

THE CHALLENGES EXPERIENCED IN RETAINING CLINICAL STAFF AT RURAL GOVERNMENT HOSPITAL IN KWA-ZULU NATAL

Sashika Gayasingh

Graduate of the Regent Business School, Durban, Republic of South Africa

Nishika Reddy

External Dissertation Supervisor Attached to the Regent Business School, Durban, Republic of South Africa

Anis Mahomed Karodia (PhD)

Professor, Senior Academic and Researcher, Regent Business School, Durban, Republic of South Africa

Abstract

Health professionals are considered a scarce commodity within the public health sector, particularly at rural facilities where the shortage of health workers is most noticeable. Despite government intervention through the implementation of various policies and financial strategies, the Department of Health is still faced with a huge challenge in retaining clinical staff at rural hospitals.

This is due to skilled health professionals such as doctors, dentists, pharmacists, nurses and allied health workers seeking employment out of rural facilities to urban areas and some are even lost to overseas job prospects. This places much pressure on the public health sector because it negatively affects the delivery of quality health service particularly in the rural and, disadvantaged areas.

Key Words: Challenges; Clinical Staff; Rural; Government, Hospital; Health Professionals; Public Health; Workers; Policies; Financial Strategies; Quality Health

Introduction

The Department of Health is faced with huge challenge in retaining clinical staff at rural facilities. Despite government intervention according to HEARD (2009:8) through the payment of Occupation Specific Dispensation, rural allowance, the recruiting of foreign doctors to rural areas and implementation of community service this problem persists. This

is mainly due to the fact still that much emphasises is placed on attracting health care professionals and minimal effort on retention once the health care professionals are at these rural facilities. The inability to retain clinical staff at rural public hospitals is still much a challenge today as it was several years ago.

Objectives of the study

- To explore if demographic and geographic factors influence the inability to retain clinical staff;
- To determine if clinical staff are satisfied with current job position;
- To identify the extent to which clinical staff are seeking employment out of rural public hospitals; and
- To provide recommendation on how to retain clinical staff.

Literature Review

This section and the study as a whole will attempt to look at exploring the challenges faced by health professionals working at hospitals situated in the rural areas. These challenges faced by the health workers, force them to seek employment out of these rural surroundings. This in turn leads to the all encompassing reality to investigate three main factors that could be the leading causes to the challenge faced by health professionals. These factors include:

- Demographic and Geographic factors;
- Job satisfaction and motivation; and
- Intention to leave the rural facilities.

The Human Resource for Health South Africa (2011:31) believes the lack of health care professionals in rural areas is determined by the following factors:

- No additional benefits for working in more inhospitable environments;
- Historic deficiency in hospital infrastructure;
- The fear of one's safety;
- A lack of schooling opportunities for children; and
- A lack of work opportunities for spouses of health professionals.

In addition another major contributing factor that is negatively impacting on the staffing at government facilities, in rural hospitals in particular is the migration of skilled health care professionals. Table 2.1 according to the National Department of Health National Human

Resources Plan for Health 2006 in the Human Resource for Health South Africa (2011:32), revealed 8921 doctors are working abroad. This number is equivalent to one third of South Africa doctors registered with HPCSA. This staggering figure goes along with 6844 nurses and 7642 other health professionals. In total these amount to a high 23 407 of skilled South African health professionals working abroad.

Table 2.1: Distribution of Health Professionals Abroad

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

Source: Human Resource for Health South Africa (2011:32).

Despite government intervention as cited by Makapela and Useh (2013:129) and HEARD (2009: 8), through the introduction of various strategies the problem refuses resolution. Therefore a deep look into the factors that influence health professionals to leave rural areas need to be investigated.

Demographic and Geographic Factors

Demographic factors refer to an individual's personal factors such as gender, age, qualification and marital status whereas geographic factors relate to ones location in relation to the nearest town or city. These two factors strongly influence an individual decision to remain in rural areas believes Lehmann, Dieleman and Matineau (2008:8). In addition The World Health Organisation (2006:7) cites the increase in urbanisation has also played a huge role in the shortage of clinical staff in rural areas resulting in it being under served.

Both the demographic and geographic factors are key contributors to the rise in urbanisation.

Urbanisation

Dociu and Dunarintu (2012:47) define urbanisation as the movement of people from the rural to urban areas. This is as a result of social change in society where there is a transformation of people in terms of one's culture, behaviour and social structures that leads to a heterogeneous society as believed by Stevens (2012). People often tend to migrate to urban areas as it depicts a lifestyle that is better and easier than rural life. The attraction of the bright lights of the city along with factors such as better job opportunities, education and superior infrastructure all play a key role in the migration out of rural areas according to Dociu and Dunarintu (2012:50).

The South African government is aware of the impact of urbanisation that contributes to the struggle in retaining highly skilled staff at its rural health facilities. The reason being health professionals are reluctant to be deployed to rural hospitals as working conditions are considered to be a lot harder than urban hospitals. Furthermore government attempted to address this issue by providing study assistance to disadvantage rural communities with the mind-set being, these students will return once qualified to their respective communities to provide the skills acquired as discussed by Lagarde and Blaauw (2013:6). However World Health Organisation (2006:7) argues this is not always the case because it believes the primary reason being that young single health professionals crave the urban lifestyle that is exposed to them when study opportunities are persuaded. Material resources such as large shopping malls, excellent technological facilities and educational centres all aid in satisfying the young health professionals need to keep up with the social trends which sadly the rural areas are unable to compete. With the impact of demographic and geographic factors taken into consideration, it has led to the Department of Health formulating and implementing a policy in the form of compulsory community service and recruiting of foreign doctors particularly to rural areas to address this health crisis.

Community Service

The Department of Health aimed to tackle the staff shortage at rural hospitals through the formulation of the community service policy. In 2004 the Kwa-Zulu Natal Department of Health Policy on Community Service Officers was implemented. This policy requires health

professionals to practice in the public health sector for a period of one year following graduation. However there is still a grave shortage at rural hospitals because these disadvantage areas only received 25% of all community service placements according to Reid (2011). Although this policy was meant to address the staff shortage Reid (2011) believes it is only a good recruitment strategy but a very poor retention due to the fact once contractual obligations are met by the policy, community service officers leave the rural hospitals.

This fact is supported by the Human Resource for Health South Africa (2011:33) that states according to a survey conducted in 2009 on community services officers, it reported 17% of community services officers did not report for community service, bearing in mind these community service officers will not be able to practice in South African without completing community service allocated as it is compulsory. A further 6.1% of all who did attend community service stated they would emigrate once one

year contract is completed. This spells a huge loss for the South African health sector as it will be left with a 23.1% deficit of skilled health professionals.

Recruitment of Foreign Health Professionals

The Department of Health also focussed on another strategy through the recruitment of foreign health professionals to South Africa to mainly serve disadvantage areas as cited in HEARD (2009:37). This policy that is outlined in the National Human Resource Plan allows for the recruitment of foreign doctors to be limited to 6% of South African workforce according to Human Resource for Health South Africa (2011:36). The main reason for this decision as revealed in HEARD (2009:37) is to ensure our country does not take part in "Brain Taking" from developing countries.

The recruitment of foreign health professionals has resulted in bilateral agreements between the South African government and Cuba, Iran, Tunisia and United Kingdom as outlined in Human Resource for Health South Africa (2011:36). The total period for a foreign health worker to work in South Africa is limited to 5 years. However based on observation at a rural public hospital in Kwa-Zulu Natal, some foreign professionals particularly doctors are deployed to rural hospitals initially but opt to leave these rural facilities prior to reaching its 5 year mark. These doctors tend to migrate to the urban hospitals to complete what is left of the remaining 5 years.

It is quite evident the demographic and geographic factors play a huge role in the issue surrounding the shortage of clinical staff in disadvantage areas. The attraction to explore the urban lifestyle is what draws health professionals along with other individuals to the cities and towns as it dictates most social economic factors that young individuals aim to satisfy and sadly the rural areas fall short off according to WHO (2006:7).

Job Satisfaction

Job satisfaction is a crucial point to bear in mind when trying to establish the challenges experienced in retaining clinical staff at rural health facilities. Luthans (2005:126) defines job satisfaction as a pleasant or positive emotional state that results from ones job or job experience. Employees who are more job satisfied are usually more committed to achieve the organisations key objective according to Robbins, Judge and Odendaal (2009:83), who also highlights that job satisfaction has the a huge implication on:

- Organisational performance;
- Absenteeism; and
- Staff turnover.

Implications of Job Satisfaction

Organisational Performance

Luthans (2005:126) states employees who are job satisfied will tend to perform better at work resulting in a more effective and efficient organisation. However the reversal does also apply. If the employee is not satisfied this could lead to higher problems associated with job performance and negatively affect the organisation. Robbins et al. (2009:81) lends support to this fact and also adds on that employees who are satisfied automatically increases customer satisfaction. This is exactly what the Department of Health is wishing to achieve in the Kwa-Zulu Natal Strategic Plan 2010 -2014, which is improved, efficient and quality health service.

Absenteeism

Job satisfaction tends to have a similar effect on absenteeism as it does on organisational performance. The higher the job satisfaction the lower the absenteeism rate and vice versa. When employees are absent from work it results in lower organisational productivity according to Robbins et al. (2009:81). Furthermore Thompson, Peteraf, Gamble and

Strickland (2012:448) state when absenteeism is as a result of poor job satisfaction maybe negatively affect the organisation as it may display poor organisational culture. This will negatively influence employees wishing to join the organisation. Should this occur it could comprise the Department of Health strategy as outline in HEARD (2009:8) in attracting health professionals to the public health sector.

Staff Turnover

Job satisfaction plays a huge role in reducing staff turnover. When job satisfaction is high, it results in low staff turnover. Robbins et al. (2009:81) the reason behind this is, when employees are dissatisfied it automatically leads to the individual seeking employment out of the current job and organisation. This has a negative impact on the organisation as it will be required to invest more funds in an aim to retain the dissatisfied employee or the additional funds invested will be required to recruit new employees. Either way it results in a loss of revenue for the organisation. Hence it is crucial for the Department of Health to investigate the level of job satisfaction experienced at rural hospitals if it aims to deliver on its outcomes outlined in the Kwa-Zulu Natal Strategic Plan 2010 -2014.

Motivation

An employee that is motivated generally has a high job satisfaction and tend to be more productive hence increases the organizations performance level according to Nel et al. (2011:289) and is considered as one of the key aspects in ensuring the success of the organisation. Aswathappa (2008:359) describes motivation as a set of forces that leads people to behave in a positive manner. Furthermore motivation also urges employees to seek ways in performing the job better with main focus being on quality. Motivating employees through rewards as noted in Figure 2.1, take two routes intrinsic and extrinsic rewards. Intrinsic rewards involve:

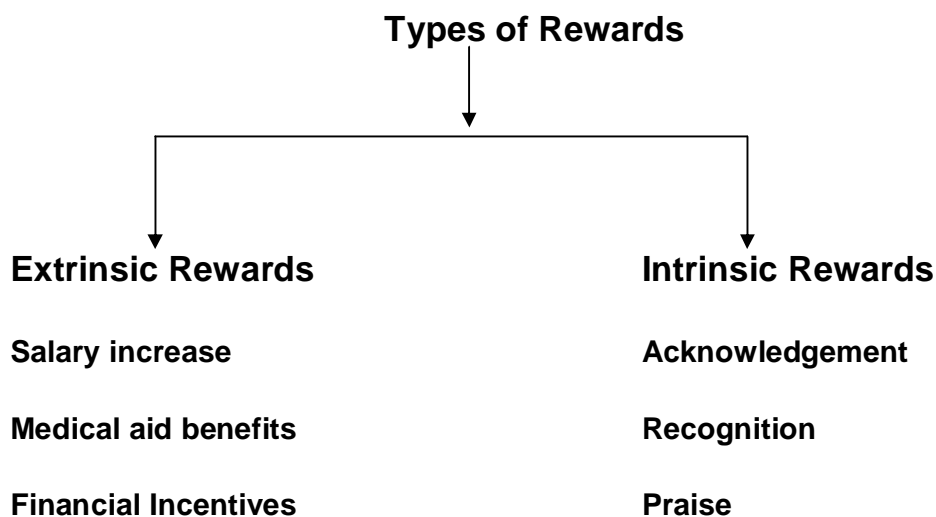
- Acknowledgement of a job well done;
- Recognition; and
- Praise.

These aspects have the ability to satisfy the employees' inner self needs. Whereas extrinsic rewards are considered more superficial as compared to intrinsic as it involves rewarding through money such as:

- Salary increases;
- Medical aid benefits; and
- Other financial incentives to name a few according to Heneman (2002).

Andrews (2009) goes on further to states that intrinsic is mainly in the form of non-financial compensation where extrinsic is a form of financial compensation. Hiriyappa (2010: 149) believes both type of rewards can highly motivate employees provide that is managed sufficiently.

Figure 2.1: Two type of Rewards



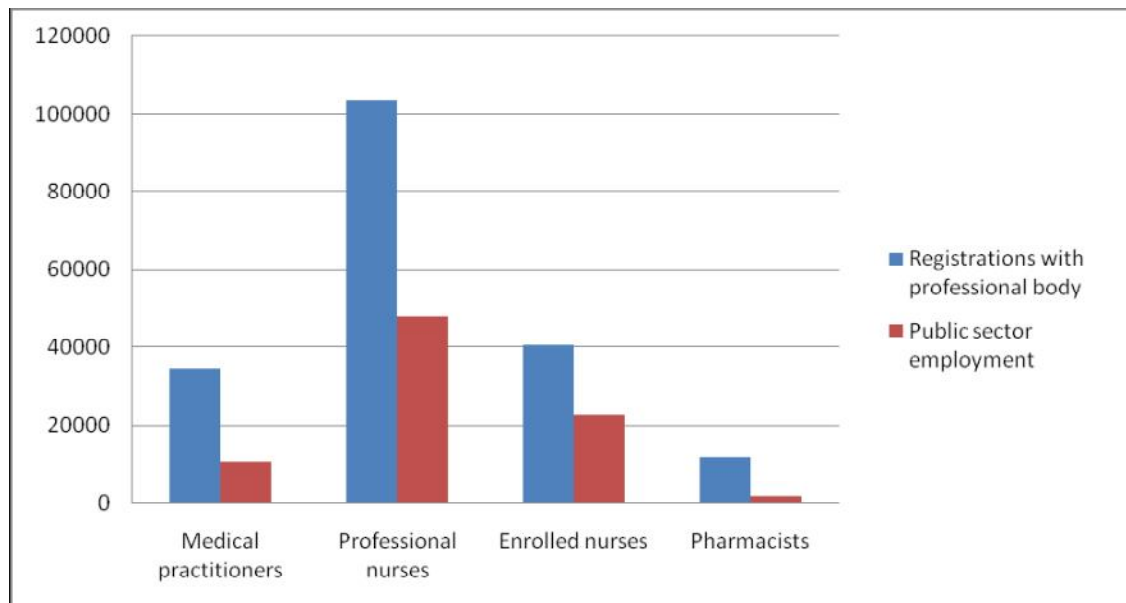
Source: Hiriyappa (2010: 149).

Financial Motivation

Financial motivation is most often the common type of motivation adopted by most organisations as revealed by Aswathappa (2008:359). The Department of Health explored this type of motivation to attract its health professionals to the public health sector. This was done through the payment of OSD, scare and rural allowance as cited in HEARD (2009:8). This was mainly introduced to address the shortage of health professional in the government with particular emphasis on disadvantage areas. Figure 2.2 illustrates the severity of the shortage of health professionals in the public sector during 2007 to 2008 as revealed by Day and Gray (2008).

Figure 2.2: Number of health professionals employed in public sector,

2007-2008



Source: Day and Gray (2008).

Figure 2.2 indicates the following percentage of health professionals that were employed by the public health sector were as follows:

- 30.7% of medical practitioners;
- 46% of professional nurses;
- 56% of enrolled nurses; and
- 15% of pharmacist Day and Gray (2008).

Scarce Skills Allowance

This allowance was introduced by the Department of Health as a strategy to attract and retain health professionals to the public health sector. It was designed to ensure South Africa maintains its skilled human resources and not lose it as a result of the phenomenon “Brain Drain” that seems to be sweeping our country according to HEARD (2009:39). With reference to Kwa-Zulu Natal Human Resource Circular 87 of 2004, saw the implementation of scarce skills allowance. However due to several problems encountered in the actual implementation of scarce skills allowance, has led to it being absorbed by payment of Occupation Specific Dispensation policy in line with Public Health and Social Development Sectoral Bargaining Council Resolution 1 of 2010.

Occupational Specific Dispensation

Occupational Specific Dispensation (OSD) was developed and implemented by the Department of Health to improve the conditions of service and remuneration for health professionals in South Africa according to HEARD (2009:41). With reference to a statement released by the Department of Public Service and Administration (2007), OSD was basically a revised salary structure based on an individual occupation in the public health sector. Mahlali (2009) states the key objective of the OSD were to:

- Aid the public health sector to attract and retain its health professionals;
- Provide a unique salary structure as per occupation; and
- Provide adequate and clear salary progression.

According to the Kwa-Zulu Natal Human Resource Management Circular 96 of 2010 address the implementation of OSD in line with the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC) Resolution 1 of 2010. With the implementation of OSD well on its way, Human Resource for Health South Africa (2011:24) reveals payment of OSD is estimated to have cost the Department of Health R60 323 121 877. Table 2.2 illustrates the different occupational categories with the specific occupational costs as well as the overall cost.

