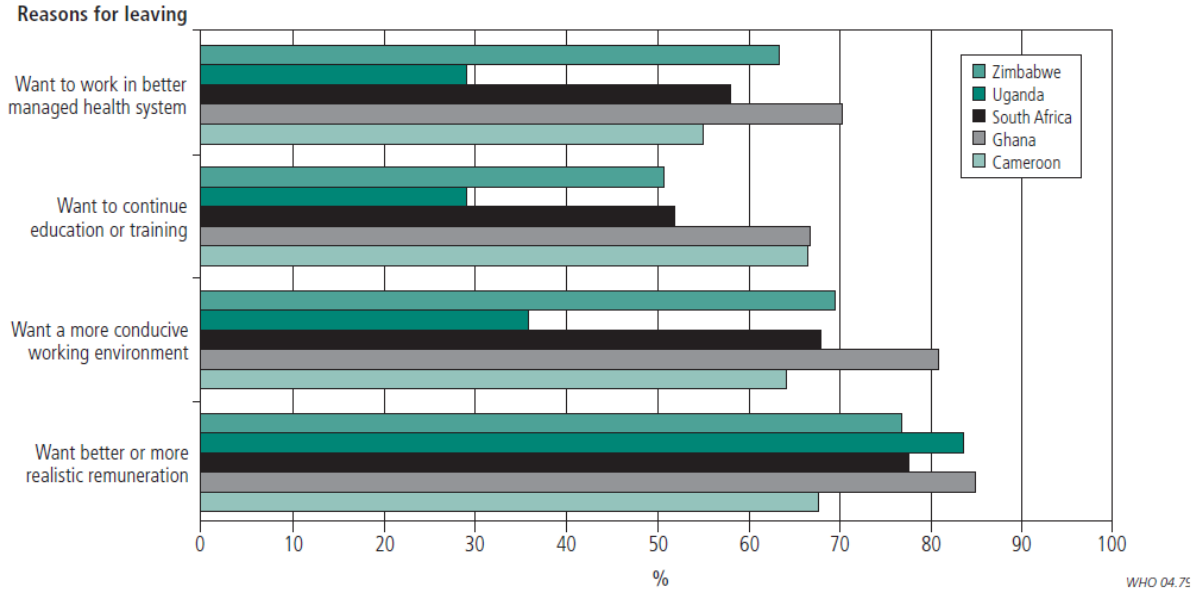
According to the Human Resource for Health Draft HR Strategy (2011: 22-23), slow growth of health professionals in the public health sector is linked to a number of variables which include, lack of funded public sector posts, lack of proactive planning and poor recruitment management processes. According to this, 70% of new graduates produced in key professions (such as doctors, engineers, nurses, law professionals and etc.) over a period of 10 years were not absorbed in the public sector. It mentions that in SA, over a 10 year time frame 11,700 MBChB were trained and yet only 4403 medical practitioners were employed over the same time in the public sector. The Human Resource for Health also reports that over 80% of Physiotherapists and Occupational Therapists were not retained in the public sector, and over the same period 2104 dentists were trained and only 248 employed in the public sector (2011: 23).

The Human Resource for HRD (2011: 22) also mentions that factors affecting migration of health workers are: HIV &AIDS, working conditions, workload in the public sector, workplace security, relationship with management in the public sector, morale in the workplace, risk of contracting TB, personal safety. In particular the working environment and management relationships are identified as critical factors affecting health professionals to leave (2011: 24). 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 capacity is vulnerable to a number of factors which have to do with the migration of staff. T**able 2.1** below, highlights some of the contributing factors to staff movement in five African countries, including SA (Stilwell *et at*. 2004. 3). Working

conditions, remuneration and professional development are some of the most dominant factors in these countries.

Table 2.1: Reasons for staff movement



A multi-country study conducted in Zimbabwe, Uganda, South Africa, Ghana and Cameroon by Dieleman and Harnmeijer (2006: 9), established that staff shortages limit accessibility to health services and programmes, which in turn affect health outcomes. Staff shortages also have a negative effect on the human resource capacity to provide health services, and negatively affect the motivation of the remaining staff as they create increased workloads, causing more stress, turnover and absenteeism (Dieleman & Harnmeijer, 2006: 9). It is reported that loss of health workers in rural areas severely contributes to accessibility problems for patients. Klemick *et al* defines access by looking at its four measures (2008: 5);

- The probability of getting the correct diagnosis at the closest facility,
- The travel time required to reach the closest facility,
- The probability of getting the correct diagnosis at the facilities patients are most likely to visit, and

- The average travel time required to reach the facilities patients are most likely to visit.

In addition, treasury made a provision for an increase of up to 30 000 HRH in various health professional categories between 2006 and 2012. Whether these targets are realistic and attainable or not, is another issue, but it is good that the government can recognise this challenge. Literature reveals that in recent years foreign health professionals, especially doctors, have been used to respond to the shortage of health professionals in rural areas. It is reported that in 2006, approximately 3 128 foreign doctors were estimated to be registered with the HPCSA, with 2000 employed in public health sectors (Human Resource for Health in South Africa, 2009: 8).

South Africa is currently experiencing a devastating challenge of the HIV epidemic which has also affected human resource capacity significantly. A study done by Health Economics and HIV & AIDS Research Division (HEARD) in 2009 established that the HIV epidemic has affected human resource capacity in health facilities. HIV prevalence of was found to be 20% amongst health workers between 18 and 35 years old, and 15% between health workers between 25 to 35 years old (Human Resource for Health in South Africa, 2009: 7). HIV prevalence was also found to be high amongst student nurses (13.8%) and within health facilities in rural areas (Human Resource for Health in South Africa, 2009: 7). This study mentions that in 2008, more than 63.7% of the nursing population were beyond the age of 40 years. The HIV epidemic also has had a devastating impact on the government's plans for scaling-up ART programs within the country, preventing South Africa from achieving the HIV prevention goals of the NSP 2007-2011.

Literature also reveals that poor human resource capacity has significant impact on the health workforce performance. Health workforce performance is critical since it has an

immediate impact on health service delivery and ultimately on population health. It is important to mention that a well-performing workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances.

Lochhead and Stephens (2004: 12) identify that **1) compensation and benefits, 2) recognition and rewards, 3) work-life balance, 4) job design and work teams, 5) training and professional development** as very important retention and pull factors if implemented right. These are explained below;

1) **Compensation and benefits**: Most of the sources consulted in this study stress the importance of compensation in attracting and keeping good employees, particularly for workers whose skills and responsibilities are unique or indispensable to the organization, or for those workers in whom the company has invested considerable resources in recruiting or training.

2) **Recognition and rewards**: Recognition and rewards—as part of a more comprehensive effort at keeping workers or adopting good workplace practices—can contribute to increased retention. According to this study, the category "Recognition and Rewards" is in some ways a catch-all phrase as it includes a diverse range of formal and informal, financial and non-financial, incentives given to individual employees, groups of employees or to an entire staff (Lochhead & Stephens: 2004. 12). They come in all shapes and sizes: small employee of the month awards (e.g., gift certificates, recognition plaques), company-sponsored sports teams, company parties, prizes, clothing, etc. They are often incorporated

into a company's overall HR policy, but are just as often awarded "as the need arises" and at the discretion of middle-level managers or team supervisors. It must be mentioned that such acts of recognition do have a positive impact on staff, both for retaining existing staff and attracting new.

3) **Work-life balance**: The study by Lochhead and Stephens (2004: 12) highlights work-life balance programs to cover a variety of interventions, and include such practices as dependent care leave, childcare subsidies, eldercare programs, counselling and referral, and flexible working hours. As the list suggests, the concept of "work-life balance" recognizes that employees have important family and extra professional obligations that compete with their professional commitments; benefits that may be grouped under this concept therefore allow people to strike a more meaningful and potentially less stressful balance between obligations at the workplace and obligations at home. These are very important issues which play a positive role to retaining and attracting professional staff. This acknowledges the fact that families do have a very influential role on decisions made by professional staff on whether or not to leave an area.

4) **Job design and work teams**: The study by Lochhead and Stephens (2004: 12) suggests that for retention of employee, workers stay with a company for reasons other than just good pay, benefits and other sundry perks. With respect to retention, the literature suggests that "intrinsic" rewards are just as important as material rewards. That is, workers value their jobs not only when they are well compensated, but often because doing the job is in itself a rewarding experience — in other words, it is fulfilling, challenging, interesting, and stimulating. The study further suggests that practices such as autonomous or semi-autonomous

work teams, ‘self-scheduling,’ and job rotation can not only improve retention but have also been shown to improve a number of other important indicators such as productivity, accidents and injuries and product quality.

5) **Training and professional development**: According to the study by Lochhead and Stephens (2004: 12), there is no doubt that training and development are so enthusiastically embraced as key factors to good retention, and that well-developed training programs are becoming ever more essential to the ongoing survival of most modern workplaces, whether or not retention is an important issue to that company.

The above study concluded that retaining key employees lies in the organization's capability in supporting employees by understanding and answering to their intrinsic motivators. It is important for employees to perceive a positive and valuing attitude of the organization toward them in order to have greater motivation for staying in the company. Such condition for employee retention is based on the social exchange theory which holds that the exchange relationship between employer and employee goes beyond exchange of impersonal resources such as money, information, and service.

Findings and recommendations made by Lochhead and Stephens (2004: 12) are acknowledged and will be explained as part of this study. However, in addition there is a need to also look at the same elements using a different method. This time explore how these affect human resource capacity from two different settings. Hence this study selects health facilities from two different settings (rural and urban) to explore factors which influence human resource capacity and taking into account a number of issues raised by previous

studies which include; pull and push factors, retention strategies, motivational aspects, work-life balance and so on.

Conceptual Framework

This study explored factors affecting human resource capacity in two district hospitals in the Eastern Cape Province, in SA. Research done by Padarath *et al*. (2003: 7) identified "pull and push factors" as determining the movement of personnel. The study also focused on factors which compelled health workers to move from one workplace to another, as they affect human resource capacity. The "push factors" are factors that make people move. These include low remuneration and poor salaries, lack of job satisfaction, work associated risks, as well as lack of career development opportunities.

Padarath *et al*. (2003:7) refer to the "pull factors" that attract health professionals to employment as the opposite of the "push factors", i.e. better paid salaries, job satisfaction, security and career development opportunities. These factors reflect the fact that conditions of service in general are strong determinants of the movement of health professionals. Other factors that can be put forward as "push" factors include poor occupational health and safety, lack of training and, poorly supplied medical facilities, too few staff, and poor management and overall health system governance.

In contrast, pull factors favour human resource capacity. Some health facilities may be able to pull staff due to a number of reasons. This shows that rural allowance, on its own, cannot be a pull factor given the fact that other staff would not really see that as a major problem compared to other factors. Hence, there is a need for a more comprehensive approach to identify where the problem lies, including retention of staff. Staff retention refers to a systematic effort by employers to create and foster an environment that encourages

current employees to remain employed by having policies and practices in place which address the diverse needs.

Table 2.2: Pull and push factors (WHO 2006: 24)

	Push Factors	Pull Factors
• Economic and demographic	• Poverty • Unemployment • Low wages • High fertility rates • Lack of basic health and education	• Prospect of higher wages • Potential for improved standard of living • Personal or professional development
• Political	• Conflict, insecurity violence • Poor governance • Corruption • Human rights abuses	• Safety and security • Political freedom
• Social and cultural	• Discrimination based on ethnicity, gender, religion	• Family reunification • Ethnic homeland • Freedom from discrimination

The factors highlighted in **table 2.2** above can affect human resource capacity both in a positive or a negative way, also taking into account different contextual factors which are economic, political and social. Push factors influence existing staff to consider leaving their current workplace due to a number of factors highlighted above, which are unfavourable to them such as low salaries, poor governance or even discrimination. If staff move as a result of these factors, the capacity of human resource decreases. As a result, this can affect delivery of services to the affected community.

"Pull factors" attract health professionals to employment as the opposite of the "push factors", i.e. better paid salaries, job satisfaction, security and career development opportunities. These factors reflect the fact that conditions of service in general are strong determinants of the movement of health professionals. According to Ali Shah *et al.* (2010: 170), push factors are aspects that push employees towards the exit door. Ali Shah *et al.*

(2010: 170) refers to these as controlled factors because they are internal and can be controlled by an organisation. He makes reference of other studies which have established that it is relatively rare for people to leave jobs in which they are happy, even when offered higher pay elsewhere. However, employees can be pushed due to dissatisfaction in their present job to seek alternative employment. The capacity of human resource is then affected by this because the choice of health workers can either benefit the facility, if staff choose to stay, or weaken the capacity if staff decide to leave. Other factors which make employees to quit include, salary, benefits, size of the organisation, stability in organisation, internal communication system, management policies and practices, and location of the organisation (rural or urban).

