

**THE ATTRITION LEVELS OF KWAZULU-NATAL NURSES WITH
SPECIFIC REFERENCE TO SEEKING EMPLOYMENT
OPPORTUNITIES IN OTHER COUNTRIES AND IT'S IMPLICATIONS
ON HEALTH SERVICES DELIVERY WITHIN THE PROVINCE**

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DECLARATION

I DECLARE THAT THIS THESIS IS MY OWN UNAIDED WORK. IT IS SUBMITTED FOR THE DEGREE OF DOCTOR OF PHILOSOPHY AT THE UNIVERSITY OF ZULULAND, KWADLANGEZWA, IN SOUTH AFRICA. IT HAS NEVER BEEN SUBMITTED FOR ANY OTHER PURPOSE. ALL THE SOURCES USED OR QOUTED HAVE BEEN ACKNOWLEDGED BY MEANS OF COMPLETE REFERENCING



.....
WINIETH LUNGILE NDLOVU

DEDICATION

THIS WORK IS DEDICATED TO MY PARENTS, ALZINA AND ANDRIAS, MY HUSBAND KHULEKANI, MY BROTHERS AND SISTERS, MY DAUGHTER AND SON, PHUMELELE AND SANDILE RESPECTIVELY.

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I sincerely thank my husband Khulekani, my daughter Phumelele, and my sisters for their support, all the way through.

ABSTRACT

The purpose of the study was to examine attrition levels of KwaZulu-Natal nurses with specific reference to those that seek employment opportunities in other countries.

The objectives of the study were to (a) examine the attrition levels of KwaZulu-Natal nurses in relation to seeking employment opportunities in other countries, (b) identify the factors influencing the KwaZulu-Natal nurses to seek employment opportunities in other countries, (c) examine the demand versus the supply of nurses through the training programmes supported by the KwaZulu-Natal Provincial Department of Health, (d) determine the effects of attrition on the health care service delivery within the Province of KwaZulu-Natal, (e) examine the role-played by the Department of Health in controlling the attrition rate, and (g) examine the role-played by the South African Nursing Council as the watchdog of the public in controlling such attrition.

The study sample consisted of 54 registered nurses, 9 Deputy Directors (Nursing) at health district levels, and the registrar of the South African Nursing Council. The results indicated that the attrition levels of KwaZulu-Natal nurses were high in that 1159 nurses resigned

with the intention of seeking employment opportunities in other countries. The nurse training academic institutions could not cope with the replacement from the number of graduates that they produced within the same study period. That is, only 889 diplomates graduated, versus 1159 that left the country, excluding those that left the service due to natural attrition, for example, death resulting from HIV/AIDS. The main factors that contributed to the nurses to leave the province were poor salaries, poor working conditions, poor relationships either at work and within marriages. There was a remarkable decline in the standard of patient care due to the shortage of skilled nurses in clinical settings. Strategies to deal with the problem were still at the planning stage at the time of data collection, but one would say that those were the good plans that would contribute to resolving either the actual problem or its effects on health care delivery. The study recommended amongst others, (a) improvement of salaries of nurses, (b) improvement of the conditions of service, (c) establishing a database for all nurses in the “diaspora”, (d) creative contracts between the source and destination countries, (e) investing in education, and (f) intensifying the Employee Assistance Programmes.

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CHAPTER ONE ORIENTATION TO THE STUDY

1.1 Introduction

South Africa has over more than three decades seen both considerable immigration and considerable emigration of skills, the major sub-categories being the engineers and related technologists, medical practitioners, specialists, dentists, nurses, education and related occupations, accountants and related occupations. The patterns of these inflows and outflows have been traced for several years. It is further argued that the movement of all these occupational categories track each other very closely, suggesting that there are very similar explanatory underlying factors. (Kaplan 1996: 46)

The pattern is clearly the one where generally official flows are positive, except following major political crises, when emigration increases rapidly and there is an outflow. The substantial outflows in South Africa followed Sharpsville in 1961, the period of nationwide unrest following Soweto uprisings in 1976, the declaration of a state of emergency in 1985 and the period leading to and following the change to a government of national unity in 1993 (Kaplan: 1996: 46).

The official data reveal that between 1947 and 1995, South Africa enjoyed a net gain of immigrants over emigrants for 40 of the 48 years. The same picture is essentially held for the professional and semi-professional categories. By contrast, over the last decade, there have been four years, that is 1986, 1987, 1994, and 1995 when a net loss was experienced for all occupations and for the professional and semi-professional categories (Kaplan 1996: 46).

While the official data are probably useful in revealing overall trends in immigration and emigration, they are almost certainly misleading. Firstly, they massively understate the true extent of emigration. Secondly, people leaving South Africa are not required to indicate whether they are leaving South Africa permanently, and it is evident that for a number of reasons, many people prefer to state that they are leaving only as tourists (Kaplan 1996: 47).

1.2 Background to the problem

South African emigration data has been compared with that of the other countries. The official South African data record that for the

period 1984 – 1993, there were 28, 965 emigrants who left for the United Kingdom (UK) , while 33, 640 immigrants arrived from the United Kingdom, giving an overall net gain for South Africa of 4, 675 (Kaplan 1996: 91).

For the same period, the United Kingdom data give the total number of immigrants from South Africa as 100, 700 and the emigrants to South Africa of 52, 600, giving an overall net loss for South Africa over 50, 000. The United Kingdom emigration figures are well over three times the South African figures, while South Africa's immigration data are also understated, by a little over one-half. With respect to Australia, the data discrepancy is also large. The South African data indicate that 1,330 South Africans immigrated to Australia in the year ending June 1995. According to the Australian data, the number of South African immigrants was 2,792 (Kaplan: 1996:92).