Table 2.2: OSD costs of public sector health professionals, 2010

Occupational Classification	2010 Costs (OSD)
Medical practitioners	R 9,294,131,808
Medical specialists	R 4,748,741,068
Pharmacologists pathologists & related professional	R 49,455,092
Nursing assistants	R 4,525,970,064
Professional nurse	R 21,769,124,619
Staff nurses and pupil nurses	R 4,396,470,650
Student nurse	R 1,798,116,100
Dental practitioners	R 446,212,512
Dental specialists	R 140,999,624
Dental technicians	R 9,391,536
Dental therapy	R 62,894,832
Ambulance and related workers	R 5,690,826,240

Emergency services related	R 2,345,434,044
Pharmaceutical assistants	R 101,736,012
Pharmacists	R 1,351,830,060
Radiography	R 288,253,112
Supplementary diagnostic radiographers	R 28,734,360
Community development workers	R 28,743,792
Dieticians and nutritionists	R 217,143,696
Environmental health	R 224,543,088
Health sciences related	R 1,801,467,360
Medical research and related professionals	R 21,344,400
Medical technicians/technologists	R 112,983,024
Occupational therapy	R 238,203,504
Optometrists and opticians	R 35,858,592
Oral hygiene	R 55,210,848
Physiotherapy	R 276,054,240
Psychologists and vocational counsellors	R 150,549,168
Speech therapy and audiology	R 112,698,432
TOTAL	R 60,323,121,877

Source: Human Resource for Health South Africa (2011:24).

Rural Allowance

The introduction of rural allowance was to correct the misdistribution of health professionals between the rural and urban areas in South Africa as stated by HEARD (2009:39). The intention of the rural allowance was to attract and retain health professionals to work full-time in public health services in rural, under-served and other inhospitable areas identified by provincial health departments according to Makaphela and Useh (2013: 129). This policy was designed in accordance to PHSDSBC Resolution 2 of 2004, to attract and retain skilled health professionals to the rural and disadvantaged areas. The allowance is based on two factors:

- A fixed percentage to the annual salary of the health professional; and
- As well as location of the rural hospital in terms being classed as rural or deep rural.

Table 2.3 illustrates the payment of rural allowance according to the health professionals' designation and location of the rural hospital. However government awarded the rural allowance to doctors, dentists, dieticians, pharmacists, psychologists, radiographers, therapists and professional nurses with 4-year diploma or degree. The policy excluded junior nurses such as enrolled nurses with 2 years of training and nursing assistants with 1-year training.

Table 2.3: Summary of Rural Allowance

Rural Allowance	Percentages
Deep rural	22% Doctors and Dentists 17% Pharmacists 17% Allied Health Professionals 12% Professional Nurses
Rural	18% Doctors and Dentists 12% Pharmacists 12% Allied Health Professionals 8% Professional Nurses

Source: Department of Health (2004).

The payment of OSD, scarce skills and rural allowance were all financial incentives utilized by the Department of Health to attract and retain skilled health professionals to the public sector more particularly so to the underserved rural areas. Despite these interventions by government HEARD (2009:8) reports although government is commended for a strategy that aims to attract the health professionals there still seems to be a shortage of clinical staff at rural facilities, highlighting the issue of retention in disadvantage areas.

Non- Financial Motivation

Hiriyappa (2010: 149) states that intrinsic rewards most often are based on non- financial motivation. As the name suggests non –financial does not involve monetary compensation to the employee. Instead it can be administered through:

- Recognition and validation;
- Creating a positive working environment; and
- Training and development of staff.

Furthermore Aswathappa (2008:359) emphasises that non-financial motivation does indeed contribute to improved organisational performance.

Recognition

Songstad (2012:51) points out that recognition is fast becoming an important motivator to health workers as it assists in improving the quality of health care in areas with poor resources. Furthermore motivation through recognition makes the health professional feel valued at work despite negative circumstances. Recognition is regarded as one of the most powerful tools used to motivate employees according to Mondy and Noe (2005: 321) and can serve as a good retention strategy in most organisations. Hiriappa (2010: 154) highlights recognition as part of the key motivator factors in the Herzberg's Motivation Theory. This theory is based on two main questions that need to be asked:

- What factors lead people to experience dissatisfaction with their jobs?
- What factors lead people to experience satisfaction with their jobs?

This leads to the formation of Herzberg's hygiene factors and motivators according to Truelove (2011:9), states that although hygiene factors such as:

- working conditions;
- pay company policies;
- supervision; and
- interpersonal relationships.

And Motivators such as:

- Recognition;
- Responsibility; and
- Advancement.

Do not directly motivate an individual within the organisation, however both these factors must be present or it will result in dissatisfaction by the employee.

Recognition aims to sincerely acknowledge the employee for good work performance and can be conducted in the following ways:

- Establishing an employee of the month programme;
- Giving praising and validating an employee in front of other co-workers; and
- Issuing out little kind gestures such as “thank you “notes.

Gerber, Nel and Van Dyk (2008:39) express that these above acknowledgements by an organisation can result in an employee displaying more commitment and willingness towards the individuals' job performance.

Creating a positive working environment

Working conditions is another factor that contributes to the motivation of employees. Luthans (2005:127) emphasises if working conditions are good, the staff will find it easier to perform their jobs and vice versa. Access to sufficient resources is a key to providing good quality health service as cited by Henderson and Tulloch (2008:18). Resources create a more stimulating environment from which health professionals can operate from. Mathauer and Imhoff (2006:24) points out a shortage in medical supplies is a huge challenge at many rural facilities all across Africa. The lack of available resources at rural facilities leads to demotivated workforce, with many health professionals seeking employment out of this environment.

Furthermore Makaphela and Useh (2013:129) describe that working at rural facilities poses a huge challenge to clinical staff as there is poor allocation of resources to these disadvantaged areas. This negatively impacts on the health services as clinical staff such as doctors and nurses are unable to administer good quality care resulting in the Kwa-Zulu Natal Health Strategy Plan 2010 -2014 not achieving its key objectives.

Training and development

Most organizations are investing more money in training and development of its employees. According to Edralin (2004: 1), training is described as activities directed towards increasing knowledge and skills of employees. In doing so the aim is to assist employees in performing better at the current job position, resulting in the organization achieving its goals more effectively and efficiently. Development as believed by Nel et al. (2011:359) is long term plan aimed at developing people for future needs of an organization. Hence training and development goes hand in hand.

In addition training according to Pattanayak (2010:75) is a planned programme designed to improve the employees' performance within an organisation. The key purpose of training and development is:

- Create a readily available replacement should personnel leave the organisation or move to high position within the organisation; and
- Build a more effective, efficient and highly motivated workforce.

Training is often considered an indispensable asset to the organization and is considered strategic as it is aimed to achieve the organizations long term goals and objectives. According to Nel et al. (2011:359), through training and development employees become more aware of the organizations goals resulting in more commitment from the employees' side

This is supported by Edralin (2004:3) who further emphasizes through the knowledge and skills further obtained from training, it improves the employees job performance, resulting in positive impact on productivity. Training and development also sparks innovation that leads to the organization being more efficient and effective. Furthermore, it aids in the development of the employees problem solving skills, increasing the morale. When an organization is trained and developed it creates a stable environment leading to a decrease in the number of turnover.

Training and development is vital for an organization and what is considered crucial is the ability to identify areas requiring the training. Prior to implementing the training and development process, the current status of the organization needs to be assessed. Factors such as the organization goals and the abilities of the current employees to achieve these goals are brought to light. This is followed by two very important questions, being, where the training is needed and which employees require the training. In doing so, the human resource department of the organization can plan adequately and monitor the effectiveness of the training and development programme according to Edralin (2004:2).

One of the most critical aspects when identifying skills training is to ensure the organization has sufficient financial and non-financial resource to support the training programme implemented, if not can lead to failure. According to the Human Resource Health South Africa (2011:51), R7 billion is spent annually on health professionals' development. Ultimately, when identifying training needs, a programme is put in to place to bridge the gap

between current and future job performance for the employee. In doing so the human resource department has the ability to plan strategically to ensure the organizational goals are achieved according to Nel et al. (2011:359).

It is evident training and development of health professionals is incorporated, into the HRH Strategy for Health Sector 2012/13 to 2016/14, according to the Human Resource Health South Africa (2011:51). However it is crucial for the Department of Health to monitor it as to ensure non wastage of expenditure.

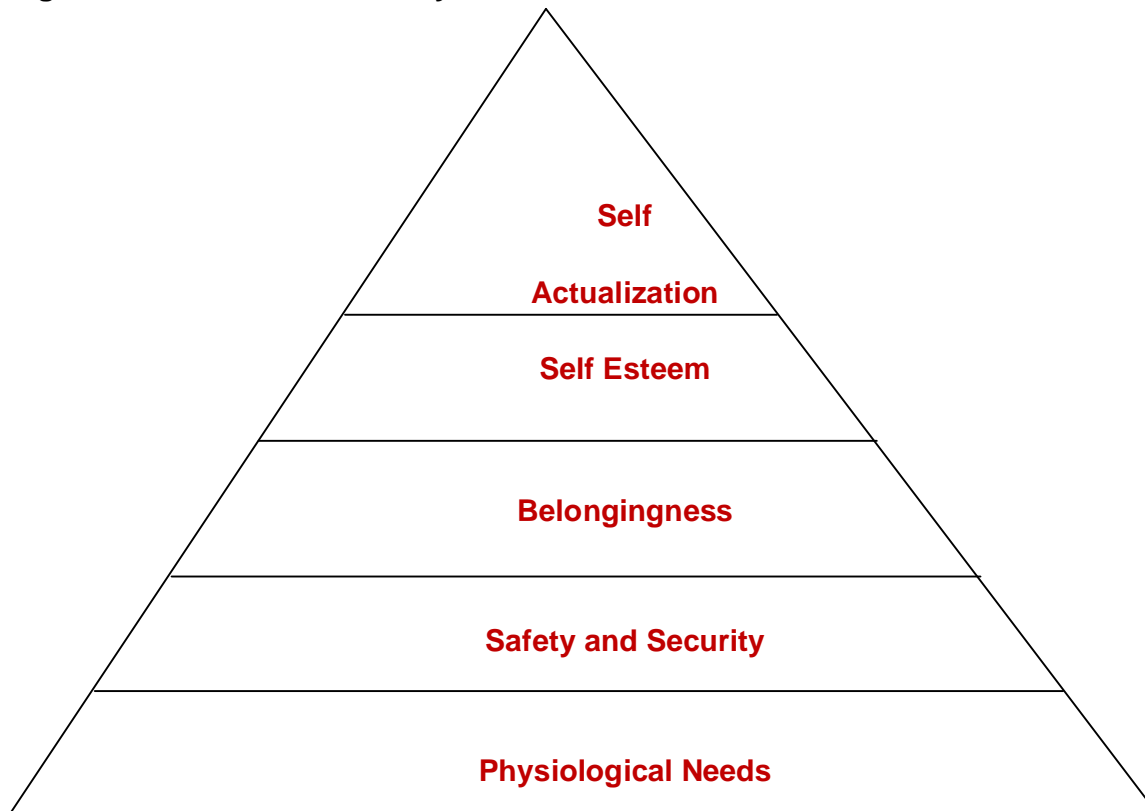
Intention to leave rural facilities

When an individual is on a quest to leave a certain area the reason most often is that the individuals basic needs are not met as cited by Hirriyappa (2010:151). The same applies when clinical staffs aim to leave rural health facilities it implies the primary needs are not met. Maslow's Hierarchy of Needs Theory believes that a person will first attempt to satisfy his or hers basics needs prior to his or hers higher order needs according to Aswathappa (2008:365).

Maslow's Hierarchy of Needs Theory

This theory reveals people needs are arranged in order of importance, starting with the basic to more complex needs with emphases place in order to escalate to the next level in the hierarchy of needs the prior needs must be fulfilled first according to Hirriyappa (2010:151). Maslow's Hierarchy of needs comprises of five levels. Figure 2.3 illustrates the five levels with the basic level starting at the bottom and higher level as the hierarch escalates.

Figure 2.3: Maslow's Hierarchy of Needs Levels



Source: Aswathappa (2008:365).

- **Physiological Needs**

This is the first and most primary need according to Maslow. Aswathappa (2008:365), states this refers to all basic needs such as food, shelter, water, electricity, income. It is believed that satisfying these needs is in line with basic human rights.

- **Safety and Security**

Aswathappa (2008:365) informs this is the second need in the hierarchy. It includes factors such as safe working environment, job security as well as protection from and form of physical and psychological harm.

- **Belongingness**

This third level focuses on the need for social interaction and belonging, be it with co-workers, friends, community or spouse. Maslow believed healthy social interaction is an excellent depiction of acceptance by the people that you surrounded by according to Hiriyappa (2010:151).

- **Self-Esteem**

Aswathappa (2008:365) states acquiring self-esteem is the fourth level of Maslow's Hierarchy. It generates a feeling of self-confidence, worth and being useful to the world. This level of self-esteem is closely related to that of recognition as the motivators in Herzberg's Theory.

- **Self-Actualization**

This is the last level and most complex of Maslow's Hierarchy Theory. Reaching this superior level is an indication that an individual has arrived to its fullest potential according to Hiriyappa (2010:152). However Aswathappa (2008:368) argues that although that maybe the case, the need for self-actualization is never fully satisfied.

The situation at rural hospitals

Kotzee and Couper (2006:581) highlight the fact that many health professionals want to leave hospitals in the rural areas to gain employment in the urban regions due to the following factors:

- Insufficient salary;
- Heavy work load;
- Understaffing;
- Poor housing;
- Safety;
- Lack of basic medical equipment;
- Personal relationships;
- No recreational facilities;
- Lack of transport;
- Lack of schooling opportunity for health professionals children; and
- Lack of job opportunities for health professionals spouses.

When categories the above factors it is clearly evident the above reasons for health professionals to leave the hospitals situated in the rural areas all fall within the first three levels of physiological, safety and security, belongingness in the Maslow Hierarchy of Needs levels.

The physiological factor is considered as the most basic needs of the health professionals and falls under the Chapter 2 in the Bill of Rights in the South African Constitution (1996). Under this Bill no individual are meant to be living in conditions of such sub-standard levels

and should have access to basics such as food, water and shelter. Next is the safety and security aspect. This refers to safety and security within the hospital as well as within the rural community in which the health professional resides. Living in an era and country where crime is a major factor Human Resource for Health South Africa (2011:31), stated ensuring the health worker feels safe and secure in these rural surroundings is of utmost importance to ensure the retention of the staff.

The next level of belongingness is also not clearly restricted to the hospital alone. This does involve healthy social interaction with co-worker but also social interaction within its community. Most often when health workers are deployed to rural hospital they usually do so alone. Families do not generally move as a whole to rural areas as Kotzee and Couper (2006:581) pointed out. Both Kotzee and Couper (2006:581) and Human Resource for Health South Africa (2011:31) indicate this is due to the lack of poor schooling opportunities for the health workers children and poor job opportunities for the spouse. Therefore it is not uncommon for the health worker to feel sense of social isolation resulting in the urge to leave the rural hospital.

It is the responsibility of the Department of Health to acknowledge and address these problems. Both Hiriappa (2010:152) and Aswathappa (2008:368) strongly believe if a person's basic needs are not satisfied, then those individuals will not be around long enough to attempt to satisfy the higher level of needs in Maslow's Hierarchy. Furthermore the Health Department needs to bear in mind the instant access to the intranet at most government hospitals and availability newspapers, provide the health professionals with a source to identify new job opportunities in urban region. This indicates it is just a matter of time before the health professionals' quest to leave the hospitals in rural disadvantaged areas is satisfied.

Research Methodology

This study research methodology utilized the quantitative research strategy. The target population and sample included 50 clinical staff from a rural public hospital in Kwa-Zulu Natal. The sampling strategy was based on the probability method particularly the stratified sampling strategy. The technique of the data collection was in the form of a written questionnaire. The type of validity applied as well as the reliability aspect was highlighted and discussed in this study. A descriptive statistic computer programme was used to assist to analyse the data obtained from this study. A pilot study was conducted to highlight

potential gaps with the question before it issued out to the actual sample. The limitation of this research was highlighted and with regards to the elimination of bias and ethical considerations aspects of this study, both were addressed adequately.

Research Philosophy

There are two common forms of research strategies which are qualitative and quantitative. Johnson and Christensen (2012:18) describe qualitative research as an explanatory research. It investigates the underlining views and trends in thought and opinions to better understand a problem on a deeper level. The method to conduct this type of study may include group discussions or individual interviews and observation. This sample is usually small. Whereas a quantitative research entails understand a problem by acquiring numerical information and transforming it into statistical data. In addition Krishnaswami and Ranganatham (2007:36) state this strategy is a fact finding investigation that focuses on a particular aspect of the problem. Unlike qualitative, quantitative make use of a large sample population. The most common method is usually in the form of surveys.

Target Population

Target population according to Goddard and Melville (2009:64) is defined as any group or collection of elements that is the focus of research interest. In this study the focus of interest in on the clinical staff at a rural public hospital that falls under the Uthukela District in Kwa-Zulu Natal. The target population comprised both of male and female individuals, however only full time working employees will be considered.

The target population are all clinical staff and comprises of:

- Medical officer;
- Dentist;
- Pharmacist;
- Allied Health Workers;
 - Radiographer;
 - Physiotherapist;
 - Physiotherapy assistant;
 - Dieticians;
 - Social Worker;

- 24 Nursing personnel's;
 - Professional nurses;
 - Staff nurses; and
 - Enrolled nursing assistants.