Pull factors are those reasons which attract the employee to new place of work (Shah *et al.* 2010: 172). These are named as uncontrolled factors because they are out the control of the organisation. Various pull factors derived from literature are; high salary, career advancement, new challenge and interesting work, job security, good location of company, better culture, life-work balance, more freedom, well reputation of organisation, values, more benefits and good management team.

Chapter 3 – Study Methodology

Introduction

This chapter describes the methods carried out during the course of this study, including design, site, population, data management and analysis, ethical consideration, and the duration of the study.

A proposal for this study was developed, submitted and approved in two different institutions (University of the Witwatersrand Human Research Ethics Committee and the National Department of Health) for review. Permission was also obtained from Eastern Cape Provincial Department of Health. The same process was followed and permission was also granted from the Office of the District Manager. The study investigator then requested the office of the District Manger to assist in getting permission from the two hospitals which were selected for the study. Permission was granted and the interview process began.

Study tool development

The study tools which were developed included in-depth interview questionnaires for health providers and district management team, observation checklist, consent form and information sheet. All these tools were reviewed together with the study proposal by University of the Witwatersrand Human Research Ethics Committee and National Department of Health. A pilot of all the data collection tools was done after approval was granted by the ethics committee. As a result the tools were revised based on the pilot findings to take into consideration sensitivity of issues raised, subtitles and rephrasing some questions which were confusing for the participants.

Study Design

This was a qualitative study, using explorative and descriptive research strategies. This research had three components, namely: mapping HR management practices, identifying the motivational environment of specific health professionals, and observation. Qualitative data collection was an appropriate method for this study because it addresses the "how's and why's" which are very significant to unpack issues related to the subjected matter of why people intend to stay or leave, and what pushes or pulls them. Dey (2003:5) mentions that use of qualitative data collection has a number of advantages which include the following:

- Flexibility for follow unexpected ideas during research and explore processes effectively;
- Sensitivity to contextual factors;
- Ability to study symbolic dimension and social meaning;
- Increased opportunities
    - To develop empirically supported new ideas and theories;
    - For in-depth and longitudinal exploration of leadership phenomenon; and
    - For more relevance and interest for practitioners.

Table: 3.1. Overview of study methods

Objectives	Activity	Methods	Data collection instruments	Type of instruments	Analysis
Describe the perceptions of health professionals regarding human resource capacity in their health facilities	For both objectives, sampling of different categories of health workers, such as doctors, nurses, pharmacist, physiotherapists, social workers and so on was done. From each	Random sampling of different categories of health workers Qualitative	In-depth interview guide	In-depth interview guide, information sheet and consent form	Thematic Analysis
Describe the					

perceptions of health professionals around "pull and push" factors	category, random sampling was done in such a way that all professional staff had equal opportunity of being selected.	data collection method			
Describe current strategies employed by district health managers to motivate and retain staff.	For this objective, only the management team from the district office were interviewed.	Convenience sampling of staff from the district management team Qualitative data collection method	In-depth interview guide	In-depth interview guide, information sheet and consent form	Thematic Analysis
Describe their suggestions to improve current working conditions and services delivery.	For both objectives, sampling of different categories of health workers, such as doctors, nurses, pharmacist, physiotherapists, social workers and so on was done. From each category, random sampling was done in such a way that all professional staff had equal opportunity of being selected.	Random sampling of different categories of health workers Qualitative data collection method	In-depth interview guide	In-depth interview guide, information sheet and consent form	Thematic Analysis
Compare experiences between a rural and urban district health facility.					
Make recommendations directed at improving the capacity of human resources.					

Observation

Observation was used as another data collection method, looking at issues such as infrastructure, equipment, geographical location and surroundings. The ideas was to look at how conducive the working conditions are, given the fact that literature reveals poor infrastructure and shortage or malfunctioning of equipment to be contributing factor on staff morale. This data is presented in form of the following themes which emerged during collation;

Description of interview guides

There were two interview guides, one for the management team and the other for different categories of health care providers. The interview guides provided themes which were aimed at identifying key factors related to human resource capacity, including push and pull factors, retention and attrition, as well as to determine staff morale and motivation. In keeping with the qualitative approach, the guides were made up of open-ended questions which also allowed the participants to bring other issues related to the subject matter. As a result, additional themes emerged during thematic analysis of these in-depth interviews. The purpose of the guide was to relate discussions in the interview back to the research question, yet also leave space for other issues to emerge from the participants themselves. All the study tools, which include interview guides, consent forms and information sheet were translated into local language, isiXhosa. These are attached as Appendix 1.

Site Selection

Eastern Cape Province is one of the poorest provinces in the country, and in 2010 was reported to have a population of more than 6 million people. The Eastern Cape Province has the third largest population (6.3 million people) in the country, with a highest shortage of health care workers. It is a very diverse province, comprising of both urban and rural human settlements. According to a survey done by Schoonraad and Radebe (2005. 23) the province is experiencing a significant shortage of health care workers, hence it was identified as the most relevant and most likely to benefit from the findings of this study.

The study was conducted in two district hospitals, which will be referred to as Hospital A and Hospital B due to anonymity reasons. The selection of the two health facilities was informed by the fact that they had similar characteristics with regard to the level

of care which includes Anti-Retroviral Treatment Services (ARVs), Emergency Services, Gynaecology Services, Kitchen Services, Laboratory Services, Laundry Services, Medical Services, O.P.D. Services, Obstetrics/Gynaecology, Occupational Services, Ophthalmology, Paediatrics, PMTC & VCT, Psychiatry, and Surgical Services. Additionally, the two health facilities have been experiencing regular movement of professional health workers from one facility to another. Comparing the two facilities may therefore give insights into movement across the facilities and more broadly. Hospital A is in a rural area, and B in an urban area. Hospital A serves a rural population estimated at 286 668 people

It extends its reach to other surrounding sub-districts which do not have a hospital. It is expected to offer a wider range of services which any other district hospitals are expected to offer, which include specialised services (surgery, physiotherapist, gynaecologist, psychologist, etc) and non-specialised. The same expectations applied for Hospital B, except that it is in an urban area. According to the Eastern Cape Provincial Department of Health, the most common diseases in the two areas are HIV and AIDS, pulmonary tuberculosis, diabetes, asthma, and epilepsy. It is mentioned that in both areas the rate of HIV is escalating due to poverty. Both study sites offer the same level of health care, which includes taking referrals from primary health care facilities from the surrounding areas.

Of the two district hospitals, Hospital A had a critical shortage of professional health workers. That implied that the sample needed to take into account of that, and make it standard for both facilities and made up of 4 medical practitioners [two from each site], 4 nurses [two from each site], 2 pharmacists [one from each site], 4 counsellors/ social workers [two from each site], 2 health inspectors [one from each site] and 2 managerial staff members [one from each site]. Table **3.2 below** shows the human resource capacity for both health

facilities. As shown on the table below, Hospital B had more health workers compared to Hospital A.

Table: 3.2. Human Resource Capacity in Hospital A and B

	Hospital A		**Hospital B**		
	Number Interviewed	**Total number of staff**	**Number Interviewed**	**Total number of staff**	**Staff Category**
Operational Manger	1	1	1	1	Professional staff
Human Resource Manager	1	1	1	1	Admin staff
Human Resource Assistant	0	0	1	1	Admin staff
Physiotherapist	1	1	1	2	Professional staff
PMDS Manager	1	1	0	0	Management staff
Doctors (Senior Medical Officer, two Medical Officers, sessional and community service)	5	5	4	17	Professional staff
Financial Manager	1	1	0	0	Management staff
Social Worker	1	1	1	3	Professional staff
Psychologist	0	0	1	2	Professional staff
Nurses (Professional, Occupational and Student Nurse)	3	16	4	27	Professional staff
Hospital CEO	1	1	1	1	Management staff
Information Officer	1	1	1	3	Admin staff
Nursing Manager	1	1	1	1	Professional staff
Pharmacist	1	1	1	4	Professional staff
Total	**18**	**31**	**18**	**63**	

Geographical location and the surroundings

Both hospitals are located along the busiest N1 route which cuts through the Eastern Cape Province. They are both located on the heart of both areas, surrounded by a number of

rural communities who also come to seek treatment. The two hospitals are also surrounded by a number of rural primary health care centres which refer people to these hospitals. Hence, participants from both hospitals mentioned their dissatisfaction with regard to servicing people who they felt should have been attended to at a clinic level, from the rural areas.

Data collection

Data collection was in three components. The first component of the research established the existing human resource management practices at the district level with the aim of identifying constraints and possibilities for improved human resource utilization. This included review of workplace policies, staff retention policies, HR policies and other policies that have been developed internally within the hospitals and externally. The second component was to map the motivational environment of specific professional health workers, such as doctors, nurses, pharmacists, counsellors, etc. with the aim of identifying key factors which could be utilized to attract and retain staff, as mentioned above, and improve human resource performance.

The third component was observation. This was done through note-taking and paying attention to certain aspects, such as the infrastructure and the waiting time of people who have come to seek medical care, in a systematic way. The objective was to use the information to support other methods of collection. This study employed direct observation whereby the researcher spent time looking at the physical setting of the research, the infrastructure and 'space' of each facility and the surrounding areas. The technique was non-participatory because the researcher stayed relatively uninvolved in the unfolding of the event. This was done to compliment other forms of data collection.

Ethical Considerations

This study did not involve the use of invasive procedures. Participation in the study was voluntary. All respondents were asked to sign an informed consent form after being given an information sheet, which included a provision that they have the right to refuse to be interviewed or withdraw from the process at any time they so deem. They were fully informed about all aspects of the study. All information collected was kept strictly confidential, and study participants and sites will receive a copy of the report. Individual name identifiers were not used, but instead their designations and pseudonyms.

- Consent

Written informed consent was obtained prior to all data collection activities. The consent form was made available to all the respondents, whereupon the respondents were asked if they agreed to participate and sign the form. Before signing their consent, the respondents were asked if they have any questions concerning their participation or about the study. The participants were also informed that, taking part or refusing to take part in this study would not affect their jobs in any way. Tape recording was voluntary, and study participants were informed that this was to make sure that there is no missing data. A separate consent form for audio taping was given to the participants to ensure that consent has been obtained before the recording the interviews.

- Benefit

There was no direct benefit from participating in the study. Rather, the benefit for the participants from taking part in this study was indirect. The results will be used to inform policy makers and strengthen the capacity of human resources, which may, in turn improve the working conditions of the health workers.

- Risk

Any potential risk from taking part in this study was considered. This included any possible identifiers of those who are taking part. To respond to this, participants were grouped into allied, admin and health workers.

- Confidentiality

All the tools used for collecting data, including questionnaires, notes from interviews, tapes of any recorded discussion were kept in a safe place. The tapes will be destroyed after 2 years, after the study has been published. All reasonable efforts that ensure that confidentiality was not breached were made. For instance, the names of the facilities have not been mentioned because that would have made it easier for the reader to identify who the participant was. Potential ethical concern in terms of this study relate to confidentiality. This involves keeping all the information confidential.

- Compensation

Participants were not being paid for taking part in the study.

- Permission

The study investigator sought all the necessary permission from relevant government departments, as well as ethics approval from the University, before the study commenced.

Sampling of Participants

In both hospitals, a list of staff members and their designation was obtained from the hospital management. The staff members were then clustered into different categories. These included Operational Managers, Human Resource Managers, Human Resource Assistant, Physiotherapist, Doctors, Social Workers, Psychologists, Nurses and Pharmacists. A random

selection of staff was then done to become participants in this study. The sampling was done in such a way that every person had the opportunity to participate in the study. Hospital A had a significant shortage of staff, as a result in some categories there was no option for sampling. All the staff members who participated during the piloting of tools were automatically excluded during data collection.

Piloting

The qualitative data was collected in the form of in-depth interviews. Instruments, which include interview guide and consent forms were piloted with eight people drawn from Hospital A, and through this process refined. The names of these pilot participants were highlighted to prepare for exclusion in the study sample. This was meant to avoid their selection during data collection since they had already participated in the pilot.