Limitations of the Study

The limitation of this study is as follows:

- The research was only conducted at one rural hospital in Kwa-Zulu Natal;
- The staff participating was only be clinical staff;
- The decision by clinical staff to choose not to part of the study; and
- The questionnaire is comprised of closed ended questions hence no room for additional opinions or thoughts on the research topic.

- **Ensuring Permission is obtained**

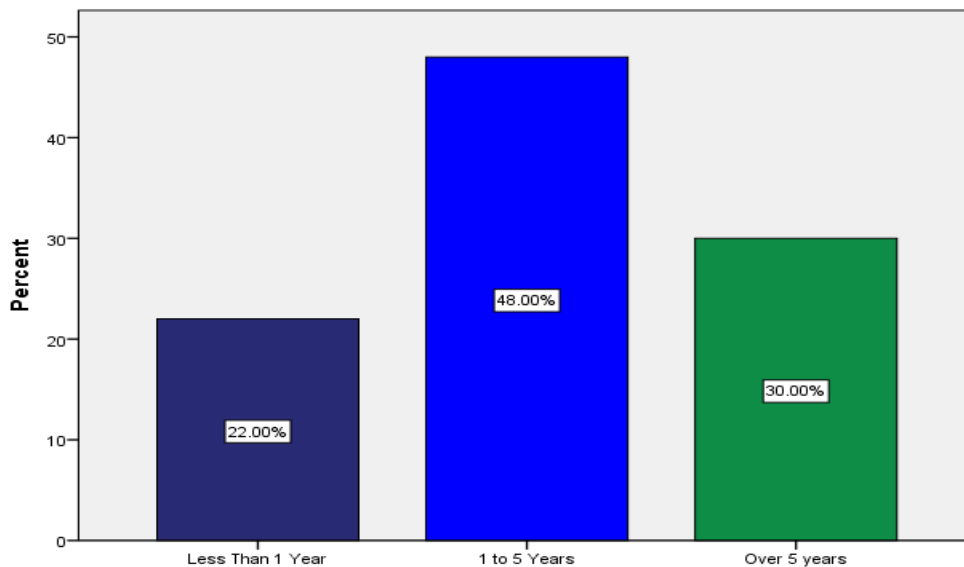
A letter of approval from the institution where the study was conducted was obtained (see Appendix C). Furthermore There was no mention of the name of the institution in this study hence anonymity was maintained.

Results, Discussion and Interpretation

In addition various inferential statistics was applied to establish the relationship between the different variables of this study. The results of the inferential statistic are discussed and an explanation will be provided.

Demographics and Geographic Factors

Figure 4.2.1: Length of employment



According to figure 4.2.1, 22% of the participants were employed for less than a year, 48% employed for 1 to 5 years and only 30% were employed for over 5 years at this rural health facility.

This clearly demonstrates the challenge experienced in retaining clinical staff because based on the results of figure 4.2.1 the percentage dropped by 18% from 48% employed between 1 and 5 years to 30% employed for over 5 years. One of the reasons that may have contributed to a high number of participants employed for 1 to 5 years may be as a result of contractual obligations such as community service placements which are compulsory for one year in line with the Kwa-Zulu Natal Human Resource Management Circular 87 of 2004.

Figure 4.2.2: Age

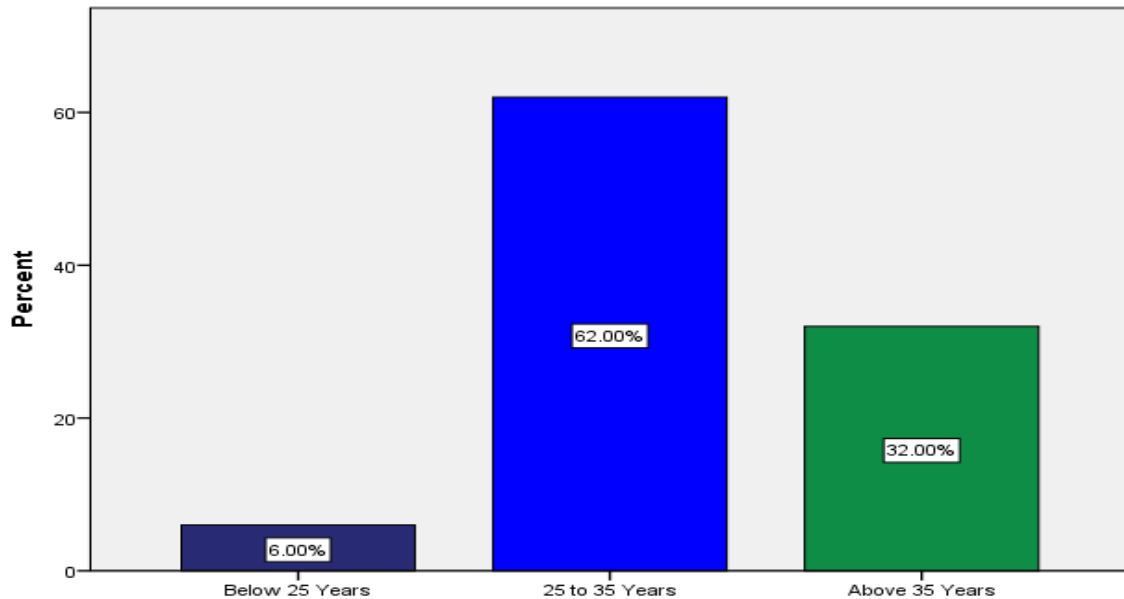
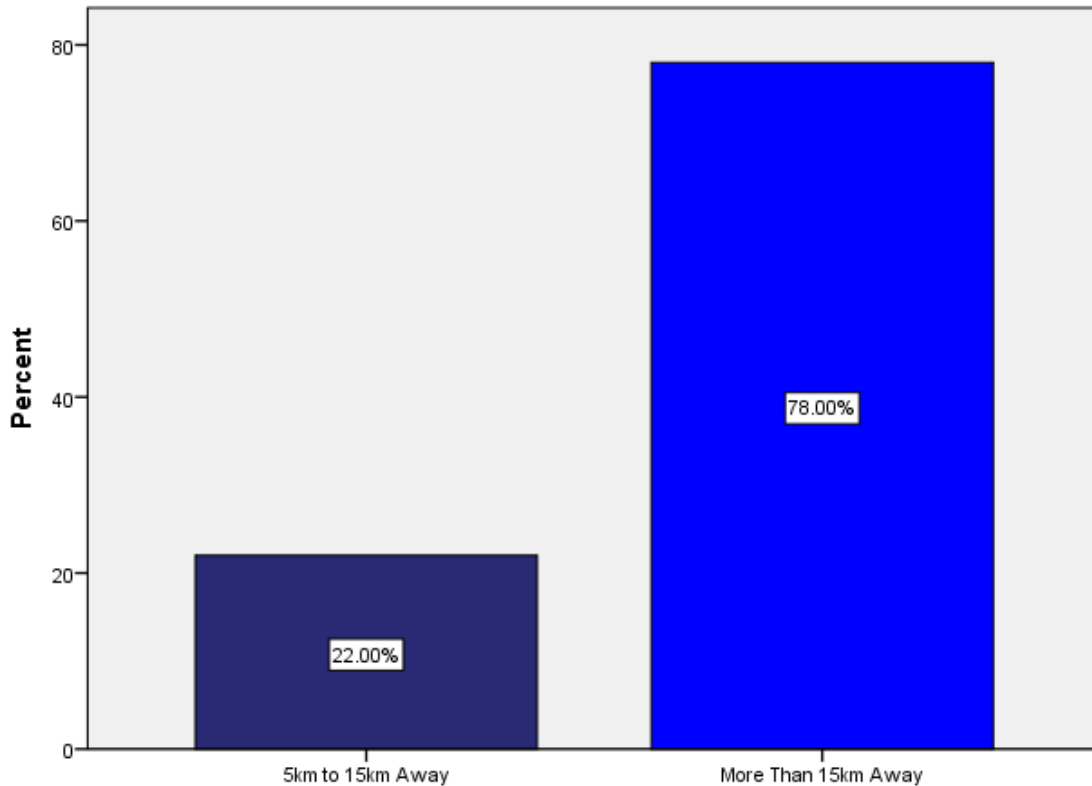


Figure 4.2.2 demonstrates the 6% of the clinical staff are below the age of 25 years, while 62 % are between 25 and 35 years and 32 % are over 35 years. Therefore it is clearly evident 68% of the staff is class as “young” health professionals.

This may pose as a problem because according to the World Health Organisation (2006:7), young health professionals crave the urban lifestyle hence the rural institution will face a huge challenge in trying to retain these individuals should they decide to seek employment out of this facility.

Figure 4.2.3: Distance to the Nearest Town



A high 78 % of the participants indicate the nearest town as being more than 15 km away whereas a mere 22% indicate the nearest town 5 to 15 km away as revealed in figure 4.2.3. The 78 % are in support of literature that indicates most rural facilities are a distance away from the most basic services such as access to banks, post office and grocery stores to name just a few hence the decision by most health professionals to migrate to urban based hospitals that provide the above services and lot more as cited by Dociu and Dunarintu (2012:50).

Figure 4.2.4: Distance from permanent residence to Institution

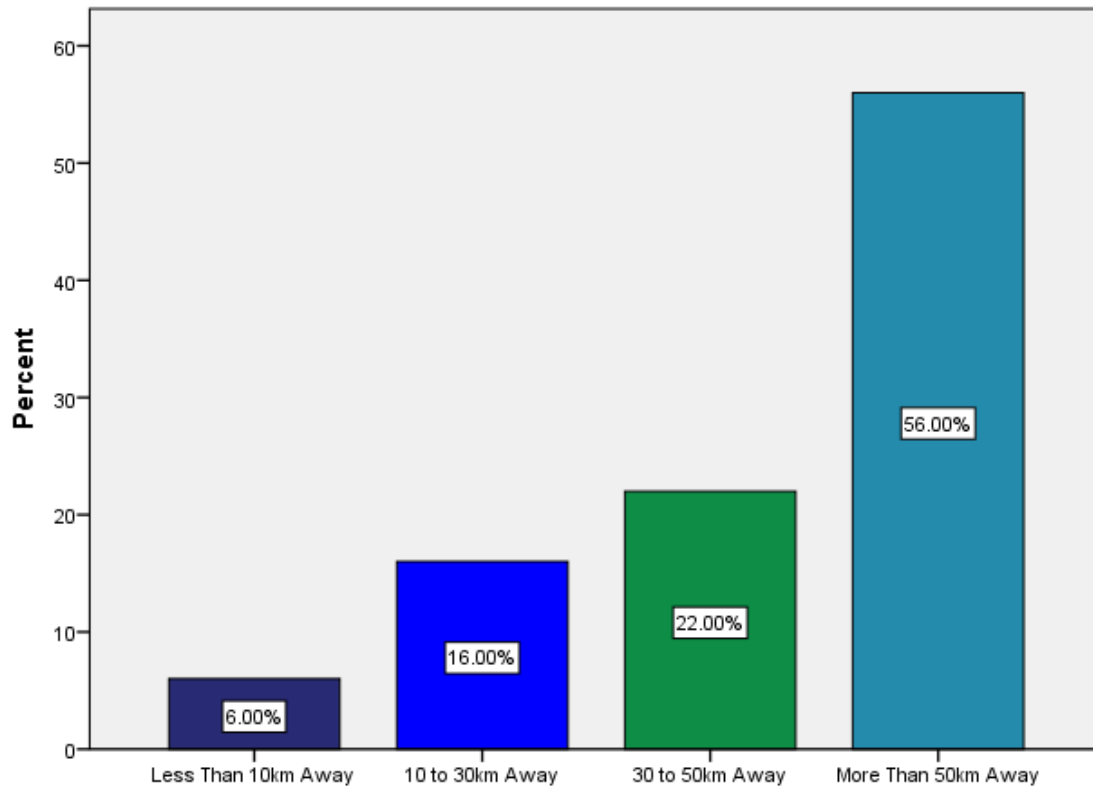
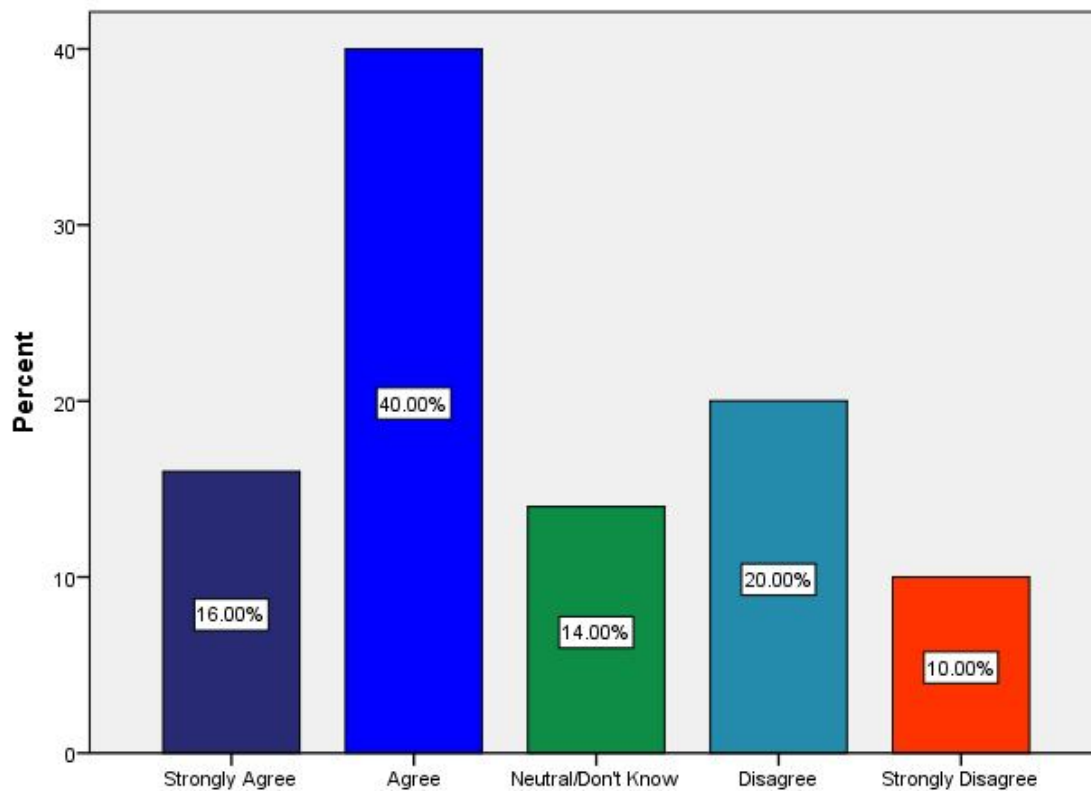


Figure 4.2.4 indicates, 6% of the clinical staff permanent residence is less than 10km away from the hospital, 16% is 10 to 30km away, 22% is 30 to 50km away and a high 56% permanent residence is more than 50km away from the hospital. The reason for such a large percentage of health professionals being so far away from their permanent residence could be as a result of the strategy used by the Department of Health to attract these health professionals to the rural facilities as outline in HEARD (2009:9).

Job Satisfaction

Figure 4.3.1: I am satisfied with my current job

The Department of Health is faced with a huge task to trying to retain its clinical staff at rural areas and based of literature the inability to retain staff could be a direct result of poor job satisfaction as cited by Robbin et al. (2009:83). However this is not supported by the data obtained in this study.

The results according to figure 4.3.1 it reveals that a total of 56% of clinical staff are satisfied with current jobs with 16% strongly agree and 40% agree. On the other hand 30% are not job satisfied with 20% disagree and 10% strongly disagree and 14% uncertain if satisfied or not. Despite the 56% percentage of job satisfaction is relatively high as compared to the job dissatisfaction, it is important to bear in mind that it indicates that approximately half the total population of clinical staff are job satisfied. When evaluating the organisation as whole 56% is not considered a very positive figure as it implies the other half of the organisation are dissatisfied.

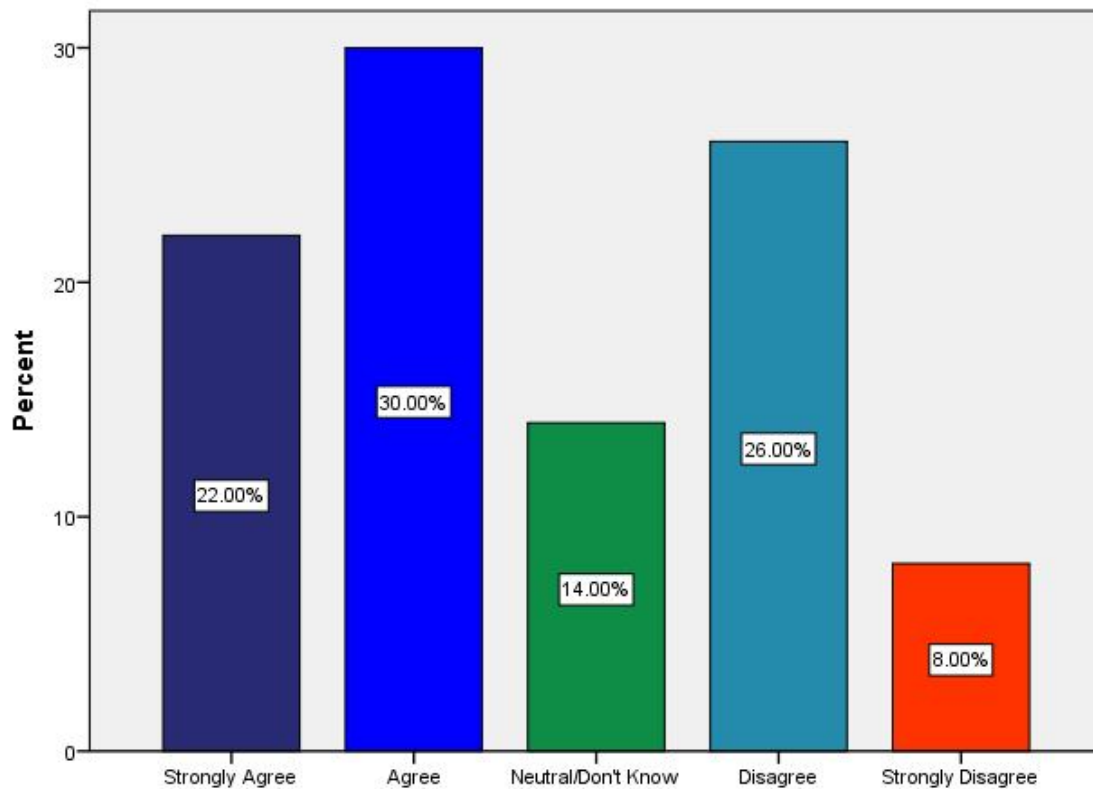
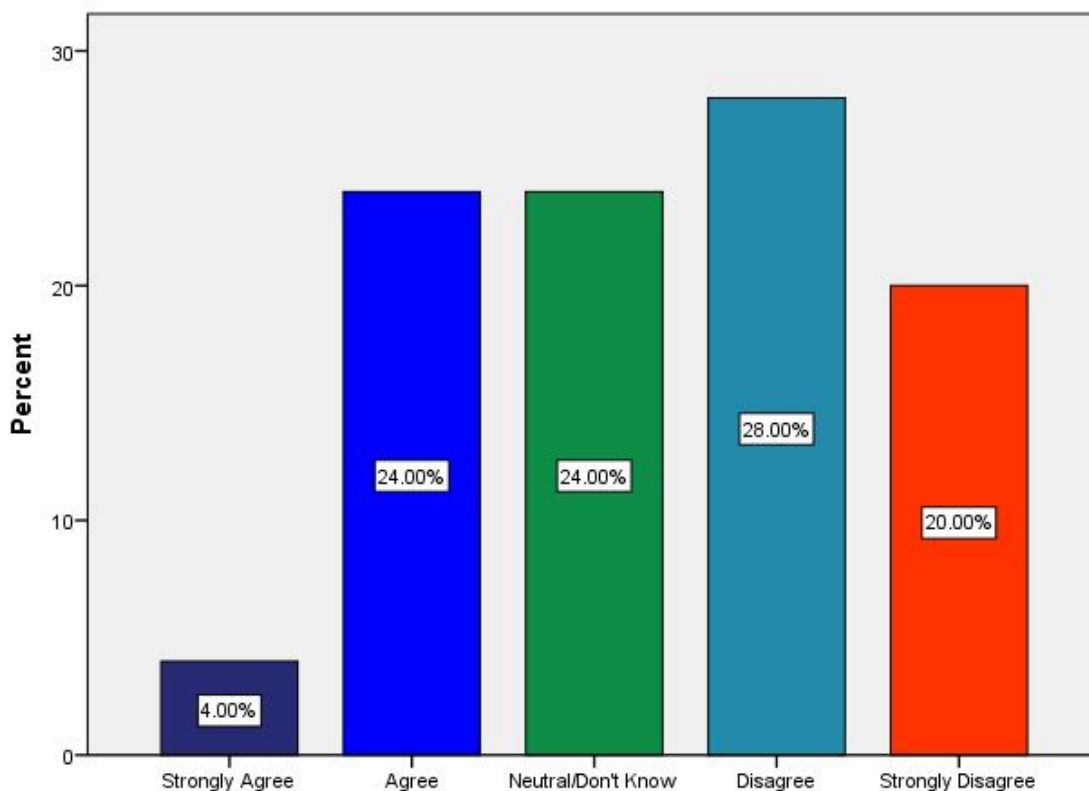
Figure 4.3.2: I am highly motivated to perform my job

Figure 4.3.2 revealed 52% are motivated to perform their jobs, with 22% strongly agree and 30% agree. Whereas 34% are not motivated, with 26% disagree and 8% strongly disagree and 14% remaining neutral. Hence it can be again said that half the total population of the clinical staff at the rural hospital are motivated.

Cole (2010:318) states staff motivation comes from the desire to perform ones job well and is strongly linked to job satisfaction. Both figure 4.3.1. and figure 4.3.2 indicated approximately half the total population of clinical staff are job satisfied and motivated respectively. This is a mere percentage hence the Department of Health needs to know the reasons as to why approximately half of its health professionals are job satisfied and motivated at rural hospitals.

Figure 4.3.3: I am satisfied with my current salary



The majority of 48% of the participants indicated as revealed in figure 4.3.3, as not satisfied with current salary. 28% disagree and 20% strongly disagree. Whereas 28% are satisfied with 4% strongly agree and 24% agree and 24% don't know.

Adequate salary payment as a means of compensation for a job performed is one the keys factors in attracting and retaining staff to an organisation according to Jensen, McMullen and Stark (2007:97). However Cole (2010:324) disagrees by arguing that money such as salary and benefits does not motivate employees at least not in the long run because salary basically aid to satisfy the physiological and safety needs according to Maslow Hierarchy of Needs as cited by Hirriyappa (2010:151). According to Figure 4.3.3, it could imply the basic needs of the health professionals are not being satisfied hence it could be a reason as to why the rural facilities are losing them.

Figure 4.3.4: I receive additional financial benefits such as OSD and rural

allowance

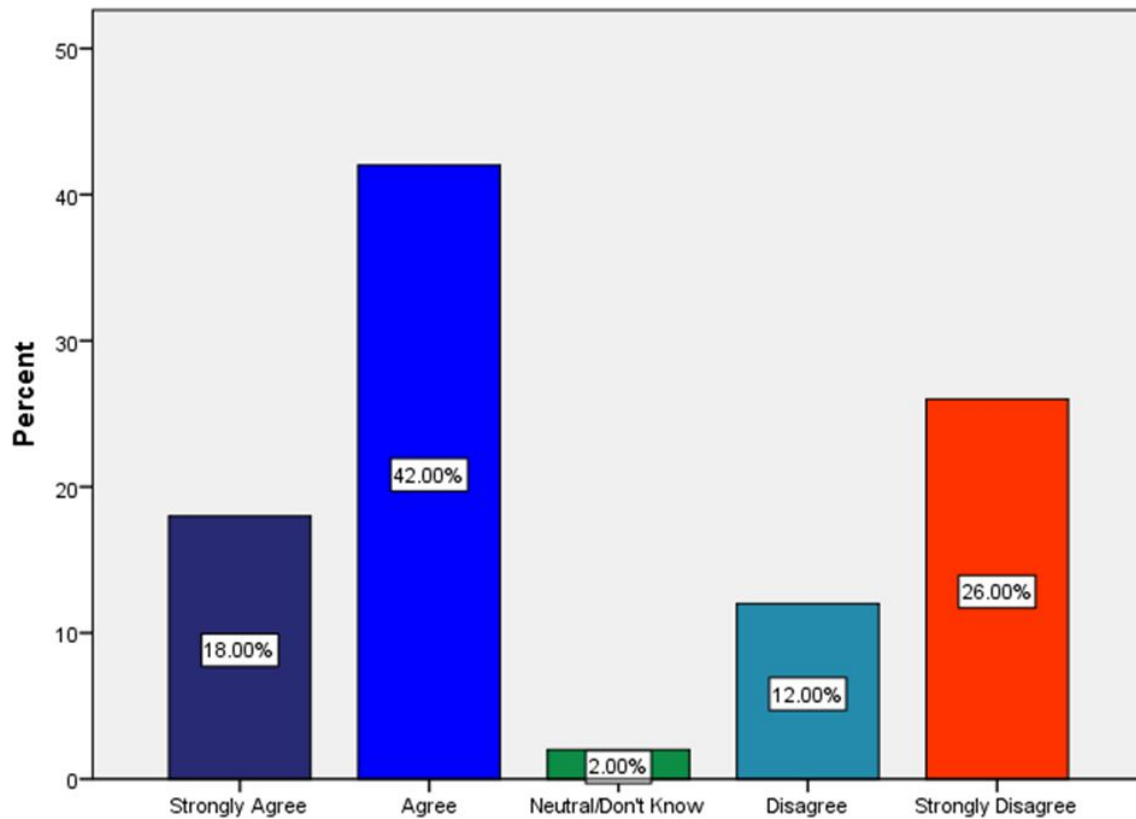


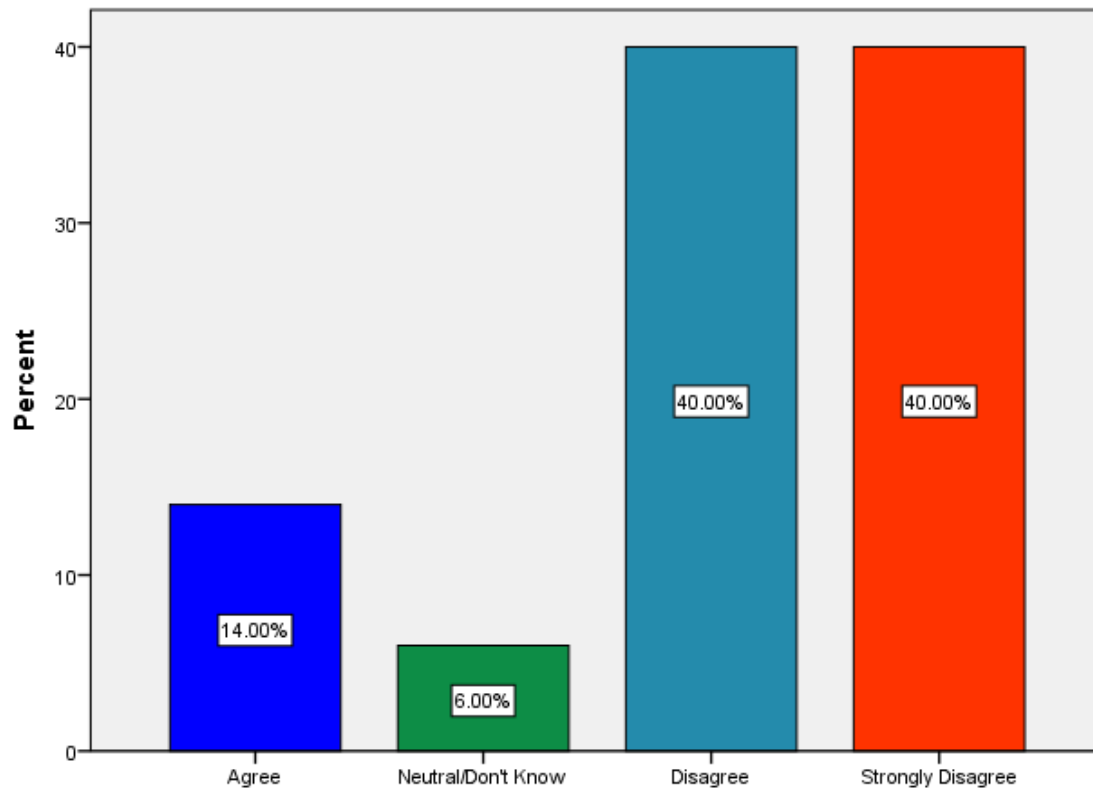
Figure 4.3.4 indicates 60% of the participants received additional financial benefits, with 18% strongly agree and 42% agree. Whereas 38% do not receive financial benefits with 12% disagree and 26% strongly disagree.

These results are indicative of the Department of Health strategy attract health professionals to government's hospitals in particular rural hospital through the payment of OSD, scarce skills and rural allowances (HEARD, 2009:8).

Furthermore the 38% who do not receive financial benefits can be accounted for the clinical staff that is not considered part of the specific categories who qualify for OSD and rural allowances as cited by Makaphela and Useh (2013:129).

Figure 4.3.5: There are career opportunities such as specializing and

promotions



According to Kotzee and Couper (2006:581), one of the key reasons for doctors wanting to leave rural facilities is due to the lack of career opportunities. Clinical staffs tend to migrate to urban health facilities to achieve this academic growth.

If this literature is anything to go by, then the Department of Health could be faced with a huge crisis because the results as indicated by figure 4.3.5 show only 14% of the participants believe there are career opportunities and promotions, 6% are neutral and a high 40% disagree and another 40% strongly disagree. This could be one of the reasons as to why the Department of Health is experiencing challenges to retain its clinical staff at rural facilities.

Figure 4.3.6: There are sufficient training and development opportunities

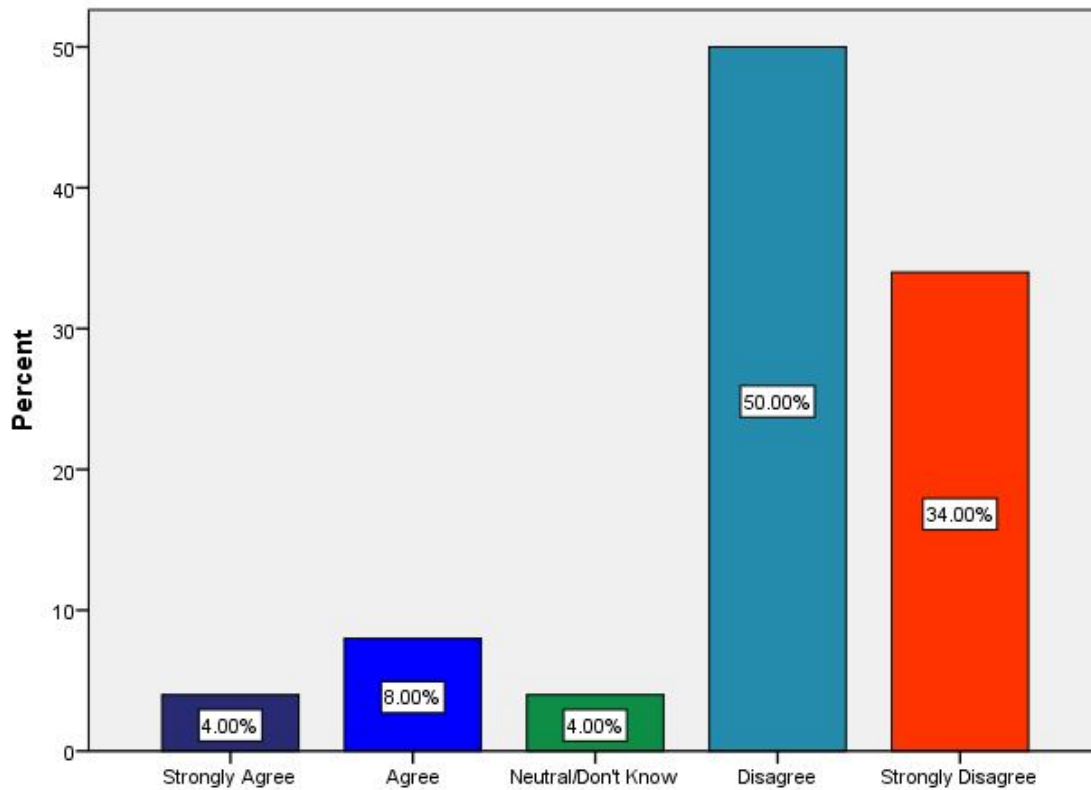
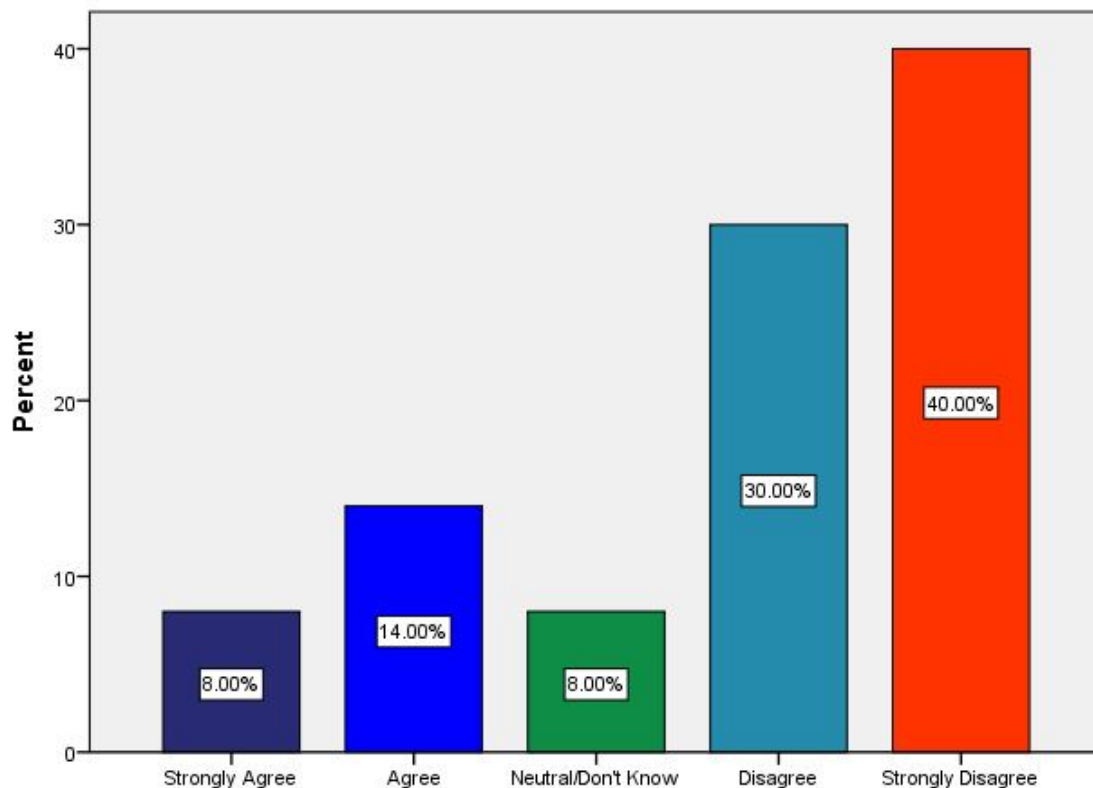


Figure 4.3.6 shows 84% of the participants indicate there are no sufficient training and development opportunities at the rural facilities where the study was conducted. 34% strongly disagree and 50% disagree whereas only 4% strongly agree and 8% agree, with 4% remaining neutral.