Data Collection

Data collection took ten days to be completed in both district hospitals. Each interview took about fifty minutes on average. In one of those days the interviewer was given permission to look around at the hospital, visiting all the hospital units, from casualty, pharmacy, all wards, consulting rooms, maternity ward, HIV clinic, operating room and admin staff offices. A checklist was used to collect relevant data during observation.

Data Analysis

After completion of data collection all the tapes were transcribed for the purpose of analysis. Since this was a qualitative study, thematic analysis was applied during the analysis. During the development of data collection tools (in-depth interview questionnaire) literature review was conducted to identify relevant themes which could respond to the objectives of the study. The

analysis was therefore done using these themes as they appeared in the questionnaire. Some of the themes emerged on the transcripts during the analysis

Transcribed data was later combined with notes which were taken during the interviews. During data analysis, no electronic software was used. Coding was done manually following themes which were on the interview guide including the ones that came up during data collection.

Thematic analysis, which offers an accessible and flexible approach to analysing qualitative data, was used, through creation of application of codes which built into themes. The table below (adapted from: Braun & Clarke, 2006: 23) shows all the phases which were followed during this process.

Table: 3.3. Summary of data analysis

Phase	**Description of the process**
1. Review of data:	Data was collected in three forms: 1) Interviews (tape recording and note taking); 2) Review of existing policies; 3) and observation (note taking). It was later transcribed and key themes were taken into consideration.
2. Generating initial codes	After data was transcribed, all the coding started. This took into account the existing themes which had been initially put on the interview guide, and the ones that emerged during the interviews and the course of the analysis.
4. Reviewing themes	During this phase it was noticed that there were some emerging themes which initially were not in the interview guide.

Duration of the Study

The first 3 months were devoted to project development which included development of instruments and application for ethical clearance. The second 3 months were used for data collection. The next 3 months were used for data analysis, and the final 5 months, for report writing. Following comments from examiners, the report was revised extensively.

Chapter 4 – Study Results

The structure of this chapter is presented in form of the thematic areas which were used in the interview guide. A total of 36 participants (18 from each hospital) were interviewed. This includes doctors (n=9), professional nurses (n=7), physiotherapists (n=2), pharmacists (n=2), Operational Managers (n=2), Human Resource Managers (n=2), Human Resource Assistant 9n=1), PMDS Manager (n=1), Financial Manager (n=1), Social Workers (n=2), psychologist (n=1), Hospital CEO (n=2), Information Officers (n=2), and Nursing Manager (n=2). .

Theme 1: Extended Staff Roles and Responsibilities

In both hospitals the HR offices were requested to provide job descriptions for each category of workers who participated in the study, to use that as a reference. These were discussed initially in the interview and also later compared to what the participants reported to be their scope of work.

In Hospital A, 13 participants reported certain roles and responsibilities which were not appearing in their job description. The following quotes below show what the participants from this hospital said;

> *"I am one of the Professional staff in this hospital. I work in casualty, but also do rounds in the wards in the evenings. I deal with all sorts of problems, but the most challenging part is also managing clinical activities at casualty. I also have a supervisory role. Sometimes we get very busy and our patients flock at pharmacy to collect their medicines. You find that some of them would even collapse because they stand in that queue for a very long time. As a result, I would go to the pharmacy and assist with the dispensing of medicines".*
>
> **(Busi) Doctor 1 from Hospital A**

The respondent reported that he is doing a number of things, in addition to all the responsibilities that are designated to him. The participant had the following to say when asked further if this could cause him to consider leaving the hospital;

> *I am certainly considering that because I cannot continue working like this for long, without any incentive to show recognition of that. I would rather do more and get paid more than doing more and get paid less or not even being recognised.*
>
> **(Busi) Doctor 1 from Hospital A**

The other respondent also reported doing more than what her designation is. She was not happy with the fact that she had to do more things which are not within her scope of work. The same respondent reported that she would still not refuse doing more as long as she contributes to saving lives of patients.

> *"I have gotten used to doing a number of things which are not falling under my scope of work. My responsibility as a health worker is to save and improve lives of sick people, and there is no way I would refuse to help, simply because something is not mentioned on the list of my responsibilities."*
>
> **(Anna) Nurse 1 from Hospital A**

Both respondents from Hospital A reported that they would often do extra work to mitigate on any staffing challenges that the hospital is experiencing. One of the participants mentioned his commitment to saving lives of people, irrespective of the working conditions. It was observed that pharmacy is one of the busiest places in Hospital A which had only one person working as a Pharmacist. Participant was also probed on whether or not this could influence them to consider leaving this health facility because of too many responsibilities.

The participants added that they do not get compensated for extended responsibilities, and that has influenced them to consider leaving the facility.

> *"Since I started working here, I have worked extra hours which I don't get compensated for. I would do work which I am not supposed to do, and yet the department or the management is not showing any form of appreciation. Because of that I have been looking for a job elsewhere, where I would get appreciation and recognition for my hard work."*
>
> **(Jabu) Nurse 2 from Hospital A**

However, the HR policies and procedures stipulated that staff members who work extra hours should be paid for overtime. The two study sites were not an exception to that. Hence participants were asked if they were aware, and do claim for their time. They responded that they do send their claims to the HR, but some would not be approved. If they do get passed, it would only be after a long time of waiting. They added that when they do a follow-up on their claims to HR, they would be told that all the claims had been sent and delayed at the district office not the hospital.

There were similar responses of other staff members willing to work an extra mile without any expectation of getting paid for that. However, some participants mentioned that they would be asked by the line managers to do something they do not want to do such as working more extra hours, or doing work they do not feel comfortable doing.

> "*I have been working overtime the past two weeks and don't think it is fair because it is not my fault that they do not have enough staff to do the work. Sometimes I would even feel tired because I don't have enough time to rest, and yet you don't get paid all those hours that you have worked. They will tell you that they can pay a maximum of so many hours".*
>
> **(Sindi) Nurse 3 from Hospital A**

The respondent below reiterated the fact that doing extra work is not really a problem when one gets compensated for that. Rewarding staff for extra work and time is presented to be a potential motivational or "pull" factor to those who are already exposed to that. Based on what the participants reported, it seems as if that would also motivate them not to consider leaving the facility.

> *"I don't mind doing extra work if I get an incentive for doing that. Here it is a problem because you don't get any reward for doing extra work".*
>
> **(Sam) Pharmacist from Hospital A**

In Hospital A, alongside the resentment and frustration that many expressed about working beyond the scope of their job descriptions, especially without financial compensation, there were other challenges which included community outreach into rural communities reported by staff.

> *"This area has a lot of aging population, more especially those from the surrounding rural areas. I also spend a lot of time with them. I struggle to visit those who live in deep rural areas because of the roads there, and that sometimes I would even struggle to get a hospital car which is driveable in those roads".*
>
> **(Sandy) Social Worker from Hospital A**

The Operations Manager also expressed some frustrations with regard to their own scope of work. In both hospitals, they reported that they do quite a number of things which are not supposed to be their responsibilities, but because they have to keep the hospital running then they do extra work. This is highlighted on the quotes below;

"I always avoid talking about my job description because I know that a lot of things that I do are not there, but then as the head of the house I have to feature in all areas to ensure that we are able to do what we are expected to do. I remember there was a time when we did not have an Information Officer. I had to ask my PA to do that, and you will never believe me if I tell you that I had to assist her with that, especially when the submission dates were due. So the job description in a work environment sometimes does not count, especially when you are in a position of responsibility".

(Lucky) Operations Manager 1 from Hospital A

Members of the senior management team also reported being affected by the shortage of staff, and felt they were expected to do more. Some of the respondents who are part of the management team seemed reluctant doing extra work, and expressed some form of coercion to do more than what is in their scope of work. This view is expressed by the respondent below;

"*That's an interesting topic which can easily get one dismissed. You will be opening a can of worms. Here we have a staff shortage and those positions have not been filled, hence the existing staff is expected to share those responsibilities. It doesn't matter whether you like it or not but you are expected to do something, whether it is in your job description or not. I am working without an assistant; I even have to do what my assistant should be doing, such as verifying payments, getting quotes from suppliers, and so on".*

(Lucky) Operations Manager 1 from Hospital A

This was in contrast to what was reported in hospital B. In this hospital, 16 out of 18 participants reported not doing anything that is not in their job description. Four participants said they would not be willingly to do anything that is not in their scope of work because they get paid their salaries for what is on their job descriptions. One participant also added that as much as she would want to assist in other units, she would still not be comfortable doing

something she has never been trained in, for example, she was one of the few nurses without VCT training.

> *"I have never worked extra hours. That would only happen if there is an emergency, but even then it would be a matter of less than 30 minutes because the other sisters would come and relieve me. I don't mind doing some other work, as long as it is something I'm trained on. At the end of the day it is not all about money, but saving the lives of people. If I refuse to help simply because it is not in my area of work, then I would be contributing to their bad health status. I have been given this gift by God to go out there and help people's health conditions to improve"*
>
> **(Brenda) Nurse 1 from Hospital B**

Hospital B did not have many problems with shortage of staff as in Hospital A. The respondents reported that the management is very conscious about what the staff do, including time management. Participants also reported that they would report each time they have worked extra hours to be compensated.

> *"We are very conscious about the roles and responsibilities for each employee because that what we pay them for. Staff members know their roles and responsibilities. These are not extended except that you will find a case where a Nurse or Pharmacist is late for work, and we could ask the staff on duty to be on hold until the person shows in. This is very common in rainy seasons and winter or when it is due to a family crisis"*
>
> **(Amos) Senior Management Staff 1 from Hospital B**

As a result, the respondents were then asked if they have once experienced a situation where they needed to hold for a staff member who is late for work. They were also asked about how they felt about that, and if they see that to be a problem in any way.

> *"I don't mind working extra time if one of my colleagues is late for work or experience a*

crisis. I know that I can be in that situation as well, and would expect one of my colleagues to help me."

(Liziwe) Nurse 2 from Hospital B

One of the respondents reported that their hospital management has been responding well to the issues such as working extra hours. The respondent below had all the positive things to say about the how things are managed in the hospital.

"I have worked extra hours when I feel that my colleague needs extra hand, especially on weekends. I am not forced to do that, and yet do not expect the hospital to compensate. But they have been doing that. I have been paid for all the extra hours that I work."

(Thembi) Doctor 1 from Hospital B

Theme 2: Support from other staff members

The literature has shown that getting support from other staff can help reduce workload from others, even in facilities where there is a shortage. Support from colleagues also contributes to increasing moral among the team. This can indeed have a positive influence towards staff's decisions on leaving the health facility. The theme was meant to establish whether or not participants find support from other staff to be something that exists in their workplace and motivating them on improving the human resource capacity. Participants were asked if they think they are getting any form of work-related support from staff members or the management team to do the work well. From both facilities, there were mixed perceptions. The majority of participants (n=23) were satisfied with the support they get from the fellow colleagues, but others were less happy (13).

"I don't get any support; in fact my colleagues are the ones who also run to me seeking support. That is the most frustrating part of working in this hospital. I don't even have someone that I can talk to for the second opinion because everyone depends on me with regard to guidance and the support that you are talking of".

(Busi) Doctor 1 from Hospital A

In Hospital B, different opinions among the participants emerged with regard to the support they get within the hospital. Some participants highlighted that support has never been a problem in their hospital because other colleagues are always willing to come in when they are needed to assist.

"We have a big team of health professionals who are supportive of each other. I have never received any reports of a staff member who feels that s/he is not supported by the team. Since I started working here I have always seen a good team spirit among the workers in all the different units".

(Lucky) Management staff 1 from Hospital B

Management staff mentioned that because of the nature of the work they are doing, support from other staff members is very instrumental in achieving the best possible outcomes on patient care. They said that they had never received any complaint from staff about not getting support. It is important to note that some of the participants looked beyond the internal support from staff in the facility, and also included staff from the district office.

"*If you're talking about internal support...yes there is. The only problem is that we not getting much support from the district office. If we want to do community campaigns in around this area and we seek support from them, they would not do that. If it happens it will happens ages after the problem has ceased. We have a tight budget in this hospital, and we normally rely on external funding if we want to do immunization programs...and we have not*

been getting support to do such activities".

(Brenda) Nurse 1 from Hospital B

In hospital A where there is a critical shortage of staff, participants felt that working as a team and getting support from one another enables them to manage the workload. It was reported that the hospital has a 59% vacancy rate and most of the positions are not filled.

"We work as a team, hence we don't feel the work load that much. Everyone is willing to help, when that is needed. We have a serious shortage of staff with a lot of patients to see. Imagine we are serving a big population with a number of surrounding rural areas. We sometimes get confronted with difficult cases of drug resistance…but due to team work we are able to deal with those. We have 59% vacancy rate in this hospital and we are making use of the available resources".

(Busi) Doctor 1 from Hospital A

Among the nursing staff, there was a general feeling that they support each other, especially the casualty staff. In contrast, the Senior Medical Officer and some administrative staff reported not getting much needed support from their colleagues, and yet having to give support to themselves.

"Well sometimes the staff would prefer short-cuts, and that is where I would have problems. I have been confronted with a lot of cases where staff members would not want to report their injuries, such as needle prick, but instead would want to rush to pharmacy to do self medication. They know that they are not supposed to be doing that, but follow the procedure, where they come to report the incident to me. That is the part where I feel that I am not supported. With regard to other things, we support each other a lot, with less support from the district".

(Anna) Nurse 1 from Hospital A

Overall, there seemed to be some differences between the two hospitals, with more satisfaction around support from most of the staff at Hospital B, compared to hospital A (n=4). In hospital A, only four out of eighteen participants reported to be getting support from other colleagues and this was mainly the most senior staff. These senior members reported that in their hospital they work as a team, and support each other all the time. The pharmacist also mentioned the support received from other staff members. However, the majority of the participants felt that they are not getting support at all because each person concentrates on their own work, which is already overly-burdensome. In Hospital B participants reported that they staff members were supporting each other at all times.

Theme 3: Capacity to provide the required health services

This is directly related to human resource capacity, and participants were asked if they thought that their hospital had enough required capacity to provide health services. Literature shows that professional staff get more attracted to work in health facilities which have the capacity to provide services compared to those with no capacity. In both hospitals there were mixed feelings about this. In Hospital A most participants (n=9) felt that their hospital did not have capacity, and this affected their morale.

> *"We do our best to meet the demand of the community. Of course there are other demands that we cannot meet and for such we are forced to send those patients to East London. We need more staff so that we can meet all the demands of our community. Sometimes it feels bad to refer someone to East London knowing that people do not have money to travel, and that they may end-up not going there at all. And the structure needs to be build all over again. This is an old building and during the raining seasons we experience a lot of complaints from the wards due to water leeks and power failures"*
>
> **(Lucky) Management Staff 1 from Hospital A**

Poor human resource capacity was attributed to a number of factors which include staff shortage, poor infrastructure and equipment. The nurses highlighted this to have compromised the quality of services that are offered, such as discharging patients who are not ready or poor equipment affecting the healing time of minor injuries.

> "*The hospital does not have the capacity at all, such that some of the patients are discharged even before they get well. The hospital is servicing a large community, not just their area but also the surrounding towns and a large rural community. If you can look at this room, you can see that I don't have the equipment at all to support my work. I am currently using all stuff, and this had led into a situation where my patients take long to heal, even for the minor injuries"*
>
> **(Anna) Nurse 1 from Hospital A**

The hospital management team (n=4) from Hospital A were impressed with the way their staff has been able to respond to an increased workload, and their level of professionalism. The management team felt that the hospital was ready and able to provide all its designated services as a district hospital. However, health workers presented a different view on this because they felt unable to offer all the designated services due to shortages on professional staff.

> "*I am very fortunate in this hospital to have a highly skills team of both health workers and admin staff. We are ready for any task that is within our designation. I would be lying if I tell you that we are not coping with the workload. We can do everything that is expected of us to do. Remember we are seated on along the national road, and we get to see all sorts of cases…including accidents. There is a general shortage of professional staff, but I don't complain because we are not the only hospital which experiences that. Since we have not turned any patient away, I believe that we have all the required capacity".*
>
> **(Andiswa) Management staff 2 Hospital A**

In Hospital B, as opposed to Hospital A where just two participants reported having enough capacity to provide health services, fifteen participants said that there was enough human resource capacity but some gaps were identified during the interviews.

> *"We have vacant unfunded positions, and we are mostly depending on equitable share as opposed to conditional grants. As a result that leaves us with some operational gaps in certain areas within the hospital".*
>
> **(Andiswa) Management staff 1 Hospital B**

Respondents (n=14) from Hospital B shared the same sentiments with their Clinical Manager. They expressed satisfaction with regard to the capacity of the hospital, and that they are even able to deal with most cases though the case load is always high because of the people who get referred from the clinics. From both hospitals, doctors and nurses highlighted some challenges with regard to staff shortages, which has influenced the capacity. However in hospital B (n=16) as opposed to hospital A (n=4), the majority of participants reported that the hospital does have human resource capacity to provide the required services.

Theme 4: Working Conditions

Literature has shown that working condition can either be a "pull" or a "push" factor. Professional staff generally prefer to work in health facilities where the working conditions are good and favourable to their work. In both study sites, there were differences in how the participants felt when they were asked about the working conditions in their hospitals, and how that influences on decisions to stay or leave. In Hospital A the participants (n=14) expressed frustration about bad conditions under which they work.

One participant expressed the working conditions as being "horrible".

> "*The conditions are horrible. We have two toilets for 37 patients. We do not have any*

restrooms for night duty staff. The lifts are not working"

(Anna) Nurse 1 from Hospital A

Another participant expressed the working conditions in hospital A as "extremely bad". However, she also highlighted that these conditions have not discouraged them from providing services to those people in need. The participant mentioned that the staff in the facility tries it's best to do the most they can even though there are serious constraints, and that the management has been very important.

"*The working conditions are extremely bad, but that does not take away the fact that I love my work. I make sure that I do my best within these constraints. I am very sensitive when it comes to the needs of staff, and I always make sure that they are serviced well. I love my job and have sacrificed a lot, including working long hours. Everything is okay except the resources. The managers are very supportive."*

(Lucky) Management staff 1 from Hospital A

In Hospital A it was also reported that poor working conditions have affected the provision of services, in that staff are unable to perform certain medical procedures required. The poor working conditions have also led into some form of forced referral, whereby people are encouraged to seek medical care from other health institutions.

"The conditions are extremely bad. The structure is very old and equipment is not in a working order. We're unable to perform other procedures, and in most cases we ask people to go and do that in a nearby private clinic, then come back or we would advise them to go to East London...and that is sad because most of them cannot even afford to go there".

(Sakhi) Professional staff from Hospital A

In Hospital B there were also mixed perceptions about the working conditions. Some participants (n=14) found the influx of patients from rural areas to create challenging working conditions for them.

> "*There is shortage of ambulances and we are also not safe at casualty. People from the township come and kill people at the hospital while we are busy resuscitating them. That is why you are seeing those securities at the entrance, but in most times they get over-powered because these kids carry guns and shoot every person who stands their way*".
>
> **(Zoleka) Nurse 2 from Hospital B**

The conditions at Hospital B were far better than Hospital A, but there were also challenges as highlighted. The hospital had good infrastructure, almost all the required medical equipment, better staff complement and a good sense of team work. The statements made by respondents were supported by what was observed. Though Hospital B had a few things which needed to be improved, the hospital generally looked far better than Hospital A. Participants (n=16) reported that working conditions in Hospital A have contributed to the movement of professional staff to Hospital B and well established health facilities, including private hospitals. Exposure to violence came up during the literature review as one of the reasons which influence the movement of professionals to a safer environment. Safety was an issue for staff in Hospital B (n=8), and although Hospital B seemed to be more attractive compared to Hospital A, this could be an issue which could drive staff away.

Theme 5: Relationship with other staff members

Literature has demonstrated that good working relationship among staff may contribute to human resource capacity in a number of ways which include;

- Better coordination and management of work among staff

- Staff not feeling workload or over worked because of support from other staff
- It could even be a pull factor attracting more professional staff, and retaining the existing staff
- Increasing the moral of staff because they feel supported

Participants (n=15) from Hospital B reported that the hospital management has been very open on everything that affects the employees, including the operation of the institution. The management developed a strategic plan which was developed in consultation with staff in the hospital. Participants (n=15) reported that this increased coordination and management of work among staff. The was expressed by the responded below;

> *"I don't think we will be where we are if it wasn't for the management. Our Acting CEO has been very open about on the running of our facility. We have collectively developed internal guidelines which assist us on doing our work"*
>
> **(Dan) Pharmacist 1 from Hospital B**

The results show that participants from both study sites reported good working relationships with their colleagues, although some mentioned tensions with administrators. In Hospital A the management team all highlighted good working relationship with staff members, though they also acknowledged some challenges with regard to the working conditions.

> *"The relationship is very good. When we have our staff meetings we seat together as a family to confront all the problems that we are faced with. I have a good working relationship with everyone in this hospital. What makes us even more closely is the fact that we are aware about the conditions that we work under. Salaries would always be an issue, where some groups of people are getting more money than others and yet they do less".*
>
> **(Lucky) Management staff 1 from Hospital A**

The management team mentioned that staff members work in a team spirit and this that has contributed to the good quality of care. They also mentioned that there are times when the relationship between staff and management team becomes intense, especially when the needs of staff are perceived as not being attended into.

> *"The relationship with other staff is good, and we form a great team. Of course there are those intense situations, more especially with our administrators, when we want our claims to be processed. It takes long to have those done but they have always been explaining to us that the delays are at the district office, because they would send all our papers immediately, but get delays at the district office".*
>
> **(Anna) Nurse 1 from Hospital A**

Theme 6: Recommendations to District Health Management on Staff Retention

In both Hospitals all respondents (n=38) expressed mixed feelings on whether or not the district office is doing enough to address the issue of staff retention. The majority of respondents from Hospital A expressed more frustration, that their needs are not being met. In this hospital respondents had the following to say;

> *"They must recognize people for their work, and put in place more incentives and awards to motivate people more. They must address our grievances promptly, because we provide services to a poor community who do not have any medical aids and cannot afford to go to private doctors. They come here in numbers. Everyone should be allowed to attend district meetings, not only the senior management. People should be given the opportunity to go and attend such meetings".*
>
> **(Anna) Nurse 1 from Hospital A**

Some of the respondents from both facilities mentioned that the district office needs to be more responsive to the needs of their hospital. They highlighted that the delays had led to a situation whereby the staff feel discouraged and neglected.

> *"Firstly I would ask their office to be very responsive when it comes to the needs of the facilities; otherwise the facility will be unable to offer health services for this community. We have very good policies and guidelines, and we can utilize those to improve the delivery standards. It is really frustrating to work here; sometimes people do not get paid even the doctors. Sometimes you would find that a new professional staff member is not paid for more than three months…tell me how that motivates the person to stick to the decision of coming to work here…how are they expected to live without being paid".*
>
> **(Lucky) Management staff 1 from Hospital A**

The participants also advised that the district health management team needs to do constant visits to the facilities to check if the operational needs are being met. They mentioned that such visits would make them understand the challenging environment under which they work and perhaps close communication gaps and improve responsiveness.

> *"The replacement posts must be filled immediately to bring stability to the institution. You find that after a person has left, that position will be vacant for so many years and we would struggle to find a replacement. They have to make sure that the basic equipment that is needed is available. This includes transport and accommodation. At the district level we also need someone who is health orientated who will best understand the needs of the hospitals, not a politician. When they employ people they should also look at their maturity and ability to respond immediately to the needs of hospitals".*
>
> **(Andiswa) Management staff 2 from Hospital A**

In Hospital B (n=16), the respondents also advised that more resources need to be invested in professional development to ensure that staff members are able to advance their

skills and expertise. The participants indicated that such things could be very motivational to them, and contribute towards staff retention.

> *"They must put more money on professional development. At the moment we have to find bursaries for ourselves and in most cases it turns out to be a difficult thing to do on a first come first serve basis".*
>
> **(Dan) Pharmacist 1 from Hospital B**

Some participants felt that getting paid more and improvement of equipment could also play a positive role with regard to retaining of staff.

> *"They must give the staff more money. People do not concentrate on their work because of loans. We also have transport problems. Our ambulances need to be replaced. Some of the nurses even moonlight because they want more money, and they would come to work tied".*
>
> **(Brenda) Nurse 1 from Hospital B**

Theme 7: Staff Retention Issues in Hospitals?