This is a huge cause for concern because as Kaila (2012:337) believes if an employee feels a sense of career stagnancy then that employee will have the urge to leave the current organisation. Therefore it can be said this may be one of the contributing factors leading to poor retention of health professionals at rural hospital

Figure 4.3.7: I have been trained and developed within the last year in my current job position



A total of 70% of the participants indicate they were not trained or developed within the last year as shown in figure 4.3.7, with 30% disagree and 40% strongly disagree. However 8% strongly agree and 14% agree, with only 8% being neutral.

The 70% percentage of clinical staff not trained or developed within the last year will have a negative impact on the rural facility because training is often considered as a return on investment for any organisation as training encourages employees to perform better and more efficiently according to Jensen et al. (2007:21). This is a strategy the Department of Health should consider to adopt.

Figure 4.3.8: There are sufficient resources such as equipment and medical supplies to do my job

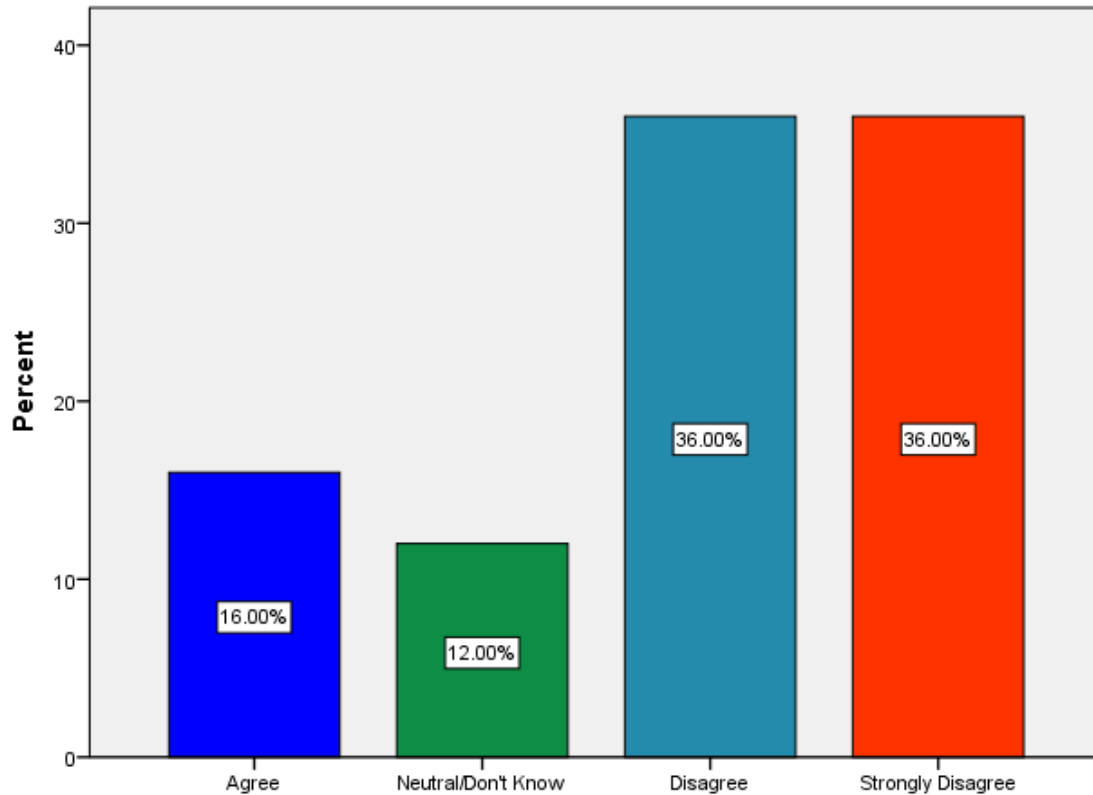
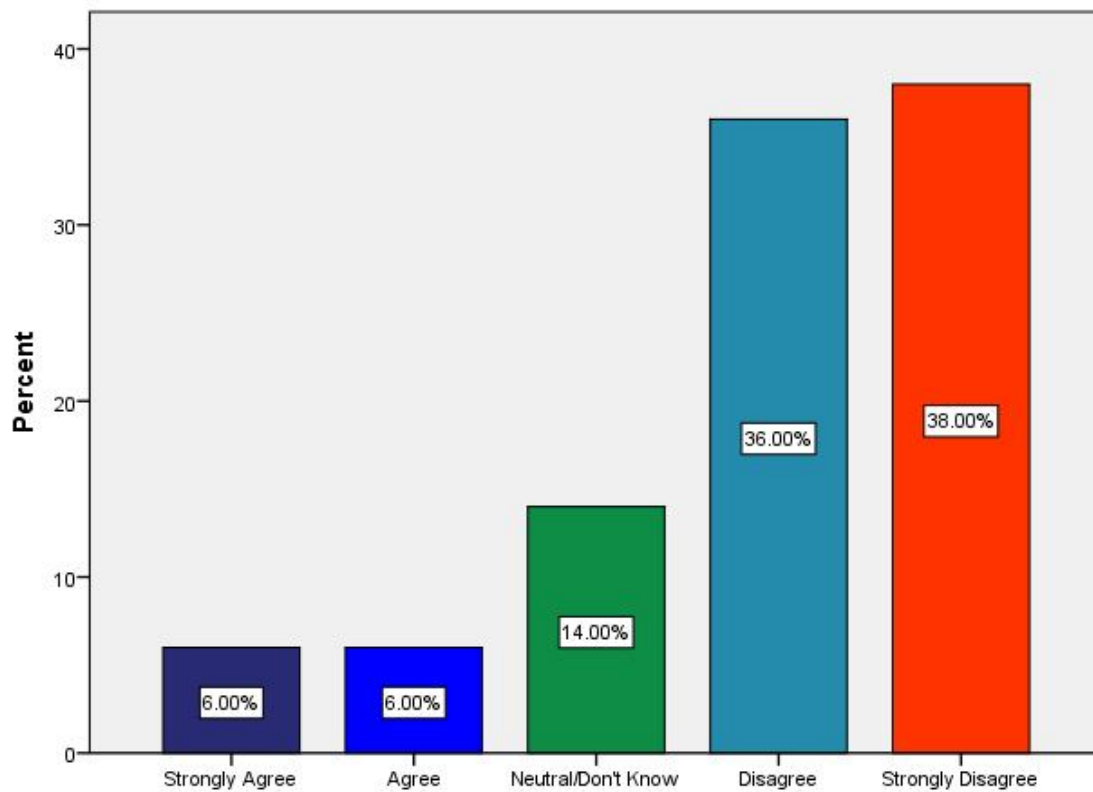


Figure 4.3.8 show that a majority do not believe there is sufficient equipment and medical supplies to perform ones job. The results reveal 36% disagree and 36% strongly disagree to the statement regarding availability of resources in the questionnaire. However, only 16% agree and 0% strongly agrees along with 12% remaining neutral to the above statement.

The above results are supported by literature that highlights the challenges surrounding the insufficiency of medical supplies to disadvantaged and rural health facilities. (Makaphela and Useh, 2013:129; Mathauer and Imhoff, 2006:42).

Figure 4.3.9: I often get recognised and appreciated for work that I have done

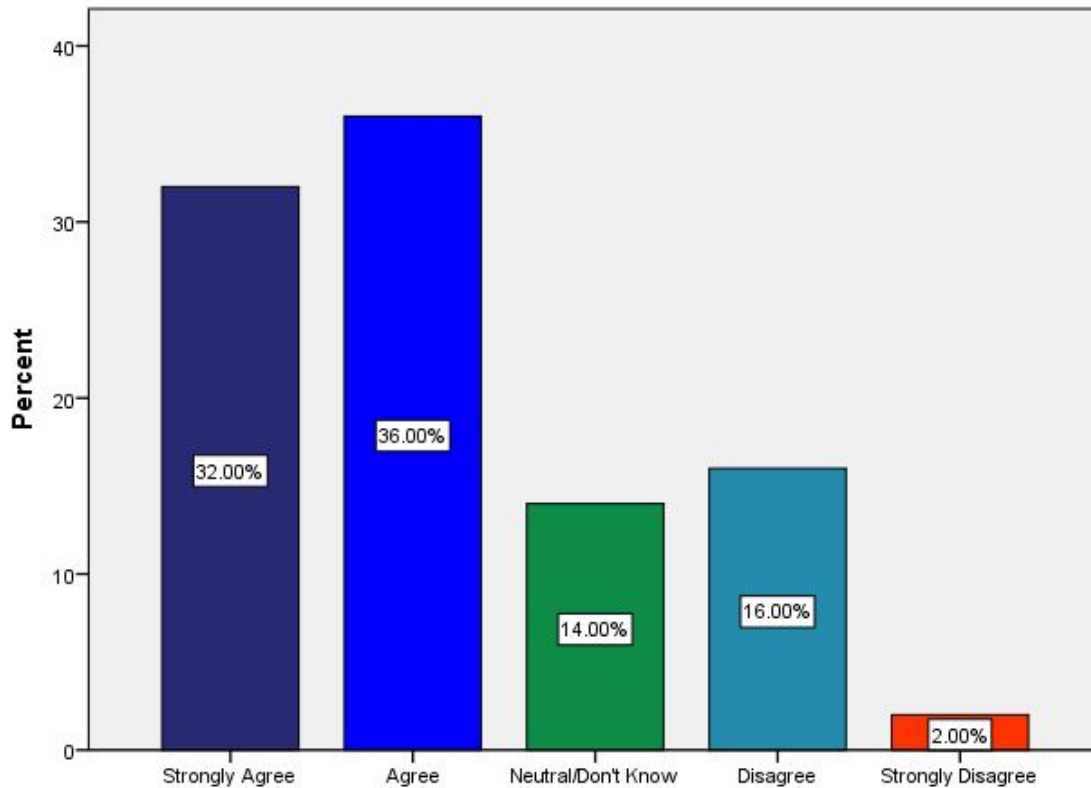


A total of 74% of participants as illustrated in figure 4.3.9 indicate not getting recognised and appreciated for work done. 36% disagree and 38% strongly disagree with the question regarding recognition and appreciation. However 6% agree and 6% strongly agree with 14% remaining neutral. Jensen et al (2007:215) considers recognition as one of the motivational powers of non-monetary rewards to employees.

Although the literature supports the recognition and appreciation strategy, however the Department of Health in particularly rural institutions have not adopted and implemented this strategy and this is clearly evident based on the results depicted in figure 4.3.9.

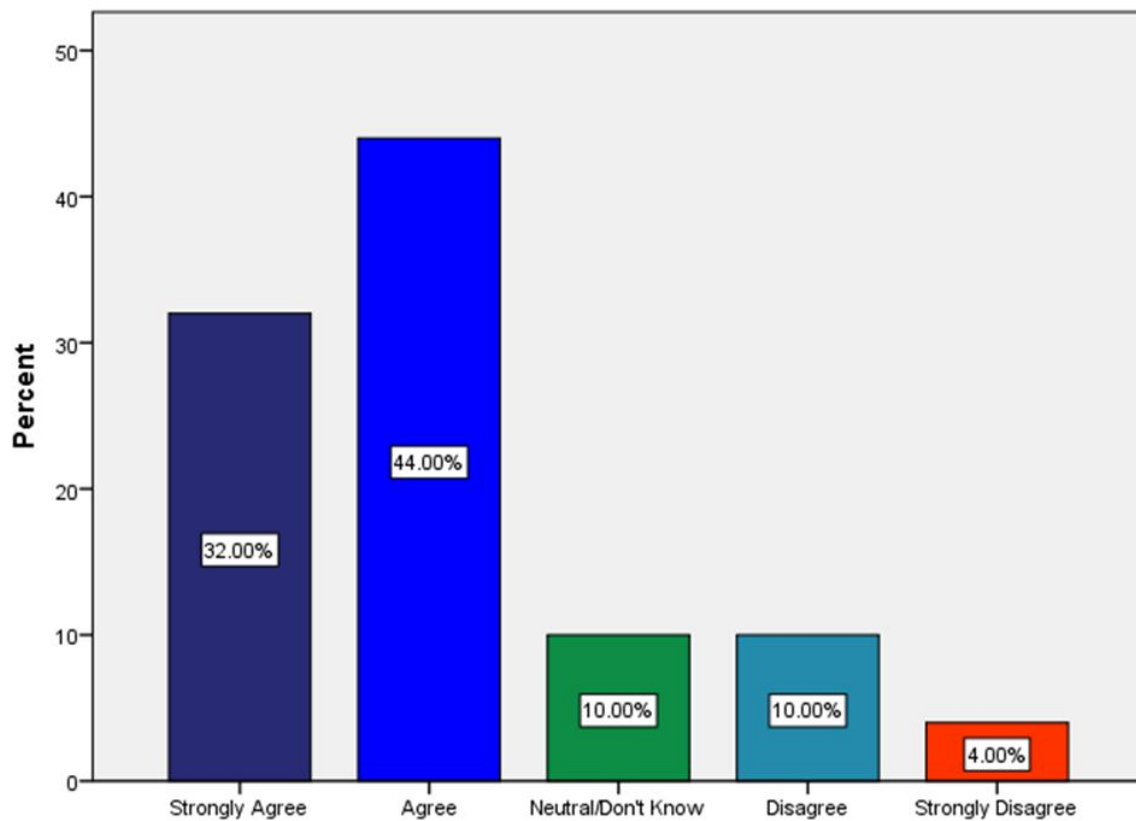
Intention to leave rural facility

Figure 4.4.1: I often consider leaving my current job



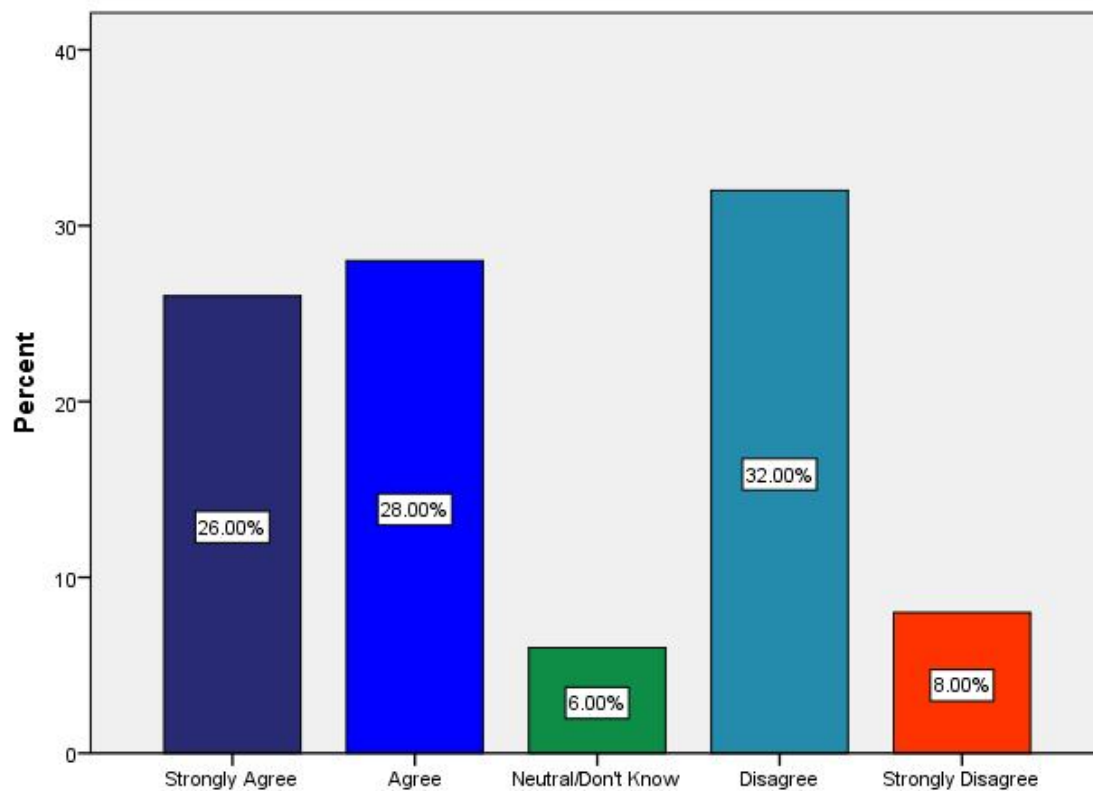
Based on the question of I often consider leaving my current job 68% indicated that they do according to figure 4.4.1. 32% strongly agree and 36% agree, however 16% disagree and 2% strongly disagree leaving 14% remaining neutral with regards to the question posed. Figure 4.4.1 demonstrates the evidence that the Department of Health is experiencing in the retention of clinical staff at hospitals in rural and disadvantaged areas.