Participants from both hospitals were asked if they think staff retention is a problem or not in their hospitals. They were probed to provide more comprehensive responses which include factors which influenced retention of staff in their hospitals, and how this affects human resource capacity. In both hospitals it was mentioned that staff retention is a problem because people always want to move for what they perceive as more challenging positions in other institutions. The surrounding private hospitals have been attracting a lot of staff due to

better incentives and working conditions. In fact, it appeared that some of the professional nurses are already working there on part-time basis.

> *"We are unable to sustain our families with the current incentives, and that is the reason why some of us have decided to moonlight at the private hospitals to earn an extra income. However, that is on its own tiring because we don't get enough rest at all".*
>
> **(Anna) Nurse 1 from Hospital A**

In Hospital B respondents mentioned that staff retention is not really in a crisis. They mentioned that their hospital has been doing well with regard to attracting new professional staff from other health facilities and newly qualified professionals in and outside the province. However, there were cases of those who intended to leave the facility for more professional growth in a private sector.

> *"I cannot say that staff retention is not a problem here because some people had decided to go and work in East London for private hospitals. They leave for different reasons but a lot of them due to wanting increase on their salaries, and I guess professional development as well"*
>
> **(Brenda) Nurse 1 from Hospital B**

In Hospital A the respondents highlighted that as much as staff development could be one of the ways to retain staff, some staff members leave immediately after having been supported by such trainings.

"*It is a problem because none of our professional staff stay for a long time. Perhaps if they can increase the entry level of doctors from 9 to 11, that could influence most doctors to consider working here. We only have level 10 in the hospital".*

(Busi) Doctor 1 from Hospital A

Additionally, the respondents felts that entry level salary of advertised positions do have a contribution with regard to attracting professional health workers. Hence it is also difficult to recruit new employees for positions which have been left vacant in their hospital.

"*People leave every month in this hospital and they don't get replaced. As I mentioned, there are no doctors, there are no nurses. I mean I don't know why the hospital is still open. The two student doctors that we have, have been honest to say that they will leave. The professional nurses prefer to work in East London, more especially the youth because they choose to live in urban areas. We only have the aging staff here...sorry if that sounds offence-full, but is a fact. It is happening".*

(Liziwe) Nurse 2 from Hospital A

Participants from Hospital B (n=7) also expressed some issues which have created some concern about staff retention. These include; posts are not competitive and market related, salary levels for professional staff need to be re-evaluated, and that staff is not happy with the fact that they are servicing a large volume of population from rural areas without getting any extra incentive for doing staff.

"Staff retention is not really a problem here, but what creates discomfort to people is the fact that there is so much centralization of power in this hospital. The senior staff likes taking decisions that affect the rest of the team without consulting us first.

(Zoleka) Nurse 2 from Hospital B

In Hospital B, a completely different issue was raised in relation to decision making in the hospital. The staff (n=3) felt that they are not being consulted by the management team before taking decisions that affect them. For instance, the Hospital Management decided to out-source some of the responsibilities of the Human Resource Department without a consultation of those affected.

Theme 8: Hospital Staff Turnover?

The respondents below highlighted that sometimes choices are not based on individual preferences, but families do put pressure as well on whether or not they choose to stay in a particular area.

> *"I cannot leave this place now, my everything is here. You would not understand what is happening here until you come and live here. The Department of Health cannot address the problem on its own. Even if they can improve the Hospital in such way that would match the standards of other good hospitals, professionals would not come here anyway because their families would not want to come and live here with them. There is nothing here that is why people drink a lot get injured and come to this hospital. It is because there are no recreational centres or facilities. Even the schools are not good and I would not want my children to study here"*
>
> **(Zukiswa) Physiotherapist 1 from Hospital A**

The professional staff nurse below concurred with what is being said above, that families do play a role with regard to the movement. Some participants mentioned that their family location also influences their decisions about leaving or staying where they are. Some of the participants in Hospital A mentioned that, as much as they would want to continue working in the hospital, there are just too many challenges which they experience.

> *"I am currently looking for a job. I want to move closer to my family, because even if I had to ask them to come and stay in this place they would refuse. That is one of the reasons. Otherwise, I would love to work in a stress free environment where there is a possibility of learning new things every day, with more resources. I understand that sometimes you would*

not get everything you want in life, and have to settle and make the best use of what you have. But there is too much of need here".

(Anna) Nurse 1 from Hospital A

The respondent below also expressed the same sentiments; in addition that Hospital A currently relies on the services of professional staff who are from foreign countries and nearing retirement.

"I am looking for a job because I cannot continue working this way. I also want to stay with my family. Staff retention is a serious problem. The only people they are able to retain are the foreign nationals who are reaching the retirement age".

(Liziwe) Nurse 2 from Hospital A

"I did not choose to come here, but was told. Well I have a choice to choose whether or not I want to stay or leave. I have no intentions to stay here. I'm happy for all the experience I have gained, though it was difficult, it was a learning experience for me. I am now prepared for a bigger challenge. Working here for me was extremely good because if I had started in a hospital where everything is available and abandoned, I wouldn't have gained this much experience".

(Mark) Student Pharmacist 1 staff from Hospital A

In Hospital B the participants (n=11) mentioned that the reason why they had considered looking for a job elsewhere was related to the fact that incentives were low. They continued mentioning that their salaries need to be revised, and they should also be entitled to some allowances.

"*There is a lot of work in this hospital and we're getting too little money because we*

don't get any allowances. We have a lot of patients coming from the surrounding rural areas, and yet we don't get any rural allowances."

(Sphiwe) Pharmacist 1 from Hospital B

"There is no money here. My salary is too little for what I'm doing. I know a lot of people who work on the private sector and get more money, and yet they do not have too much work to do like us."

(Brenda) Nurse 1 staff from Hospital B

Theme 9: Staff development, incentives and motivation

Issues related to staff development and incentives were raised by participants from both hospitals. In Hospital A, a lot of things came up, compared to Hospital B.

"*The working relationship with other staff is okay. I think I am managing my HR office very well because I have never received any complaints from my colleagues. There would be problems sometimes when the staff does not get paid, because they always think that my office is the cause. I would then explain to them, that the HR office has sent all the paper work to the district. The delays caused by the district affect us a lot. The HR office gets blamed because of the delays from the district office. Besides that, our working relationship is good".*

(Lucky) Management staff 1 from Hospital A

As mentioned earlier, participants (n=8) mentioned that staff development is also a problem in Hospital B. They also expressed their concerns with regard to study allowances.

Although some of the issues raised by participants were specific to each site, some of the issues were cross-cutting. There were also specific issues in both hospitals. A lot of concerns raised by the participants (n=18) from Hospital A were related to working

conditions, the significant staff shortage, overburdened, and others as mentioned in this chapter. Participants (n=16) also raised a lot of dissatisfaction about the district health management office. They were not happy about the fact that this office was taking long and sometimes not responding to their needs. It appeared that in both health facilities there were cases whereby all new staff would not get paid in their first three months of employment. In Hospital A fewer participants (n=8) mentioned that they are experiencing a lot of resistance from the staff who have been working there for a long time. They also highlighted that it is only the aging staff who feel most comfortable about working in Hospital A.

Participants (n=14) from Hospital B also expressed some concerns about staff development. They indicated that though the hospital does advertise opportunities, only certain people do attend such trainings. They mentioned that the management sometimes keep the information into them, and would know about the opportunity once it has passed.

"They is no transparency when it come to staff development opportunities. Some opportunities are made known to all staff members, but some are kept behind closed doors. Sometimes if you want to study, they would tell you that you don't have enough days or what you want to study is not going to benefit this hospital".

(Andiswa) Management staff 1 from Hospital B

The District Management Team

Four interviews were conducted with the district officials using an interview guide to understand the current retention practices and constraints. The participants reported a number of constraints that the entire province is experiencing with regard to a general shortage of professional personnel.

"It is not only our district which has challenges with regard to human resource and infrastructure. It is a common problem across the province, more especially in the rural settings like that area".

(Sipho) Respondent Three: District Management Team

"We do have a retention strategy in place which we asked our assistant to make a copy for you. Drafting the strategy is not a problem, but when it comes to the actual implementation that is when the problem starts. Eastern Cape has more challenges than other provinces with regard to human capital, availability of resources and technology. And because of that we are unable to compete with other provinces, hence you see a lot of people like yourself deciding to leave this province".

(Nelson) Respondent One: District Management Team

During interviews with the district team, Hospital A was highlighted as one of the problem areas where the department is struggling to attract and retain health workers, and this was raised as having affected the delivery of services.

"Hospital A is the most prioritized in the district and we have been struggling to reach our targets. It is the most rural area in our district and perhaps that's why professionals are resistant to work there".

(Nelson) Respondent One: District Management Team

Most of the respondents (n=4) from the district office mentioned that the challenges experienced in their district can only be addressed at a provincial or national level since they are beyond their control. They highlighted that their district is not the only one with such challenges. A lot of problems were highlighted, and participants mentioned that though Hospital A might be seen as the worst, there are others in the province with the same

conditions. When asked about the delays in service delivery by the district office to respond to the needs of the hospitals, one of the participants had the following to say;

> "*The hospitals fail to submit reports and required paper work and this has been causing a lot of delays with regard to addressing their matters. When they have a new staff we ask them to always submit all the required documentation, and they only do that on the very last minute when the person expects a salary. As a result some would not get paid because of that. Also, when they do requisitions*"
>
> **(Joshua) Respondent Four: District Office Management Team**

Some of the statements raised by the respondents were contradicting what the participants in the hospitals had said; that the district office takes long to respond to their needs and this contributes to poor performance. In contrast, the district reported that the problem exists because of inefficiency in the hospitals to adhere to deadlines and procedures. The district mentioned that it is not purely their responsibility to attract and retain staff, but the entire responsibility of the hospitals.

> *"We have been blamed that the hospitals do not have equipment. We have enough budget for that, but to release the funds or proceed with procurement we need to follow the procedure. The hospitals know about that but they do not comply. For instance, there was a time when hospital A wanted to purchase some equipment we asked them to complete all the necessary documents and attached three quotations. They did not do that and we could not help them. They presented this as failure from our side. If they are unable to do such small things, how will they expect their staff to be support and motivated to stay there."*
>
> **(Thuso) Respondent Two: District Management Team**

The respondents mentioned a number of issues which the hospital administrators fail to do according to procedures. The above respondent explained why the district office is sometimes unable to respond immediately to the requests of the hospital. The respondent further mentioned that, in most cases they assist the hospitals to do all the things properly because they understand their problem of not enough staff to do what is required. He mentioned that they would even send someone from the district office to the facility to assist them when submitting their requisitions.

Observation

Of the two hospitals, Hospital A had an old structure with peeling walls, broken windows, malfunctioning escalators and doors. The respondents also added that in the wards during the rainy seasons the water was leaking, and there was nothing much the staff could do. The air-conditioning system was also not functioning and those patients who managed to go and sit outside on the sun did that to escape the cold inside the wards. It was also difficult for disabled patients to move around the hospital since the escalators were not working. When asked, the staff reported this to sadden them. In contrast, hospital B had great infrastructure except that the casualty unit was perceived to be unsafe for both patients and staff. Besides that, the structure looked very good. The staff even expressed satisfaction.

Equipment

In hospital A the equipment was old, and some in the physiotherapy unit were not working well. Even the staff complained that it takes long for their patients to recover during the rehabilitation course because of poor and old equipment. Hospital B seemed very updated, as opposed to hospital A. Almost all the medical equipment was in a very good working condition. The staff showed frustration with regard to poor, old and malfunctioned

medical equipment used for rehabilitation, and mentioned that it affects their work significantly.

Staffing complement

There were significant differences from both hospitals with regard to the complement of staff. Hospital A had a critical shortage of staff, with the total of 31 employees. Hospital B doubled the number, with a total of 63. Hence the waiting time for patients in hospital A was extremely high (more than an hour), compared to hospital B. In hospital A there was one pharmacist, assisted by a professional nurse, who was awaited for by more than 100 people to get their medication. This was one of the busiest areas in the hospital. In hospital B the four pharmacists were managing the workload fairly well, with queues moving faster (pateints getting attended within 20 minutes of their waiting) compared to hospital A.

Document review

Document review was also done to complement other forms of data collection. In hospital B, a lot of material had been developed internally. This included job aids, flow charts and algorithms which were developed to help health workers do their job better. This did not exist in hospital A, hence in most cases the Senior Medical Doctor was always approached to assist. In hospital B all the patient's files were easily accessible due to a good record keeping method. It was very easy for health workers to identify patients who had come for a follow-up, as compared to hospital A. In hospital A patients spent a lot of time waiting for their folders to be retrieved.

Chapter 5 – Discussion

The findings of this study complement what is presented on the literature review section, but at the same time presented emerging issues which include could potentially help policy makers to make informed and relevant decisions when developing retention strategies. Data shows that factors which contribute to retention do not stand in isolation to one another, but rather connected enough to influence healthcare professional's decisions whether to move or not. One of the major gaps on the response of countries to retention of health professional was that these factors have always been treated in isolation.

Countries need to realise that there are growing opportunities encouraging movement of health workers in search of better professional and economic opportunities, often from the countries where they are needed most. Though the situation is complex, in many cases migration is a symptom of a deteriorating health system characterized by low wages, poor working conditions, few incentives, as well as a lack of technology and facilities to carry out their roles effectively.

Ensuring staff receive adequate pay for their work is not the only key to retention. However it is not just salary that is important. In many contexts, the low numbers of trained health staff in remote areas is due to the lack of supporting infrastructure and opportunities for staff and their families. In fragile contexts, these factors include poor living conditions, the lack of safety and security in the workplace, and the absence of continuous professional development.

This study was employed to explore and describe factors that influence movement and retention of health workers, and make appropriate recommendations to relevant authorities so as to better utilize existing human resource capacity in health facilities. The discussions with participants were centred on their perceptions on how "pull and push" factors affect human resource capacity.

In South Africa the government has responded in many ways, and one of them was passing policies and legislation to reshape capital flow in the health sector, across all public health institutions, in both rural and urban areas (Dambisya & Modipa, 2009: 7). The overall objective of such policy is to strengthen the health system in the country, through decentralisation and at different levels of care. Specific objectives include, streamlining governance of health professionals, maximize effectiveness and efficiency of available health care resources. These reforms have impacted heavily at a different degree to all public health facilities in South Africa. The Eastern Cape Province has also been affected, including the health facilities where the study was conducted.

Factors influencing the movement and retention of health workers in Hospitals A and B

The data reviewed in this report highlighted a number of factors which influence the decisions of health workers to move or remain in their current workplaces. In both hospitals, good working conditions, availability of staff, and availability of allowances were frequently reported as important factors affecting participants' decisions to stay. These are discussed in detail below;

Working conditions

The literature has shown that working conditions are said to be one driver of staff retention and motivation. Literature shows that if the working conditions are bad, staff members are likely to leave, and the levels of motivation for those who stay are affected. It also becomes difficult for that hospital to fill the positions, and people become reluctant to seek employment in areas where they know that the conditions are not favourable to their work.

Study participants in Hospital A were completely unhappy with the working conditions. In contrast, participants in Hospital B mentioned that the working conditions in their hospital are not bad, although some did feel they needed further improvement and participants were concerned about their safety at casualty and the shortage of ambulances and transport for staff.

It is also important to note that although there are certain unfavourable conditions, especially at Hospital A, these do not necessarily influence staff to move from their workplace, they may not be immediate "push-factors" in isolation. Rather, it is important to consider a holistic working experience in the broader context of people's lives, including external factors such as the family location or even the surrounding environment out of the workplace. This came up a lot in Hospital A where the participants mentioned that their decision not to move was influenced by the fact that their families live in the area.

In Hospital B some of the participants mentioned that they would want to move and find jobs elsewhere, especially where their families live, or where the surrounding environment out of the workplace if favourable for the family. These are interesting dynamics over which the health system has no direct control, but could still contribute towards by offering housing or school allowances, for example. As much as the Department of Health

can do its best to improve the working conditions in these health facilities, and even, up to a point, within the surrounding location, it is fair to acknowledge that some of the challenges fall outside of the Department's control. Working conditions remain a concern in other parts of South Africa too, for example, in a review of working conditions for doctors in the rural hospitals of the Western Cape Province, problems identified included under-staffing, excessive workload, inadequate supervision or support and long working hours, which were said to compromise the quality of care in these areas (De Villers *et al*. 2004: 23). De Villiers *et al.* (2004: 25) also reaffirmed other conditions in rural practice which include lack of recreational facilities, poor housing, inferior clinical facilities, violence and inadequate pay as having an effect with regard to failure to attract professional staff. Similarly, in this study, the management staff and the district personnel reported that it has been difficult to attract new professional staff in hospital A because of issues related to poor staff development and service delivery in the area.

The surrounding conditions in Hospital A were in a very poor condition with dirt roads, dilapidating structures, limited access to electricity, limited access to sanitation and running water. In a survey conducted by the Development Bank of Southern Africa (DBSA), it was presented that Eastern Cape remains the poorest province in South Africa, with also a population size increase of 3,8% between 1996 and 2007. It is important to stress that Hospital A exists within this context, but it is difficult for the facility to address some of these problems. However, poor working conditions – both within and surrounding a facility - do affect a person's choice whether or not to stay in a workplace. This can be exacerbated when the surrounding environment is also found not to be at a desirable standard, pointing a need for inter-sectoral collaboration among different government departments and other relevant stakeholders.

Doing extra work is not necessarily perceived as a push factor if there is some form of recognition or compensation from the employer, either monetary or otherwise. What seemed to be a "push factor" was the fact that participants felt they are not recognised or acknowledged for the extra work they were doing, hence deciding to leave. There is no doubt that if this staff decides to leave, human resource capacity would be more compromised, increasing the workload burden even more to those who are left behind.

It appears that extended responsibilities or increased workload can influence staff to think about leaving their current workplace, as indicated by participants from Hospital A, compound to Hospital B. Such movement would certainly affect the human resource capacity. However, it must be mentioned that staff also showed willingness if there were immediate benefits from working extra time, or extra duties.

Staff shortage

According to Dieleman and Harnmeijer (2006: 2), staff shortages limit accessibility to health services and programmes, which in turn affect health outcomes. Staff shortage also has a negative effect on the human resource capacity to provide health services, and negatively affects the motivation of the remaining staff as they create increased workload, causing more stress and the risk of more staff leaving or being absent at work. It is reported that loss of health workers in rural areas in particular contributes to accessibility problems for the community in the affected area.

It was reported that hospital A has 56% vacancy rate, and this reflects a serious shortage of staff. Consequently, some of the responsibilities of the staff who had resigned are taken over by the existing staff, increasing their workload more and more. In hospital B the problem was not highlighted to the same extent as in hospital A. In hospital A, of the 13

participants who reported doing extra roles and responsibilities which do not appear in the job description, nine of them felt pressured and seemed to be doing this unwillingly.

The hospital management in hospital A strongly believed that job descriptions should not 'have a say' when it comes to doing the work, especially in such a facility where there is a shortage of staff. It was also stressed that what is important is getting things done, instead of using the scope of work as the measurement of how much someone can do. But staff generally was not happy with the fact that they need to do extra work that is not within their defined-scope. There were different perspectives between managers and staff about the role of the job description.

Not all the professional health workers interviewed expected to get a financial incentive for doing extra work. In both hospitals, some of them looked adopted a holistic perspective, that of being morally responsible for improving the lives of people in their communities. For example, some of the participants from Hospital A felt that they cannot ignore the Children's Clinic and let it shut down because the person who was running it had left. They felt that it is their responsibility to also use their skills and expertise to help children.

It seemed that there was a relationship between levels in hierarchy and seeing things differently. The management staff in both hospitals, especially in hospital A, believed that it is their responsibility to ensure that the hospital is running and providing services to the community, irrespective of all the challenges that are currently encountered. Morale is attributed more to achievements than to any other factor such as pay, supervision, work space and etc. This emerged in the study findings as participants from different hierarchy in both hospitals mentioned that seeing patients getting better is what they like most in their working environment.

The problem of staff shortage is neither limited to these areas, nor in the Eastern Cape Province, or South Africa only. Rather, it is an international problem. It is reported that the Department of Health is currently engaged in an urgent and sustained recruitment and retention campaign to address the problem, including the recruitment of foreign doctors and junior doctors, and a range of incentive measure for junior doctors such as taking over of student-loan debt. However, during data collection junior doctors from hospital A mentioned that they will leave the area after spending a certain period of time and gaining more skills, to go and work where they can gain more experience and guidance.

The two hospitals, especially hospital A, had a lot of gaps on the organogram due to vacant positions. This was reported to have resulted in a fall in the quality of health services, with many very sick patients having to wait for a long time to get medical attention. In hospital A, it was reported that some patients had even died while waiting to be seen by a doctor. There is no doubt that this puts more stress on health workers, which can drive them into deciding to leave the current workplace.

Rural versus urban areas

The Rural Doctor's Association of Southern Africa (RuDASA) has focussed its attention on finding constructive solutions to recruit and retain professional staff in rural areas, with recommendations regarding community service, senior doctors and foreign doctors. This includes fast tracking of registration for suitably qualified practitioners from developed countries and the introduction of a substantive increase in rural allowance. Some of the participants in hospital A highlighted that they would just prefer to live in an urban area where they can have unlimited access to other activities. Similarly, those doing their community service in hospital A reported that they would leave immediately after finishing their course, without even considering coming back. However, there is no doubt that some of

these recommendations by RUDASSA can help to breach the existing gaps in hospital A. Getting rural allowances also proved to have a certain amount of influence among the professional staff's decisions to work in this hospital.

This was not an issue for everyone, especially those whose families live in the area. They mentioned that even if they decide to leave, it would still be difficult to leave the family behind or move with all of them. While this can work in favour of the hospital, if the professional health worker decides to stay because of family related issues, it can equally be a push factor, especially if the family does not live in the area.

In hospital B, access to amenities and activities did not come up as the hospital is located in an urban area. Instead the participants raised concerns about providing a service to many people from rural areas. Though hospital B is in an urban area, participants felt that there were certain services which they were still unable to access. The majority of participants, especially professional health workers, mentioned that they prefer to live and work in urban areas where they can also have access to better services and facilities, such recreational facilities, better school systems, shopping centres and etc.

In a case control study conducted by Reid, Cooper and Volmink looking at the educational factors that influence the urban-rural distribution of health professionals in South Africa, it was established that doctors in urban areas were significantly more attracted to working there due to professional development and postgraduate education opportunities, including family factors (SAMJ, 2011: 17).

In Reid *et al.* cases were identified on the basis of receiving rural allowance at the designated hospitals according to the South African Department of Health gazetted list, and controls to be as doctors who work in public hospitals located in urban areas, and who were

not receiving rural allowance (SAMJ, 2011: 17). This study also established that rural practice as an undergraduate does influence the choice of where one would like to practise. The study found that family issues and previous rural exposure do have influence on respondent's choices with regard to choosing their site of practice.

The above study showed the need for greater postgraduate training and career opportunities in rural areas. It highlighted professional or career development, family needs, and opportunities for personal growth as some of the indicators which attract people into working in urban areas. However, the study also established some interesting points, including that rural areas are enjoying the loyalty of professional health workers who are of rural origin, although this was not an issue that emerged in this study.

Allowances

The table below is taken from the Health Systems Trust research report on "monitoring the effect of the new rural allowance for health professionals" (Reid, 2004: 6). It highlights ways in which the allowances have been allocated.

SCARCE SKILLS ALLOWANCE

15% of basic Salary

• Medical and Dental Specialists, Dentists, Medical doctors, Pharmacists, Pharmacologists

10% of basic salary

• Dental technicians, Psychologists, Dieticians & Nutritionists, Occupational therapists, Physiotherapists, Radiographers, Speech therapists

• Professional nurses with qualifications in:

Operating theatre technique, Critical care (intensive care), Oncology

RURAL ALLOWANCE

ISRDS Nodes

• 22% Doctors and Dentists

• 17% Therapists, Pharmacists and Dental technicians

• 12% Professional nurses

PSCBC designated rural areas:

• 18% Doctors and Dentists

• 12% Therapists, Pharmacists and Dental technicians

• 8% Professional nurses

Other inhospitable areas

• To be determined by the Provincial Head of Health, depending on availability of funds, from within provincial budgets (Note: Community service professionals and Interns included)

The results of the above HST study showed that around 1% of health professionals working in rural hospitals were influenced to remain by the former rural allowance (Reid, 2004: 3). After the initiation of the new rural allowance the numbers improved significantly. The study presented that between 28% and 35% of rural professionals, largely professional nurses, changed their short-term career plans, deciding to work in rural areas.

The participants from hospital A did not say much whether rural allowance attracts them to work there. But one of the doctors mentioned that rural allowance does help to attract staff, although in most cases it gets overweighed by other issues such as bad working conditions, lack of potential growth, and abnormal workload. It was established that as much as the allowances can be made available for staff, they still want a balance with regard with other things (good working relationship, good working conditions, and etc).