Figure 4.4.2: I often look at newspapers, intranet, and internet for new jobs



Along with the intention to leave the rural health facility comes along the actual extent to which the participants are seeking employment out of their current working environment. Figure 4.4.2 shows a large percentage are seeking employment through mediums such as newspapers, intranet and internet with 32% and 44% strongly agree and agree respectively with regards to the question posed and 4% strongly disagree and 10% disagree with the final 10% remaining neutral.

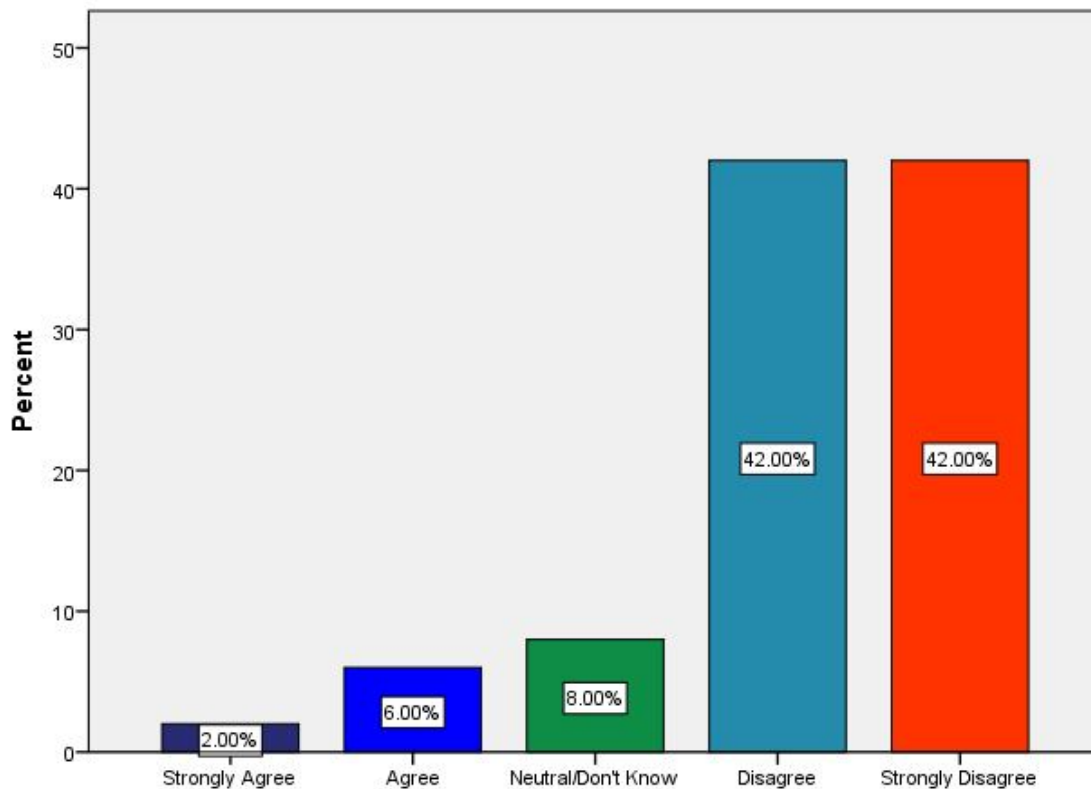
The results shown in figure 4.4.2 the intention to leave the rural hospital is present while the process to leave has already been initialised.

Figure 4.4.3: Only family responsibilities prevent me from leaving

Based on literature it is not uncommon for an individual to remain in a certain job purely due to family responsibilities. According to Hirriyappa (2010: 151) family responsibilities are considered as physiological factors in Maslow's Hierarchy of needs. Aswathappa (2008: 265) emphasises that basic needs need to be fulfilled prior to escalating to the next level in Maslow's Hierarchy. Therefore, the reason for participants to remain in their job due to family responsibility is understood.

Figure 4.4.3 supports the above literature as the results show that a total of 52% indicates that only family responsibility prevents the participants from leaving the rural institution. 28% agree while 26% strongly agree; however, 32% disagree and 8% strongly disagree while 6% remain neutral.

Figure 4.4.4: It is easy to relocate my family to rural areas



One of the key reasons health professionals leave rural facilities is due to the lack of schooling opportunities for the health professionals' children and job opportunities for the spouses as cited in Human Resource for Health South Africa (2011:31).

Therefore it comes as no surprised when figure 4.4.4 show a total of 84% indicating it is not easy to relocate ones family to rural areas with 42% both indicating a disagree and strongly disagree emotion to the above statement. Only 2% strongly agree and 6% agree, leaving an 8% remaining neutral.

Figure 4.4.5: There are sufficient basic necessities such as suitable housing with running water and electricity in this environment

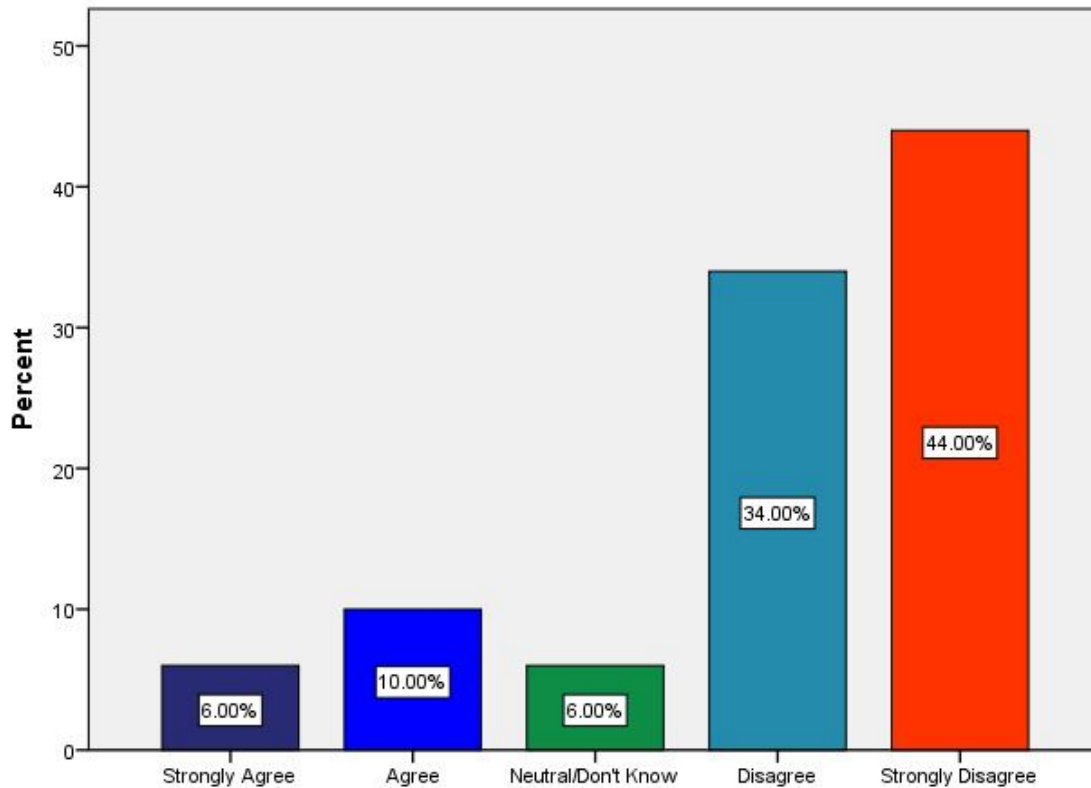
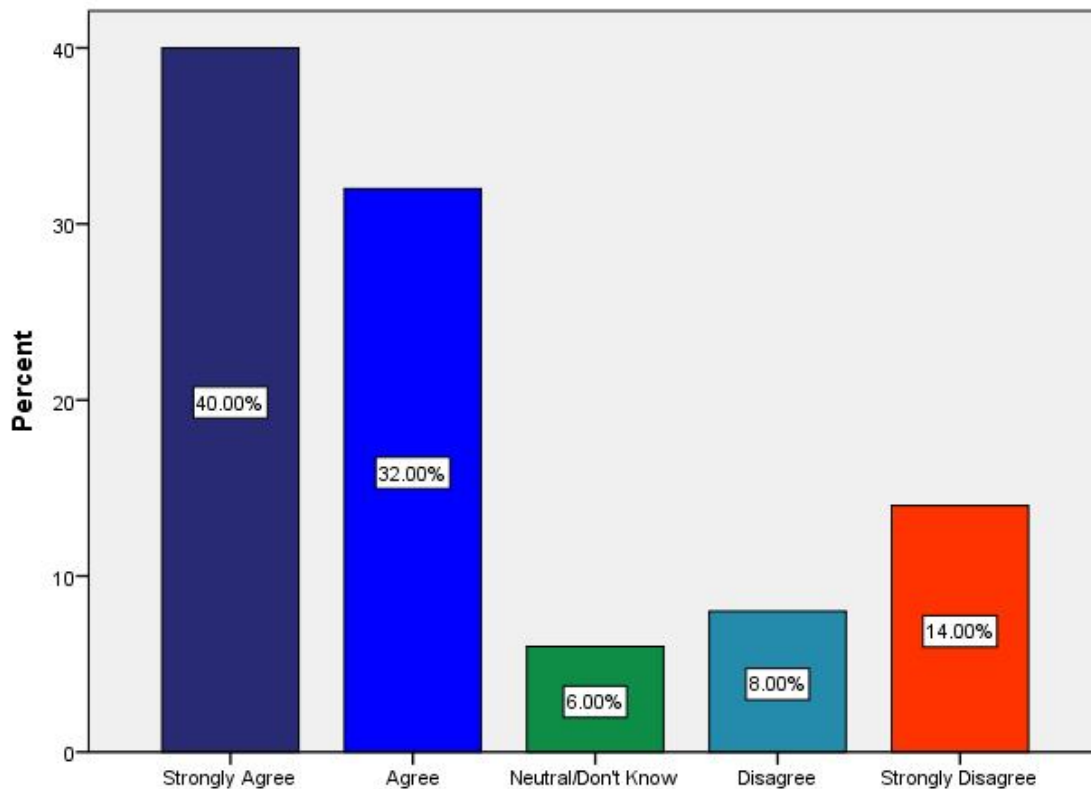


Figure 4.4.5 illustrates a total of 78% indicating there are insufficient basic necessities in rural environment with 34% and 44% disagree and strongly disagree respectively. Only 6% strongly agree and 10% agree, leaving 6% remaining neutral with regards to the question posed.

The results from the above graph are in line with the data from Statistics South Africa (2012) that cities, there is a higher proportion of households in rural South Africa with no access to clean water and toilet facilities in rural areas. Furthermore the results shown in figure 4.4.5 are from a rural hospital within the Uthukela District correspond to the results obtained in the Okhahlamba Local Municipality Annual Report 2012-2013, that states 28.7% of households in the Uthukela District has no access to piped water within dwelling hence highlighting the severity of this situation.

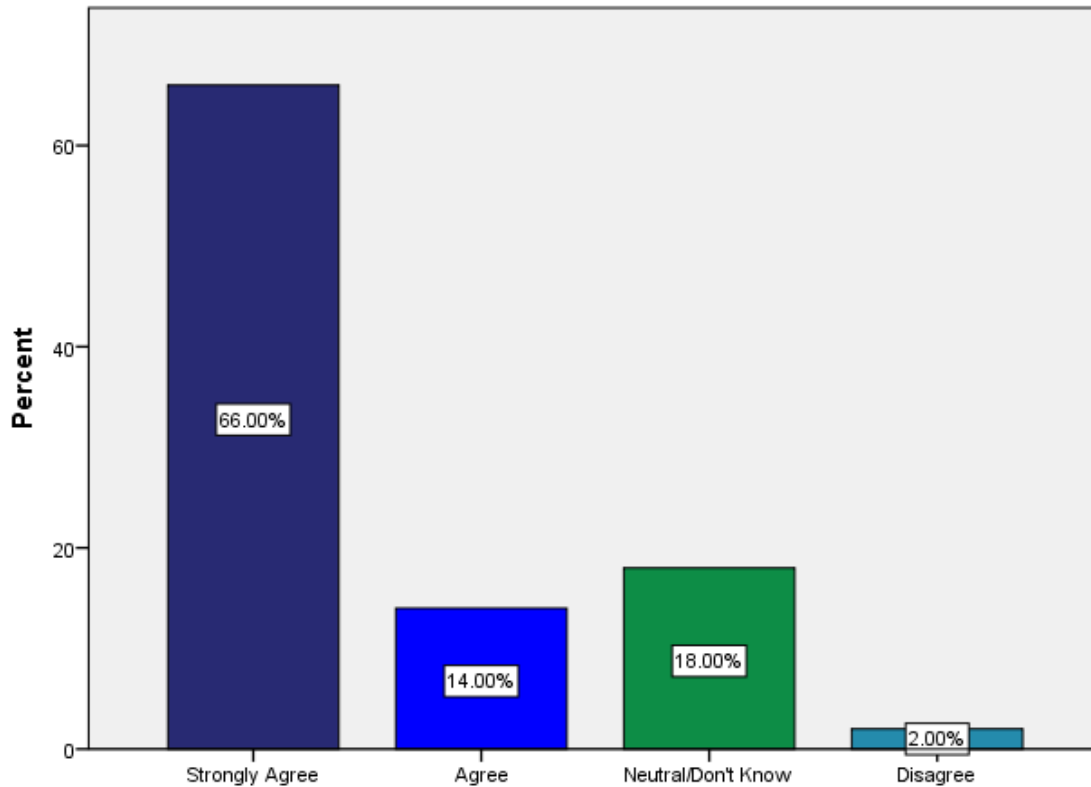
Figure 4.4.6: Transport from home to work is a challenge



According to literature one of the contributing factors as to why health professionals intend to leave rural hospitals is due to the lack of adequate transport as cited by Kotzee and Couper (2006: 581). Furthermore Lagarde and Blaauw (2013:10) state there is a scarce transport to cover large distances in particularly rural areas.

The results as illustrated in figure 4.4.6 can support the statement made because the above figure indicated a large 74% believe that transport from home to work is a challenge with 40% and 32% strongly agree and agree respectively, while 8% disagree and 14% strongly disagree leaving 6% remaining neutral.

Figure 4.4.7: I will definitely leave this hospital within the next three years



If the results illustrated in figure 4.4.7 are anything to go by then the Department of Health is going to have a huge crisis at rural facility because the above figure indicates 80% of the participants aim to leave the rural facility within the next three years with 66% strongly agree, 14% agree, 18% remaining neutral and a small 2% disagree only.

The results in figure 4.4.7 is evidence the problem to retain clinical staff at rural hospitals is still a huge problem that requires addressing by the Department of Health in order for it to deliver on its strategic goals as outlined in Kwa-Zulu Natal Strategic Plan 2010- 2014.

Inferential Statistics

Inferential statistics is a body of methods used to draw conclusions or inferences about characteristics of population based on the sample data as cited by Keller (2009:19).

The inferential statistics for this study included:

- *Single sample Chi-Square Analysis* that is used to determine the relationship between two nominal values or are they independent of each other;
- *Correlation Analysis* used to determine the nature, direction, strength and significance of the relationship between two variables; and
- *One-way ANOVA Analysis* use to indicate whether or not there is a significant mean difference in a dependent variable between two or more groups.

Single Sample Chi-Square Analysis

A series of Single Sample Chi-Square analyses were conducted to determine if there were significant differences between the responses of the participants' across the categories that were assessed in each of the particular questions within the Section B: Job Satisfaction and Section C: Intention to Leave portion of the questionnaire. In conducting the Chi-Square tests, response categories devoid of any responses were omitted from the analysis.

The results for each of the Single Sample Chi-Square tests are presented below in Table 4.5.1. For each question that was examined, the null hypothesis tested was that there would not be a significant difference between the response frequencies across each of the categories. A *p*-value below 0.05 denotes a rejection of the null hypothesis and a significantly greater number of responses across one or more categories as compared to the others. Except for the Section B: Job Satisfaction questions 2 and 3, which did not evidence statistically significant differences between the frequencies of the responses per question category, the remaining questions were significantly different in the response frequencies for each category within each question.

In an attempt to sum up the reasons as to why there was such a difference in response to the questions from the participants, it can be said that the following factors contributed to the differences in response. The first factor is a variety of clinical staff was selected to participate. It included doctors, nurses, dentists, pharmacists and allied health worker. All of who responded to each question according to their own specific jobs performed and not as clinical staff collectively.

The second factor is the participants' ages extended from below 25 to above 35 years old. Hence a difference in opinions based on years of experience could have contributed to this aspect.

The third factor to bear in mind is the clinical staff who participated in this study is from areas surrounding the hospital as well as from places afar. Some of the responses could be due to exposure from other influences from surrounding areas where the participants came from and based on previous work environments. Hence the outlook of many questions is seen differently and not from one homogeneous view only.