In hospital B participants seemed to challenge the legislation about who qualifies for both rural and scarce skills allowances. While they were aware that only professional staff who work in rural areas qualify, some argued that professionals who provide services for the rural population, even while working in hospitals that are classified as urban because of their location, should also qualify. In hospital A participants highlighted allowances as one of the positive contributors to their stay, but at the same time mentioned that there are other competing factors such as the working conditions which can affect retention. In other words, allowances alone cannot overwhelmingly influence the stay of professional staff, but improvement is also needed in other areas such as working conditions.

Staff development

Staff development is a strategy aimed at further enhancing the skills and performance of staff in a workplace. The objective is to ensure that staff is capacitated and that they are able to provide quality services. This is not a once-off activity, but continues over time to ensure that staff is able to keep up with the surrounding dynamics which influence their work. In some instances, professional staff also get CPD (Continuing Professional Development) points for attending the training activities which they are required to accumulate every year.

In both sites, the participants raised a lot of challenges with regard to staff development. In hospital B the participants were not happy with the fact that they have to look for funding if they want to study. They mentioned that the Department of Health is not doing much to assist them in that regard. In hospital A participants reported having limited access to such opportunities.

It was mentioned by the management team that some of those who get the opportunity to attend trainings resign when they come back from whatever training they have attended.

Though participants have highlighted access to training and staff development opportunities as one of the strategies which could make them decide to stay, it is difficult to establish whether or not it has indeed contributed positively to retention in these health facilities since some do seem to decide to leave after receiving the training.

However, the hospital management in both hospitals, highlighted that staff development does have a positive contribution towards improving the quality of services. They mentioned that not all staff leave after having attended those trainings, and the ones who decide to remain at their health facilities do improve in their areas of work with increased levels of motivation. Hence the hospital management found it necessary for the district office to prioritize rural health facilities for staff development.

Current strategies employed by district health managers to motivate and retain staff

The Eastern Cape Provincial Department of Health developed a staff retention policy which was adopted by all the districts across the province. This policy defines staff retention as a process of ensuring that employees are kept within the department, especially those with valued or needed skills or experience in a scarce or critical field where it is difficult to recruit.

However, the effectiveness of this policy is limited by factors that fall beyond its scope of control yet which may influence staff into leaving, such as poor infrastructure. During the interview with the district management, it was established that the district office is aware of the challenges experienced by the two district hospitals. However, they highlighted that there are certain things that the Department of Health can and cannot do.

The district management team made an example of maintaining the infrastructure in the hospitals as something that it is not their overall responsibility, but that of other

government departments. It was mentioned that if other government departments are not prioritising these challenges, there isn't much that the district can do. The participants also said that it is even difficult for some people to access health care because of poor roads, which similarly makes things more difficult for their mobile clinics to reach deep rural communities. At the same time, the district management team highlighted a number of initiatives which are being undertaken to address retention of health workers.

The strategies highlighted above were mentioned by participants in the hospitals and the district, as areas where the management lacks. In both hospitals there were differences between management and staff with regard to perceptions about what is currently being done to retain staff. The participants mentioned different concerns which include poor communication, lack of staff development, poor morale and so on. Hence, it is suggested that adopting these different elements could assist the management in addressing the problems.

Improving current working conditions and service delivery

Being one of the poorest provinces in the country, Eastern Cape Province has experienced a lot of problems with regard to the delivery of services, which have affected the working conditions of employees, both in the public and private sectors. This has also led into a situation whereby the quality of services is compromised such that communities do not have much trust, and prefer to live in areas which seems to be performing well with regard to service delivery. In the area where hospital A is located, most of the participants reported their families as influencing their decisions about staying. Participants from both study sites kept mentioning that the district office is not providing the needed support to the hospitals. In hospital A almost all the participants, including the senior management, expressed frustration on the way the district office responds to their requests. They highlighted that it takes long for

the district office to respond to their needs, which include payment of new staff and other requisitions.

However, the district office had its own way of interpreting the problem. They mentioned that hospital A has always been a problem with regard to doing this the right way as specified on the protocol. The hospital was reported not to be complying with the required procedures, hence the district office was not responding promptly. This appeared to have something to do with capacity and staff shortages at hospital A. The management mentioned that some of the positions do not have designated personnel, such as procurement officer. As a result, some of these positions have been filled-in by unqualified people to keep the work going, but at a very substandard level.

In most cases capacity building, in form of skills development and on-going mentoring, does help in addresses challenges like these. Literature shows that mentoring does helps people get better at their jobs, and it is the cheapest way to train new employees or upgrade skills of less experienced staff (Ensher & Murphy, 2001: 16). It is also documented that new employees who are placed under mentoring, are twice as likely to remain in their job as those who do not receive mentorship (Kaye *et al*. 2005 117). This is indeed a model that the district could propose to the hospitals to ensure some improvement on the quality of work, which could also see district office responding promptly.

The article below is taken from a local newspaper, and it describes some of the conditions which were uncovered by the Eastern Cape Health MEC during a visit to Hospital A. The MEC's observation supports findings of this study on the working conditions there.

MEDIA ROOM

Press Releases

Patients unattended at Eastern Cape hospital

Source: *SAPA*

People who were taken to [Hospital A] after a car accident on Friday were not attended to by Monday, Eastern Cape health MEC Sicelo Gqobana said.

"When I went there I found that five people who were in an accident on Friday last week were not being attended to. The bandages had not even been changed," he said after a surprise visit to the hospital.

The injured were transferred to other hospitals, under the MEC's instructions. A woman with severe back injuries was airlifted to an East London hospital. Gqobana said there was no linen on the beds -- which were old, "from 1942" -- no food in the hospital kitchen, no instant milk for babies and no equipment at the hospital.

The babies' milk arrived after Gqobana's visit. The hospital was also dirty, he said. The hospital clearly had management and human resource problems.

"They are badly understaffed even though we allocated them ten nurses," he said.

Management have been told to fast-track the acquisition of food for the facility. The MEC would meet hospital management on Tuesday to help improve the situation there. He said management had to be up to the task they were employed to do. Gqobana said

he would continue to pay unannounced visits to the province's hospitals to ensure that they ran smoothly.

5.1. Limitations

For the purpose of this report, the participant's designations have been clustered into more generalised categories, such as professional staff, administrative and support staff, to ensure confidentiality and avoid potential identifiers. As a result, the limitation is that the readers will not be able to get a sense of how specific designations, such as doctors or professional nurses, expressed their views on retention. However, it is noteworthy that there were very few differences if any, among these specific cadres.

During the process of getting permission from both hospitals to collect data, the hospitals CEOs were contacted by the office of the district manager with supporting letters from the Provincial Department of Health to introduce the interviewer. Though the interviewer explained the purpose of the study and confidentiality clause, the senior management staff (hospital CEO, Clinical Manger, Human Resource Manager, and Nursing Manager) seemed at times very reluctant to give out certain details about what is happening in their hospitals with regard to the issues that were discussed. Perhaps they feared that the information would be shared back up to the hierarchy, even though they were guaranteed

with confidentiality. Therefore, some issues may not have been raised or explained in as much detail as desired.

Four interviews with clinical staff were conducted in a rush because the participants had patients waiting to see them. The arrangement was that each interview would take around 45 minutes, but there was a request that they should be made even shorter because that would delay the flow of patients. As a result that had put pressure to the interviewer to finish the interview early in honour of that request and certain issues could not be explored in the depth initially hoped for.

Some of the interviews were not conducted in a private setting because of space problems. This also compromised the richness of the information as some of the participants got distracted during the interview, and their attention was compromised. Two interviews were terminated, and continued later after the participant had done what s/he had been called to do, in order to minimise this limitation.

5.2. Unintended Consequences

> *"I know that you showed me the job description which I was seeing for the second time since got employed here. The first time was when I was signing my contract. I have never look at it after that. I did not have to read that in a piece of paper. So after you have showed me this I have noticed that I have been doing something that I am not supposed to do...that of home visits. I'm sure the A is supposed to do that not me, but I have been doing it because I thought it is also my responsibility after seeing her also doing that for her patients. My other colleague is also doing this, and I'm not sure if she knows that she is not supposed to do it. When she came to work here I was already part of the team, and I think she saw me doing that and also decided to do it".*
>
> Nurse 1 from Hospital B

After this interview, the researcher discussed job roles and divisions of responsibilities with A, who expressed some discomfort about the fact that she has to go to rural areas, instead of those people there being services by clinics in those areas. The urban area is surrounded by many rural areas which all have their own clinics, but still referring to Hospital B for more complicated medical conditions which require specialized treatment. Also due to capacity issues, they would refer to Hospital B for cases which do not really require a specialised health care.

Chapter 7 – Recommendations

Though allowances for professional staff working in rural areas have made a contribution to the satisfaction-levels of staff at hospital A, staff development and opportunities to further personal careers seem to be a corresponding desire at both hospitals. Therefore, this study recommends the development of professional advancement policies, aimed at enhancing and supporting staff to contribute towards the strategic objectives of the health facilities in both rural and urban areas. However, it is important to manage this in a careful and equitable way as proposed by recent research studies.

Improving conditions in rural areas is also a necessary step. Despite the introduction of rural allowances for health professionals working in rural areas, rural public health facilities still experience a significant shortage of professional staff, especially doctors. Building better staff housing and ensuring that facilities do not experience shortages of drugs and equipment could go some way towards improving working conditions in rural areas and making vacant positions more attractive, tying any such initiatives to other policies, such as the Reengineering of Primary Health Care in South Africa, instead of tackling these issues in isolation, is also important. Similarly, strengthening partnership within government departments (such as the Department of Public Works, Transport, and etc.) and framing rural-area improvements as inter-sectoral action between government departments, rather than the sole responsibility of the Department of Health, is also important.

Capacity building and strengthening of existing systems in the form of on-going mentoring support visits is needed at the health facility level. This can improve the relationship between staff, management, and other levels of government within the

Department of Health. This recommendation responds to the finding that reflected tensions and miscommunication between the district and the health facilities. It also responds to the need for capacity building and training that the staff identified at the study sites.

Within this study, it was not clear how district health inspectors have made a contribution towards the improvement of district health systems. Further research is recommended to explore the scope of work for district health inspectors, and how they can contribute towards improving the district health system.

The Department of Agriculture and Environmental Affairs in the Province of KwaZulu Natal developed a good staff retention policy which touches all relevant aspects and strategies that could be implemented to successfully retain staff. This is shown on the table below. Based on the discussions with study participants, there is no doubt that if the two district hospitals, especially hospital A, can adapt this model, it could have a great positive impact on staff retention.

Staff Retention Strategies	
Scarce Skills	- The risk of losing staff (scarce/critical skills) must be assessed. - In assessing the supply / demand, the department must determine the scarce/critical skills on an annual basis. - Where scarce/critical skills have been identified, an executing authority may set the salary for a post or an employee above the minimum notch of the salary range indicated by the job weight. - The process may also be initiated where an employee with scarce/critical skills and/or experience has received a higher job offer and the executing authority may give a counter offer to retain his/her services.
Encouragement of performance	- Employees are encouraged when they are given exciting jobs. This gives them the determination to do their job.

	- Have flexible work arrangements that will suit the employee and their families. - Avoid overloading your top performers with secondary tasks. - Reward employees who are performing well so that those that are under performing can be motivated. - Balance the performance level by pairing new employees or under performers with top performers.
Morale Building	- Lead by example as a manager to achieve better results. - Give employees a chance to develop by trusting them with high profile responsibilities. - When an employee has performed well, show appreciation. If an employee goes unacknowledged, a message of their unimportance will be sent. - Attend to staff needs timeously. - Introduce rewarding techniques such as issuing a certificate for a project/task well done.
Boost employee's self esteem	- A conducive environment should be provided where an employee can learn from his / her mistake. - Recognize a job well done. - Value employees who are performing well and make them feel valued.
Sense of ownership	- Less supervision is important. Employees do not like to be followed at each and every step they take because they may not feel trusted with the work they are doing. - Involve employees in decision-making processes. This will make employees have a sense of ownership of what has been proposed and they will do their best to achieve high results. - Avoid de-motivating employees because once they are de-motivated it is difficult to motivate them again. Employees are de-motivated when they are doing the same job for many years. Introduce staff rotation to allow for exposure to learn new activities. - Allow employees to see a project through from start to finish.

Communication	- Interact equally with employees. Do not lead them into thinking that there is favouritism within the department. - Listen to employee's ideas and take them seriously. - When in a meeting, give an employee your full attention. This makes an employee feel valued. - Encourage feedback and exchange ideas by meeting in an informal basis with the employee. - Technology plays a critical role in communicating corporate messages to all employees. For instance, the employees can learn about employment benefits, job openings and the latest product initiatives on the intranet.
Performance appraisal	- Performance appraisal is a two-way process as it includes the employ (appraisee) and the manager (appraiser). - Performance appraisal must take place within the department's policy on performance.
Staff development and training	- Staff development and training embraces the formal and informal acquisition of knowledge, skills, attitudes, thinking and habits required of an employee to render quality service and secure him/her a rewarding career. - Practices that promote staff development include self-development, formal and informal training, career development, study aid, job rotation, job enrichment/enlargement and mentorship and coaching. - Employees, who obtain higher qualifications, should be given preference in the filling of vacant posts which require such qualifications. - In a situation where the employee cannot be accommodated in a suitable post, his / her job should be reviewed with an intention of adding more responsibilities and re-evaluating the post to ensure the maximum utilization of the employee's potential.

Chapter 6 – Conclusion

This study sought to explore and describe push and pull factors which influence the movement and retention of health workers in two district hospitals in Eastern Cape Province, and make appropriate recommendations to relevant authorities, who were very supportive of the study and quick to grant permission and access for the research. This was achieved by adopting a qualitative approach, with exploratory and descriptive components. An interview guide was developed and used to interview different categories of health workers including management from two district hospitals, one rural and the other urban. Document analysis was also conducted to support in-depth interviews from the two district hospitals. Interviews were also conducted with the district management team to explore retention strategies, including guidelines and polices. Observation was also employed, focusing on structural issues and equipment, including the surrounding environment.

Overall, participants from the urban hospital (Hospital B) were more satisfied with the state of equipment and infrastructure compared to those in hospital A. Additionally, relationships among staff members were reported to be at an acceptable level there, compared to hospital A where participants reported tensions between staff members, and to be experiencing problems with management staff.

Loosely labelled as "working conditions", these were perceived to be 'better' and therefore less likely to be push factors for staff in the urban-hospital B than rural-Hospital A. One consequence of difficult and poor working conditions in this hospital was that participants spoke more readily about the possibility of leaving, unlike those in hospital B who seemed more satisfied with their jobs. Management styles and expectations about the

scope of work that staff should take on (linked partially to the availability of staff) differed between the hospitals, and those in hospital A were more likely to feel overstretched and unacknowledged for taking on extra duties. Managers at this hospital, however, felt that staff should fill in for each other as a response to a critical staff shortage.

Geographical differences, including surrounding infrastructure and the availability of services, including schools and recreational facilities, also affected staff decisions and intentions to stay or leave (more pronounced in the rural-hospital A). Participants in hospital A particularly expressed their dissatisfaction with regard to the surrounding environment, which they also found not to be conducive for their families.

Perceptions about who should qualify for a rural allowance affected staff in urban-hospital B, who felt unjustly excluded from the policy on the grounds that they service a rural-population even although they are based in an urban area. Hence there is a need to engage professional staff who work in urban areas that service a large proportion of surrounding rural populations, to understand the rationale of such allowances which they are not entitled to.

Opportunities for professional development were also perceived to contribute towards the retention of professional health workers. In both hospitals, staff highlighted that training and study-opportunities were positive 'pull' factors keeping them motivated in their jobs. However, they did also speak of the potential for training to provide a 'step-out' of their current work environments into new jobs.

The relationship between the hospital and district management also differed between the two facilities, and was better for hospital B, which had greater capacity and a better understanding of policies and procedures – factors that limited delays in their requests to the

district. Hospital A was seen as experiencing more challenges by the district managers, unlike hospital B which was considered to be doing things perfectly well.

However, on a positive note, the management team in hospital A mentioned that challenges do exist in all hospitals, not only in theirs, and that they have been able to provide services to the community without having to turn people back. This trend was noticed in both district hospitals, though hospital B seemed, overall, to be experiencing fewer challenges as compared to hospital A.

Though the results of this study cannot be generalised, they highlight different aspects which can provide guidance to policy makers, on what they need to do to address such challenges. These aspects are also important for professional health workers, to get an understanding of challenges experienced by health facilities and what is currently being done to address those.

Salaries were not the main feature in this study, though salaries, especially feeling underpaid, constantly emerges in the international literature as a reason for migration out of the public sector. At the same time, creating financial incentives to retain staff may not alone be enough to keep over-worked and under-supported professional staff, especially in rural health facilities where the working conditions are bad, with no opportunities for further career advancement or good schools to send children to. A recent study on motivation and retention of health workers in Tanzania, Malawi and South Africa has also highlighted the unintentional consequences of financial incentivisation as a retention strategy, including creating tensions between staff and having a negative impact on good team-work (Thomas, et al, 2011: 4). Therefore while salaries and access to allowances such as the Rural Allowance for those in hospital A, with a strategy for engaging about why staff at hospital B do not qualify for this allowance, will always be an important part of any recommendation around

staff retention and motivation in South Africa, it is important to proceed cautiously as recommended by Thomas *et al*. (2011: 4) and also, to consider the non-financial push and pull factors that give people either a sense of place and belonging, or alienation and dissatisfaction.

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❖ Appendix A

EXPLORING PULL AND PUSH INFLUENCING HUMAN RESOURCES AT TWO SOUTH AFRICAN HEALTH FACILITIES

Information sheet for In-depth interviews

Dear Potential Participant

My name is Nathi Sohaba. As part of my MPH Degree at the University of the Witwatersrand, I am undertaking a research project that is aimed at understanding factors which contribute to maximizing the human resource capacity in district health facilities. The research project is entitled, "Exploring Factors Affecting Human Resource Capacity at the South African Health Facilities". It does this by exploring and describing factors that influence the movement and retention of health workers, and by making appropriate recommendations to health authorities. Your health facility is one of two district health facilities that have been selected for this research.

I would like invite you to take part in this research by answering some questions. These are general questions that ask you about your perceptions and experiences about your job. Your participation is absolutely voluntary and there will be no negative consequences to you for not participating. If at any time you wish to withdraw from this process, you will be allowed to do so. Before the interview you will be asked to sign a consent form. The information gathered during the interview will only be known by the researcher and there will be no identifying factors. After the completion of analysis, a copy of the results will be available at your hospital.

Thank you for considering participating in this research. If you have any questions in relation to this research, be free to contact the following people:

Nathi Sohaba or Bronwyn Harris

❖ Appendix B

EXPLORING PULL AND PUSH INFLUENCING HUMAN RESOURCES AT TWO SOUTH AFRICAN HEALTH FACILITIES

Informed Consent Form [In-depth interviews]

I (please print)_____have read the information on the research, which is currently being conducted in my health facility, and all my queries have been answered to my satisfaction.

I agree to participate in this research and I understand that I can withdraw from it any time without reason or penalty. I also know that my responses will be kept confidential and not discussed with my supervisor and my fellow colleagues. My identity will not be revealed to anyone other than the investigator conducting the research.

Signature_____

Date_____

Interviewers Declaration

I_____ Date_____

Hereby declare that I have explained clearly to the participant, the aims, objectives, and benefits of being involved in the research survey. I have received his/her consent.

Signature_____

❖ Appendix C

EXPLORING PULL AND PUSH INFLUENCING HUMAN RESOURCES AT TWO SOUTH AFRICAN HEALTH FACILITIES

Letter of permission - Health Facility

Dear Sir or Madam

I kindly wish to apply for permission to undertake a study that is aimed at exploring factors affecting human resource capacity at the South African health facilities. The study seeks to explore and describe factors that influence the movement and retention of health workers, and, on the basis of findings, will make appropriate recommendations to health authorities.

This is part of the Wits MPH Program where students are expected to conduct research studies as part of their fulfillment towards obtaining the Master of Public Health. The study will involve conducting in-depth interviews with approximately twenty health care workers at your disctrict health facility. Consent will be obtained from all the participants before taking part on the study and all the information collected will be kept strictly confidential. The participants will have a right to refuse participation, or withdraw from taking part.

At the end of the study, the results will be disseminated to all the relevant stakeholders including the health facilities where the study was conducted, and also the participants.

Herewith attached with this letter, kindly find a draft proposal, which will give you some background and more details about the study.

Yours Faithfully,

Nathi Sohaba

Appendix D

EXPLORING PULL AND PUSH INFLUENCING HUMAN RESOURCES AT TWO SOUTH AFRICAN HEALTH FACILITIES

Letter of permission - Provincial Department of Health

Dear Sir or Madam

I kindly wish to apply for permission to undertake a study that is aimed at exploring factors affecting maximization of human resource capacity at the South African health facilities. The study seeks to explore and describe factors that influence the movement and retention of health workers, and, on the basis of findings, will make appropriate recommendations to health authorities.

This is part of the Wits MPH Program where students are expected to conduct research studies as part of their fulfillment towards obtaining the Master of Public Health. The study will involve conducting in-depth interviews with approximately twenty health care workers at your health facility. Consent will be obtained from all the participants before taking part on the study and all the information collected will be kept strictly confidential. The participants will have a right to refuse participation, or withdraw from taking part.

At the end of the study, the results will be disseminated to all the relevant stakeholders including the health facilities where the study was conducted, and also the participants.

Herewith attached with this letter, kindly find a draft proposal, which will give you some background and more details about the study.

Yours Faithfully,

Appendix E

EXPLORING PULL AND PUSH INFLUENCING HUMAN RESOURCES AT TWO SOUTH AFRICAN HEALTH FACILITIES

CONSENT TO TAPE IN-DEPTH INTERVIEWS

I have read the study information sheet, and I understand that it is up to me whether or not the interview is tape-recorded. It will not affect in any way how the interviewer treats me if I do not want the interview to be tape-recorded.

I understand that if the interview is tape-recorded that the tape will be destroyed two years after the interview.

I understand that I can ask the person interviewing me to stop tape recording, and to stop the interview altogether, at anytime.

I understand that the information that I give will be treated in the strictest confidence and that my name will not be used when the interviews are typed up.

Yes, I give my permission for the interview to be tape recorded	☐
No, I do not give my permission for the interview to be tape recorded	☐

_____

Interviewer's name and signature

Date:_____

Appendix F

EXPLORING PULL AND PUSH INFLUENCING HUMAN RESOURCES AT TWO SOUTH AFRICAN HEALTH FACILITIES

QUESTIONNAIRE

A. Site Demographics

Fill out this section before starting with an interview:

1. Name of the Hospital	Frere Hospital	1
	Butterworth Hospital	2
2. Date of Interviewer	DD___/MM____/YY____	
3. Interviewer Completed	Yes	1
	No	2
4. Reason for incomplete interview		

B. Provision of Health Services in the Health Facility

Today I would like to talk about your experience about working in this health facility.

- I would like to begin this discussion by asking you to explain if you think your health facility has enough capacity to offer its designated services. What would you suggest to improve this?

- Now, can we talk about your role in this health facility: This should include your responsibilities, and also describing the nature of support that you get from your colleagues, including the management?
- Can you tell me what you like most about working in this health facility? How can you describe the following:
    - Working conditions;
    - Your relationship with other staff members;
    - Your favourite aspect of work – including the least favourite;
    - Your dislikes about working in this facility; Please suggest how this can be addressed;
    - Areas where you feel most supported and least supported;
- Please tell me about any special training you have attended to enhance your skills; can you tell me about any additional skills that you think you would want.

C. Perceptions about staff retention

- In your province/ health facility, how would you advise the district health management team on ways of retaining the staff?
    - PROBE: Please explain some of the things that they are not doing – what is being done to address these problems?
    - PROBE: Do you think that staff retention is also a problem in your health facility?
- If you have tried looking for a job elsewhere or considering doing that, can you explain what would make you do that?
- Now I would like to ask you about your own personal relationship with other colleagues. Remember that the information you tell me will be completely confidential. I can assure you that none of the information you tell will be shared with anyone, except the research team. Also, note that no one will know whose response these are since I am not writing down names. So I would like to know if you have any concerns related to staff development, salary and any form of motivation.
- What you like most or value most about your role in this facility?
- Is there anything more you would like to add?
- Is there anything you would want to ask?

Thank you for taking part in this discussion