Table 4.5.1: Chi-Square Results for Job Satisfaction and Intention to Leave

Table 4.5.1			
Chi-Square Results for Job Satisfaction and Intention to Leave Items			
Variable	Statistics		
	χ^2	<i>df</i>	<i>p</i>
Job Satisfaction			
Question 1	13.800	4	.008
Question 2	8.000	4	.092
Question 3	8.800	4	.066
Question 4	22.800	4	< .001
Question 5	18.640	4	< .001
Question 6	43.800	4	< .001
Question 7	20.600	4	< .001
Question 8	9.840	3	.020
Question 9	25.200	4	< .001
Intention to Leave			
Question 1	19.400	4	.001
Question 2	29.400	4	< .001
Question 3	14.600	4	.006
Question 4	40.800	4	< .001
Question 5	31.600	4	< .001
Question 6	23.000	4	< .001
Question 7	47.600	3	< .001

Correlation Analysis

The following variables were generated and were used to calculate the subsequent Pearson correlations. A variable, *Job Satisfaction*, was created from combining the Section B: Job Satisfaction questions 1 to 9. The *Intentions to Leave* variable was developed from

summing the Section C: Intentions to Leave questions 1 to 7. Prior to computing the Intention to leave variable, Section B: Intention to leave question 5 was reverse scored to coincide with the directional trend of the questions in the section.

The Pearson correlation between *Job Satisfaction* ($M = 22.68$, $SD = 5.41$) and *Intention to Leave* ($M = 25.06$, $SD = 3.22$) was negative and statistically significant, $r = -.426$, $p = .002$. This indicates that job satisfaction has a strong negative relationship with intentions to leave. In other words, higher levels of job satisfaction are associated with lower intention to leave and greater intention to leave is associated with lower job satisfaction.

Job satisfaction is a crucial element that needs to be established in any organization should that organization wish to grow positively. Robbin et al. (2009:83) points out a strong link exists between job satisfaction and staff turnover where increase job satisfaction decreases staff turnover and vice versa. This literature clearly adds support to the Pearson correlation between job satisfaction and intention to leave.

Therefore it is imperative the Department of Health address the issue of maintaining job satisfaction among its employees adequately. If this should not occur then the Health system stands a huge chance of losing health professionals at rural facilities. This in turn will result in the strategic plan outlined in Kwa-Zulu Natal Strategic Plan 2010 -2014 being negatively compromised.

One-way ANOVA for Length of Employment and Intention to Leave

A one-way ANOVA was calculated with length of employment as the grouping variable and intention to leave as the dependent variable. The result indicated a non-statistically significant difference between the intentions to leave of participants working:

- Less than 1 year ($N = 11$, $M = 24.18$, $SD = 3.34$);
- 1 to 5 years ($N = 24$, $M = 24.83$, $SD = 3.19$); and
- Over 5 years ($N = 15$, $M = 26.07$, $SD = 3.15$).

$F_{(2, 47)} = 1.210$, $p = .307$. This indicates that intentions to leave do not differ based on the participants' length of employment.

This indicates that the participants' length of employment has not directly contributed to the clinical staff decision to leave. This results forces one to evaluate other dimensions of the problem of not retaining staff at rural hospitals such as the working and surrounding environment of the employees. The reason being, it can be said there is a change in the environment has led to the health professionals seeking employment out of the rural facilities irrespective of the length of period worked because this change affects both new and old employees alike.

This change will result in the rural facility losing both fresh innovative ideas from acquired from new employees and vital work experience from the old employees hence negatively affecting the quality of care administered.

One-way ANOVA for Age and Intention to Leave

A one-way ANOVA was calculated with age as the grouping variable and intention to leave as the dependent variable. The result indicated a non-statistically significant difference in the intention to leave of participants:

- Below 25 years ($N = 3$, $M = 23.67$, $SD = 2.08$);
- 25 to 35 years ($N = 31$, $M = 25.23$, $SD = 3.31$); and
- Above 35 years ($N = 16$, $M = 25.00$, $SD = 3.31$).

$F_{(2, 47)} = .315$, $p = .731$. This indicates that intentions to leave do not differ based on the participants' age.

The above results contradict the statement made by the World Health Organization. It is believed that specifically young single health professionals have the urge to leave rural areas for the city because it satisfies the urban lifestyle that these professionals have accustomed to while perusing their studies as cited by the WHO (2006:7).

The findings of this study is of grave concern, because it indicates that the inability to retain clinical staff is not strictly limited to the younger work force but extends to all health professionals irrespective of age and is highlighted in Section C: Intentions to leave, showed that 80 % of the participants will definitely leave within the next 3 years.

Independent Samples T-test for Distance to the Nearest Town and Intention to Leave

An independent samples *t*-test was calculated with distance to the nearest town as the grouping variable (only two groups of respondents existed) and intention to leave as the dependent variable. The result indicated a non-statistically significant difference between the intentions to leave of participants living:

- to 15km away ($N = 11$, $M = 26.45$, $SD = 3.36$); and
- More than 15km away ($N = 39$, $M = 24.67$, $SD = 3.11$).

$T_{(48)} = 1.654$, $p = .105$. This indicates that intentions to leave appear not to differ based on the distance the participants' have to the nearest town.

This finding rules out the issue of the geographic location of the hospital. If the intention to leave was not based on the distance to the nearest town then one needs to place focus on the job satisfaction as well as the working and living environment of the staff.

One-way ANOVA for Distance from Permanent Residence to Institution and Intention to Leave

A one-way ANOVA was calculated with distance from residence to institutions as the grouping variable and intention to leave as the dependent variable. The result indicated a non-statistically significant difference between the intentions to leave of participants residing:

- Less than 10km away ($N = 3$, $M = 23.67$, $SD = 5.03$);
- 10 to 30km away ($N = 8$, $M = 26.25$, $SD = 3.92$);
- 30 to 50km away ($N = 11$, $M = 23.64$, $SD = 2.20$);and
- More than 50km away ($N = 28$, $M = 25.43$, $SD = 3.10$).

$F_{(3, 46)} = 1.424$, $p = .248$. This indicates that intentions to leave do not differ based on the participants' distance from their residences to the institution.

These findings are in line with the above statement made with regards to the focus being on the working and living environment of the participants' because the distance from permanent residence to institution had little impact on the choice of the clinical staff to leave yet this trend is continuing steadily.

One-way ANOVA for Length of Employment and Job Satisfaction

A one-way ANOVA was calculated with length of employment as the grouping variable and job satisfaction as the dependent variable. The result indicated a non-statistically significant difference between the jobs satisfactions of participants employed for:

- less than 1 year ($N = 11$, $M = 23.55$, $SD = 4.87$);
- 1 to 5 years ($N = 24$, $M = 22.67$, $SD = 5.82$); and
- Over 5 years ($N = 15$, $M = 22.07$, $SD = 5.36$).

$F_{(2, 47)} = .230$, $p = .795$. This indicates that job satisfaction does not differ based on the participants' length of employment.

There are various factors that contribute to job satisfaction. The above results however indicate that the length of employment is clearly not one of them. When looking at literature there seem as those nothing does support this factor hence it can be conclude that the above results are relatively accurate.

One-way ANOVA for Age and Job Satisfaction

A one-way ANOVA was calculated with age as the grouping variable and job satisfaction as the dependent variable. The result indicated a statistically significant difference in the job satisfaction of participants:

- Below 25 years ($N = 3$, $M = 29.00$, $SD = 6.08$);
- 25 to 35 years ($N = 31$, $M = 21.32$, $SD = 4.70$); and
- Above 35 years ($N = 16$, $M = 24.13$, $SD = 5.69$).

$F_{(2, 47)} = 4.044$, $p = .024$. This indicates that job satisfaction differs based on the participants' age. In order to determine which groups were significantly different from one another, Tukey's post-hoc tests were computed.

The results indicated that the job satisfaction of those below 25 years was significantly greater than those between 25 to 35 years of age ($p = .043$). The job satisfaction of the 25 to 35 years age group was not significantly different from the above 35 years age group ($p = .186$).

The reason as to why the individuals below 25 years are demonstrating significantly greater job satisfaction can be attributed to the enthusiasm experienced in entering the workplace by these young individuals. Whereas the job satisfaction for individuals 25 to 35 year of age and above 35 years of age was not significantly difference because these age groups have already started building up years of experience in the job and are relatively over the stage of excitement to enter the workforce unlike the below 25 years of age who are still enjoying this first time experience of working.

Independent Samples T-test for Distance to the Nearest Town and Job Satisfaction

An independent samples *t*-test was calculated with distance to the nearest town as the grouping variable (only two groups of respondents existed) and job satisfaction as the dependent variable. The result indicated a non-statistically significant difference between the job satisfactions of participants living:

- 15km away ($N = 11$, $M = 21.45$, $SD = 6.28$); and
- More than 15km away ($N = 39$, $M = 23.03$, $SD = 5.17$).

$T_{(48)} = -.849$, $p = .400$. This indicates that job satisfaction appears not to differ based on the distance the participants' have to the nearest town.

There are various factors that contribute to job satisfaction and based on this study the distance on the nearest town is clearly not one of them. This is however surprising because health worker tend to leave rural for urban areas as the city life satisfies this lifestyle most health professionals seek according to WHO (2006:7). So by having a town close to the rural health facility is a small attempt to satisfy what these individuals crave. However based on this result it seems the distance of the nearest town has no great impact or influence on the health worker in question.

One-way ANOVA for Distance from Permanent Residence to Institution and Job Satisfaction

A one-way ANOVA was calculated with distance from residence to institution as the grouping variable and job satisfaction as the dependent variable. The result indicated a statistically significant difference between the job satisfactions of participants residing:

- Less than 10km away ($N = 3$, $M = 29.00$, $SD = 1.73$);
- 10 to 30km away ($N = 8$, $M = 16.25$, $SD = 3.81$);

- 30 to 50km away ($N = 11$, $M = 24.27$, $SD = 5.37$); and
- More than 50km away ($N = 28$, $M = 23.21$, $SD = 4.52$).

$F_{(3, 46)} = 7.882$, $p < .001$. This indicates that job satisfaction appears to differ based on the participants' distance from their residences to the institution. In order to determine which groups were significantly different from one another, Tukey's post-hoc tests were computed.

The results indicated that the job satisfaction of those less than 10km away was significantly greater than those 10 to 30km away ($p = .001$), the job satisfaction of those 10 to 30km away was significantly lower than those residing 30 to 50km away ($p = .002$) and those residing more than 50km away ($p = .002$). The job satisfaction of those less than 10km away was not significantly different from those residing 30 to 50km away ($p = .389$) or those residing more than 50km away ($p = .168$).

When interpreting as to why those who reside less than 10km away were significantly more job satisfied than those 10 to 30 km away, the reason could be because those individuals do not experience problems with transportation to and from home to work. Those residing 10 to 30 km will face that challenge hence indicating significantly lower job satisfaction according to the above result.

If transport was the primary issue then it can be argued as to why those residing 30 to 50 km and more than 50 km away were significantly more job satisfied than 10 to 30 km because the distance is greater hence more problems regarding transport. However those individuals residing more than 30km tend to seek for accommodation closer to the hospital and in some instances certainly employees qualify for staff accommodation within the institution itself.

Hence those residing between 10 to 30 km away face the biggest challenge with regards to transport therefore are significantly less job satisfied in comparison to the rest. This reasoning is further supported by Kotzee and Couper (2006:581), who states the lack of transport as one of the key reasons health care workers leave the rural areas.

Reliability and Job Satisfaction

As a measure of internal consistency, Cronbach's alpha was computed for Section B: Job Satisfaction questions 1 to 9. The finding indicated adequate internal consistency and reliability for the job satisfaction portion of the questionnaire, $\alpha = .613$.

Conclusions and Recommendations

Findings from the study

The findings of this study are presented as follows:

- Findings of Literature Review; and
- Findings of the Primary Study.

Finding from the Literature Review

The department of Health is faced with a huge challenge in retaining clinical staff at its government health facilities and more particularly in the rural, disadvantaged areas. The magnitude of this problem is highlighted in Human Resource for Health South Africa (2011:30), which states only 12% of doctors and 19% of nurses serve a 43.6% total of the rural population in South Africa. Furthermore the country is losing highly skilled staff abroad as cited in Human Resource for Health South Africa (2011:32), which is adding more pressure on the Department of Health in retaining the clinical staff as rural facilities.

Various factors were identified to examine its contribution to this health crisis. These factors included:

- Demographic and Geographic factors;
- Job satisfaction factors; and
- Intention to leave factors.

Urbanisation plays a big role with regards to demographic and geographic factors because most health professionals chose employment at urban hospitals rather than in rural areas, more particularly the younger health workers according to WHO (2006:7).

Government recognised this situation and aimed to intervene through the implementation of community service and recruitment of foreign health professionals to the rural areas in particular as stated in HEARD (2009:9). However the problem still persists.

The next factor identified was job satisfaction. There are numerous elements that contribute to job satisfaction. Establishing and maintaining job satisfaction according to Robbins et al (2009:81), is key in reducing staff turnover because dissatisfied staff will tend to seek employment elsewhere. Along with job satisfaction is motivation, which can be in form of financial and non-financial.

The Department of Health attempted to address the issue of motivation through the financial route. This resulted in the payment of OSD, scarce skills and rural allowance to specific health professional categories. HEARD (2009: 9) reports although this strategy was adopted but it did not eradicate the problem totally because a shortage of clinical staff at rural health facilities continues.

The other form of motivation is non-financial and includes;

- Recognition;
- Positive working environment;
- Training and development.

Recognition according to Mondy and Noel (2005:321) is considered a powerful tool in motivating employees and is considered very inexpensive. It is done by giving praise and validating the employee hence emphasising the employees worth and contribution to the organisation as believed by Gerber et al. (2008:39).

Also creating a positive working environment plays a vital role in motivation. Access to adequate supply of resources is one of the key aspects in delivering quality health care as cited by Henderson and Tulloch (2008:18). However Mathauer and Imhoff (2006:24) state that many rural facilities faces the challenge medical supply shortage. Therefore should the Department of Health wish to deliver on its Strategic Plan 2010-2014, this issue need addressing.

The last form of non-financial motivation is training and development of the employees. This type of motivation is designed to improve the employees' performance within the organisation according to Pattanayak (2010:75). Furthermore Kaila (2012:337) believes if employees notice there is no signs of development or prospects of growth within the organisation then the employee will choose to leave. This is a useful strategy for the Department of Health to adopt if it to administer quality health care as outlined in its strategic plan.

The last factor identified is the intention to leave. Both Hiriyappa (2010:151) and Asswathappa (2008:365), mention Maslow's Hierarchy of Needs, which states that an individual's basic needs need to be fulfilled prior to it escalating to the next level.

According to Kotzee and Couper (2006:581) there are various basic needs of health professionals not satisfied in the rural areas such poor housing, safety, lack of transport, poor opportunity of schooling and work for the health professionals children and spouse respectively, to just name a few. These factors all contribute to the challenges faced by the Department of Health in retaining clinical staff at rural facilities.

Finding from the Primary Research

Demographic and geographic results of this study indicated that a majority of the participants were:

- Length of employment : 1 to 5 years (48%)
- Age : 25 to 35 years (62%)
- Nearest town : More than 15km away (78%)
- Permanent residence to institution : More than 50km away (56%)

Job Satisfaction indicates the results of the majority were as follows:

- 56% were job satisfied;
- 52% were motivated;
- 48% were not satisfied with current salary;
- 60% agreed to receive financial benefits such as OSD, scarce skills and rural allowances;
- 80% indicated there are no career opportunities;
- 84% indicated there is no training and development opportunities;
- 70% were not trained or developed within the year;
- 72% indicated there is insufficient resources to perform ones job; and
- 74% indicated receiving no form of recognition and appreciation for work done.

Intention to leave indicates the results of the majority were as follows:

- 68% often consider leaving current job;

- 76% are looking for new job opportunities
- 54% indicated only family responsibility prevent them from leaving;
- 84% acknowledge it is not easy to relocate family to rural areas;
- 78% indicated there is insufficient basic necessities such as accommodation, water and electricity;
- 72% indicated that transport is challenge; and
- 80% indicated they will definitely leave the institution within the next 3 years.

Conclusions

This research study was undertaken to investigate the challenges faces by the Department of Health to retain clinical staff at rural public hospitals in Kwa-Zulu Natal. The study was conducted at a rural hospital in the Uthukela District in Kwa-Zulu Natal.

The main object was to assess the following factors impact in retaining health professionals at rural, disadvantaged health facilities. This resulted in this study exploring the following objectives:

- To explore if demographic and geographic factors influence the ability to retain clinical staff;
- To determine if clinical staff are satisfied with current job position;
- To identify the extent to which clinical staff are seeking employment out of rural public hospitals; and
- To provide recommendations on how to retain clinical staff.

According to literature demographic and geographic factors certainly affect the inability to retain clinical staff, this is because most young individuals crave the urban life style which the rural environment fails to satisfy according to Dociu and Dunarintu (2012:50), resulting in the migration out of rural facilities. However according to the finding of this primary research it seems this is not the case entirely. The results revealed indicated the intentions of the clinical staff to leave the rural facility did not differ based on the participants' demographic and geographic factors.

Robbins et al. (2009:81) cites the role of jobs satisfaction plays a critical role in retaining employees to any organisation. Motivation is considered one of the key elements in gaining job satisfaction and can be in the form of both financial and non-financial rewards according

to Nel et al. (2011:289). The Department of Health has utilized the financial means of motivating clinical staff in a bid to retain these individuals at government facilities particularly in the rural areas. This was done through the payment of OSD, scarce skills and rural allowance.

The primary study revealed only 60% of the participants qualified and received these financial benefits. However there seems to be insufficient literature that acknowledges the Department of Health exploring the non-financial motivation strategy. This research results highlighted this fact because a majority of the participants indicated there were lack of career opportunities, training and development opportunities, poor working environment due to insufficient medical supplies and no recognition and appreciation for work performed.

Despite government intervention the problem continues. Clinical staff is seeking employment out of rural health facilities. The results from the primary study indicate that 68% are considering leaving and 76% are already seeking new job opportunities. The results identified one of the key reasons as to why staff are looking to leave is 84% believe it is difficult to relocate families to the rural environment, mainly because of a lack of basic necessities and according to Hirriyappa (2010:151) most often individuals leave because basic needs are not fulfilled.

The overall results illustrate 80% of the participants will leave the rural hospital within the next 3 years. These findings are disastrous for the public health sector. Therefore it is imperative for the Department of Health to remedy this situation if it wishes to deliver quality health services to the rural public.

Recommendations

On the basis of the research results it is noted the Department of Health has addressed the demographic and geographic influences adequately. Therefore the only recommendations put forward are with regards to job satisfaction and the intentions to leave.

Job Satisfaction

56% and 52% of the staff are job satisfied and motivated respectively. These figures are not very promising as it indicates just over half the clinical staff population is job satisfied and motivated. It is noted that the Department of Health has paid more attention by motivating employees financially and yet the ability to retain the health professionals is still a challenge.

It is recommended that more attention be given to motivate staff using the non-financial rewards:

It is suggested the Department of Health invest in the regular training and development of its employees. This should not just be a friendly gesture from the department side but actual formal legal policy. In doing so it assures the health workers the opportunity to grow and develop is active within the rural environment. Furthermore the clinical staff will no longer feel a sense of career stagnation but rather an opportunity to grow career wise as well.

Along with the training and development, there should also be a plan in promoting staff and create opportunities for staff to specialize. The reason behind this point being, in some instances staff are sent for training and further job development but once they return to the facility there is a lack of job positions and availability of job posts that support the training and development acquired. Hence the health professionals seek employment to an institution where the training and development acquire is sufficiently support and most often it is at urban health facilities.

The next recommendation made is with regards to the lack of available resources that compromises the ability to deliver quality health care. It is suggested deep investigation needs to be undertaken as to why rural facilities face this challenge. If the reason is poor management then appropriate action needs to be taken. Furthermore if the problem identified is the inability for the company supplying the medical resources to deliver on its contractual obligations. Then immediate action needs to be taken either to put pressure to deliver or withdraw the allocated tender from the company concern. The main suggestion with regards to this issue is the Health Department must be able to act swiftly when this problem occurs and not engage in stalling tactics from the suppliers.

The last recommendation with regards to job satisfaction is the Department of Health needs to disseminate a culture of recognition and appreciation to all its health facilities. Each institution needs to take an active part in retaining its clinical staff and one such way is through recognising employees efforts and showing appreciation. This recommendation is very inexpensive and often underestimated. However according to literature it is considered one of the most powerful tools in motivating.

Intentions to leave

A large percentage of participants indicated that basic needs are not being met in rural environment and this is supported by literature.

It is recommended the Health Department address this issue. It is suggested that the Health sector engage the participation of other public sectors such as Department of Works and Infrastructure and Water Affairs to name a few, in working together to find a solution to the inadequate supply of basic necessities. An important fact to bear in mind is although the clinical staffs from the health sector have highlighted this problem at rural areas, it also affects employees from other government sectors that operate within this rural environment.

The development of rural disadvantage areas should be included as a priority in the overall strategic plan for the South African Government. Adequate resources should be allocated to improve the living conditions not only to the clinical staff employed at rural facilities but to the rural community as a whole.

It is suggested the above recommendation be taken into consideration should the Department of Health wish to eradicate the challenges in retaining clinical staff at rural hospitals.

Area for further Research

There are several opportunities for further research stemming from this study. This particular study was conducted in a rural hospital in Kwa-Zulu Natal. It can be expanded to assess the rural environment in another province or in South Africa collectively. Furthermore new studies can look to include all employees at rural facilities rather than just clinical staff only. An even bigger expansion from this study is to assess the challenges faced by the government employees at rural, disadvantage areas which may include department of Education, Home Affairs, Labour, Public Works, Water Affairs and Energy to name a few. Lastly a similar study could be conducted in about 5 to 10 years within the same environment, to establish if any positive changes had emerged or the challenges in retaining clinical staff at rural hospitals still continues.

Conclusion

The purpose of this study was to assess the challenges experienced in retaining clinical staff at rural health facilities. Based on the literature review there is a crisis at rural facilities due

to the shortage of health workers. The Department of Health intervened through the implementation of various strategies but the problem persists.

The literature review and primary research review illustrated the Health Department utilized financial rewards to promote retention but this has not erased the problem. Based on the results from the primary research it is evident that non-financial rewards should be explored as well. This study included suggested strategies that would aid in remedying the problems areas identified in the primary research. To conclude areas of further research are identified which stem from this study.

This study has highlighted the problems, and put forward suitable recommendations. It is now up to the Health Department to take action and find a suitable permanent solution to this crisis to ensure the quality of health care in South Africa is never compromised at all cost.

NOTE: This study was presented by the principal author in 2014 as a dissertation in partial fulfilment for the award of the Master of Business Administration Degree (MBA) to the Regent Business School. The dissertation was supervised by Nishika Reddy and edited by Professor Anis Mahomed Karodia for purposes of presenting a publishable journal article.

Kindly note that the entire bibliography of the dissertation is cited and the applicable references to this research article are contained within the full cited bibliography.

Bibliography

Anderson, V. (2009). *Research Methods in Human Resource Management*. London: Chartered Institute of Personnel and Development.

Andrews, S. (2009). *Human Resource Management*. New Delhi: Tata McGraw Hill Publishing Company Ltd.

Aswathappa, K. (2008). *Human Resource Management*. New Delhi: McGraw Hill.

Blessing, T. M. and Chakrabathi, A. (2009). *DRM, A Design Research Methodology*. London: Springer London.

Cole, K. (2010). *Management Theory and Practice*. Australia: Pearson.

Collis, J. and Hussey, R. (2006). *Business Research: A practical guide for undergraduates and post graduates*. New York: Palgrave Macmillan.

Cooper, D.R. and Schindler, P.S. (2005). *Business Research Methods*. New Delhi: Tata McGraw Hill.

Day, C., and Gray, A. (2008). Health and related indicators. In P. Barron & J. Roma-Reardon (Eds.), *South African health review 2008*. Durban: Health Systems Trust. [Online]. Available from: <http://> [Accessed 1 June 2014].

Department of Health. Human Resource for Health South Africa. (2011). HRH Strategy for Health Sector 2012-13 to 2016-17.

Department of Health. (2010). Kwa-Zulu Natal Human Resource Management Circular 96 of 2010. KZN.

Department of Health. (2004). Kwa-Zulu Natal Human Resource Management Circular 87 of 2004. KZN.

Department of Public Services and Administration. (2007). Occupation specific dispensation in the public service. [Online]. Available from: <http://www.info.gov/za/speeches/2007> [accessed 1 May 2014].

Department of Health. Public Health and Social Development Sectoral Bargaining Council (2010).PHSDSBC Resolution 1 of 2010.

Department of Health. Public Health and Workers Sectoral Bargaining Council (2004).PHWSBC Resolution No. 2 of 2004.

Dociu, M. and Dunarintu, A. (2012).The Social Economic Impact of Urbanisation. *International Journal of Academic Research in Accounting, Finance and Management Science*.2 (1).p 47-50.

Doherty, J. (2013). Addressing staff shortages in public hospitals: a role for clinical associates? *Public Health Association of South Africa*. [Online]. Available from: <http://www.Addressing%20staff%20shortages%20in%20public%20hospitals%20%20a%20role%20for%20clinical%20associates%20Public%20Health%20Association%20of%20South%20Africa.htm>. [Accessed 1 May 2014].

Edralin, D. (2004). Training a strategic HRM function. *Development of business and management education*. 7 (4): p 1-4.

Gerber, P.P., Nel, P.S. and Van Dyk, P.S. (2008).*Human Resource Management*. Johannesburg: International Thomson (SA).

Goddard, W. and Melville, S. (2009). *Research Methodology: An introduction*. Lansdowne: Juta.

HEARD. (2009). Research report: Human Resources for Health in South Africa. Durban: University of KwaZulu-Natal.

Henderson, L.N., and Tulloch, J. (2008). Incentives for retaining and motivating health workers in Pacific and Asian countries. *Human Resources for Health*, 6, 18.

Heneman, R.L. (2002). *Strategic Reward Management*. USA: Information Age Publishing.

Hiriyappa, B. (2010). *Organisational Behavior*. New Delhi: New Age International (P) Limited Publishing.

Holbeche, L. (2007). *Aligning Human and Business Strategy*. Burlington: Elsevier Butterworth – Heinemann.

Jensen, D., McMullen, T. and Stark, M. (2007). *The Managers Guide to Rewards*. USA: Hay Group Inc.

Johnson, B. and Christensen, L. (2012). *Qualitative and Quantitative Educational Research*. Sage Publishing Inc: USA.

Keller, G. (2009). *Statistics for Management*. India: Cengage Learning.

Kothari, C.R. (2012). *Research Methodology: Methods and Techniques*. 2nd Edition. New Delhi: New Age International.

Kotzee, T. and Couper, I. D. (2006). What interventions do South African doctors think will retain them at rural hospitals of the Limpopo Province of South Africa? *Rural and Remote Health*.6: p 581.

Krishnaswami, O. R. and Ranganatham, M. (2007). *Methods of Research in Social Sciences*. Mumbai: Himalaya Publishing House.

Lagarde, M. and Blaauw. (2013). Pro-social preferences and self-selection into rural jobs: Evidence from South African nurses. *RESYST*. United Kingdom.

Lehmann, U., Dieleman, M. and Martineau, T. (2008). Staffing remote rural areas in middle- and low-income countries: A literature review of attraction and retention. *BMC Health Service Research*, 8.p 19.

Luthans, F. (2005). *Organisational Behavior*. USA: McGraw – Hill.

Mahlathi, P. (2009). Occupational specific dispensation for medical and dental practitioners, pharmaceutical and EMS Personnel: Presentation to Select Committee

On Social Services. Available from: <http://www.pmg.org.za/files/docs/090818health-edit.pdf> [accessed 26 May 2014].

Makapela, N.C. and Useh, U. (2013). Rural Allowance and the Retention of Health Professionals in Selected Hospitals in the North West Province of South Africa *Hum Ecol*. 44 (2): p.129-138.

Mathauer, I., and Imhoff, I. (2006). Health worker motivation in Africa: the role of non-financial incentives and human resource management tools. *Human Resources for Health*.4, 24.

Mcburney, D, .andWhite, T. (2009). *Research Methods*. WADSWORTH Cengage Learning: USA.

Mondy, W.R. and Noe, R.M. (2005). *Human Resource Management*. New Jersey: Pearson Education, Inc.

Nel, P., Werner, A., Du Plessis, A., Ngalo, O., Poisat, P., Sono, T., Van Hoek, .L and Botha, C. (2011). *Human Resource Management*. South Africa: Oxford University Press

Okhahlamba Local Municipality. Annual Report 2012-2013. Bergville.

Pattanayak, B. (2010). *Human Resource Management*. New Delhi: PHI Learning Private Limited.

Reid, S., 2011, *Community Service for Health Professionals in South Africa*.
[Online].Available from: [http://www.aaahrh.org/4th_conf_2009/Community %20Service%20for%20Health%20Professionals](http://www.aaahrh.org/4th_conf_2009/Community%20Service%20for%20Health%20Professionals). [Accessed 30 April 2014].

Robbins, S., Judge, T. and Odendaal, A. (2009). *Organisational Behavior: Global and Southern African Perspective*. South Africa: Pearson Education.

Sanders, D. (n.d.). National health insurance: can it solve South Africa's health crisis? [Online]. Available from: <http://www.wolpetrust.org.za/dialogue2009/presentation> [accessed 26 May 2014].

Saunders, L. and Thornhill, A. (2006). *Research Methods for Business Students*. England: Prentice Hall.

Shajahan, S. (2011). *Research Methods for Management*. Ahmadabad: Jaico Publishing.

Songstad, N.G. (2012). *Health workers motivation in a low-income context: The case of rural health services in Tanzania*. PhD Thesis. University of Bergen.

South Africa Constitution. (1996). Chapter 2 Bill of Rights. South Africa.

Statistics South Africa, 2012. Census 2011, Statistics South Africa, Pretoria.

Stevens, E. (2012). *Sociology: Brief edition*. [Online]. Available from: 2012books.lardbucket.org/books/sociology-brief-edition-v1.0/index.html [accessed 21 May 2014].

Thompson, A.A., Peteraf, M.A., Gamble, J.E. and Strickland, A.J. (2012). *Crafting and Executing Strategy*. New York: McGraw Hill.

Truelove, S. (2011). *Training and development: Theory and Practice*. USA: Jaico Publishing House.

Wagner, J.A. and Hollenbeck, J.R. (2008). *Organisational Behaviour*. New York: McGraw Hill Publishers.

Wilkinson, D. and Birmingham, P. (2003). *Using research Instruments. A Guide for Researchers*. London: Routledge Falmer.

Willis-Shattuck., Bidwell, P., Thomas, S., Wyness, L., Blaauw, D. and Ditlopo, P. (2008). Motivation and retention of health workers in developing countries: a systematic review. *BMC Health Service Research*, 8, p 247.

World Health Organization. (2006). *Improving health workers performance*. Geneva: World Health Organization.

Zimund, W. (2006). *Business Research Methods*. India: Thomson Learning.

Appendix A: Cover letter

Covering Letter to Participants

Dear Participant

My name is Sashika Gayasingh and I am currently registered as a 3rd year MBA student at Regent Business School.

I kindly request your participation in my research study titled:

“The challenges experience in retaining clinical staff at a rural public hospital in Kwa-Zulu Natal.”

Your participation is completely voluntary. The information provided will be regarded in strict confidence. There is no request to provide your names and occupations thus ensuring you remain completely anonymous.

Should you have any queries please contact me on:

Cell 073 349 8245

Work 036 488 8239

Email sashikagayasingh@gmail.com.

Your participation and honest input will be highly appreciated.

Sashika Gayasingh

Appendix B: Questionnaire

Questionnaire

Section A: Demographics and Geographic Information

Please mark with X

1. How long have you been employed at the institution?

Less than 1 year	
1-5 years	
Over 5 years	

2. What is your age?

Below 25 years	
25-35 years	
Above 35 years	

3. How far is the nearest town?

Less than 5km away	
5-15 km away	
More than 15 km away	

4. How many kilometres away is your permanent residence (home) from the institution?

Less than 10 km away	
10-30 km away	
30 -50 km away	
More than 50 km away	

Section B: Job Satisfaction

Please mark with X

No.	Items	Strongly Agree	Agree	Neutral/ Don't Know	Disagree	Strongly Disagree
1	I am satisfied with my current job.					

2	I am highly motivated to perform my job.					
3	I satisfied with my current salary					
4	I receive additional financial benefits such as OSD and rural allowance.					
5	There are career opportunities e.g. Specializing and promotions.					
6	There are sufficient training and development opportunities.					
7	I have been trained and developed within the last year in my current job position.					
8	There are sufficient resources such as equipment and medical supplies available to do my job.					
9	I often get recognised and appreciated for work that have done.					

Section C: Intention to leave

Please mark with X

No.	Items	Strongly Agree	Agree	Neutral/ Don't Know	Disagree	Strongly Disagree
-----	-------	----------------	-------	---------------------	----------	-------------------

1	I often consider leaving my current job.					
2	I often look at newspapers and intranet to for new jobs					
3	Only family responsibilities prevent me from leaving					
4	It is easy to relocate my family to rural areas					
5	There are sufficient basic necessities such as suitable housing with electricity and running water available in this environment.					
6	Transport from home to work is a challenge					
7	If a suitable job comes if will leave this hospital					
8	I will definitely leave this hospital within the next 3 years					

Appendix C: Permission Letter from the Organisation



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

EMMAUS HOSPITAL Office of the CEO, Cathedral Peak Road,
Private Bag x 16, Winterton, 3340, Tel: 036 4881570, Fax: 036 488 1330
E-mail: linda.mazibuko@kznhealth.gov.za

Enq: Mr. L.T Mazibuko
Date: 08-04-2014

**MS S GAYASINGH
RADIOGRAPHY DEPARTMENT
EMMAUS HOSPITAL**

RE: PERMISSION TO CONDUCT RESEARCH AT EMMAUS HOSPITAL

I have pleasure informing you that permission has been granted to you by the Hospital Management to conduct research to assess the challenges experienced in retaining clinical staff at a rural public hospital in KwaZulu Natal.

Please note the following:

1. Please ensure that you adhere to all the policies, procedure, protocols and guidelines of the Department of health with regards to this research.
2. The Hospital Management will not provide any resources for this research.
3. You will be expected to provide feedback on your findings to the Hospital Management.

Thank you

A handwritten signature in black ink, appearing to read 'L.T. Mazibuko', written over a horizontal line.

**MR LT MAZIBUKO
CHIEF EXECUTIVE OFFICER**