The abolition of apartheid in South Africa in 1994 meant an immediate demand for the country to transit at least in three dimensions. That is, the political transition from an authoritarian rule, the economic and the

social transition. The central question was whether, and under what conditions, South Africa could navigate these transitions successfully, either sequentially or all together. Research has indicated in general that, no country in modern times has made a successful transition to democracy starting from a position like that of South Africa, that is (a) fifteen years of economic stagnation and (b) ten years of outright decline in per capita incomes. Indeed, no country has succeeded from a position remotely as unfavorable, especially if one notes the inequalities of income, ethnic rivalries, and the rising levels of crime. (Turker and Scott, 1992: 51).

Similar to the views of Turker and Scott (1992: 76), Mangena (2001: 25), deputy Minister of Education, in his address at the 13th Annual Human Resources Development, Education and Training Conference, remarked that considerable progress has been made in improving the educational standards of the country. The architecture of the new learning system in South Africa, has been designed collaboratively.

Lormuno (1995: 68) maintains that the nursing profession is being challenged constantly by the rapid and unpredictable changes occurring within the competitive environment of health care. Emphasizing the need to maintain the high standards of health care service delivery, especially in democratized and educated societies, Lormuno (1995: 68) had this to say:

“ A more educated patient population with high expectations for the state-of-the-art health care delivery that has the ability to recognize quality service is demanding care customized to meet the individual, unique needs. Unfortunately, at a time when these consumers are becoming more selective, the health care environment is being plagued with a decrease of both nursing and financial resources.”

There have been numerous failures among other countries, with some, able to count several failed attempts of their own, for example, Argentina and Brazil. Failures have resulted either in a weak and ineffective democracy, or a new form of authoritarian regime, and an economic decline. South Africa’s objective was to have a “ a successful transition” and not merely “a transition.” This would require very significant changes in economic and social policies, which could only be

effected by a strong government (Turker and Scott 1996: 72).

The constitution of the Republic of South Africa as adopted on the 8th May 1996, and amended on the 11th October 1996 by the Constitutional Assembly became one of the instruments of the perceived successful transition through which democracy would be realized. Chapters and the subsections that would be important to refer to are Chapter 2, (the Bill of Rights), subsection 21, on freedom of movement and residence, and it has this to say: “ 1. Everyone has the right to freedom of movement, the right to leave the republic, right to enter, to remain in and to reside anywhere in, the Republic and the right to a passport. (Government Notices, RSA 1996: 25)

Subsection 27 (1) (a) stipulates that everyone has the right to have access to healthcare, including reproductive health, whilst subsection 27 (2), puts the responsibility to the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of each of these rights.

(Government Notices, RSA : 1996: 25)

Similar to the provisions of the Constitution of the Republic of South Africa stated above, Tobin, Wise and Hull (1992:33) hold that as consumers of health care become knowledgeable about services, costs and their rights, they tend to demand quality at a reasonable cost. Such changes add to the complexity of health care, giving rise to the need for skilled manpower, and for the development of all employees to their highest level of competency. (Tobin, Wise & Hull 1992: 33)

The challenge is that despite the provisions of the Bill of rights in terms of the constitution, the skilled professional and technical personnel including nurses in South Africa, and KwaZulu Natal, forming the backbone of the delivery of health services are perceived to be leaving the country in very high numbers in order to seek employment opportunities in other countries. (Tobin, Wise & Hull 1992: 33)

While South Africans frequently speculate about the dimensions of this intellectual Diaspora, no systematic studies have been made and there is no existent data on its quantitative or qualitative characteristics. It is sometimes reported that studies of this nature are still underway. To

mention but one, a survey to determine the migration patterns of health care workers conducted by the Geneva – Based International Council of Nurses (ICN), the World Medical Association, which represents physicians worldwide, and the World Health Organization (Tettey 2001: 13).

In order to improve health care service delivery, the new democratic government committed itself to redress the inequitable provision and distribution of services and resources. This was done through the implementation of the Public Service Delivery Strategy, known as “Batho Pele” meaning “People First.” It is a policy framework for the transformed public service, including the health care services.

The message of Batho Pele is that the primary function of the Public Service is to serve all citizens of South Africa, ensuring that their needs come first, and giving the consumers of the Public Service the “Customer Status.” (Government Notices, RSA 1997: 13).

Consultation, service standards, access, courtesy, information giving, openness and transparency, redress, and value for money are the

eight principles through which the objectives of Batho Pele would be realized. To facilitate co-operation of the clients / patients, publicizing of Batho Pele, was coupled with the release of the Patients Charter, through the office of the National Minister of Health (Government Notices, RSA 1997: 16)

When the democratic government came into power in 1994, headed by former President Dr Nelson Mandela, it is estimated that seven times as many black infants were dying than White babies, the main causes being the classic preventable conditions of poverty, for example, malnutrition, diarrhoeal diseases and measles taking a heavy toll. Nationally, each doctor had to care for 1,340 patients, but in the ten Black homelands, some 15,000 people had to share one doctor. Plans to overhaul the system had been brewing for two years in Mandela's African National Congress party, and the first action came within a month of Mandela taking office (Simon: 2003: 2).

In his state of the nation speech, Dr Mandela declared all health care for children under six and pregnant women would be free, at state

facilities and district surgeries. Later the health policy was extended to everyone at the primary care level, and became law. The policy prompted a rush of patients, especially children in hospitals and clinics across the country. By the end of 1995, two out of three people in a national survey expressed joy at the easy access to health care, with patients in rural and informal settlements the happiest.

(Simon 1997: 79)

Provincially it is estimated that KwaZulu Natal had almost 750 000 infected people, followed by Gauteng with 466 000 infected. The Northern Cape, with the smallest population has an estimated 22 000 HIV infected people. In addition, special efforts need to be made to prepare for the emerging health care needs. (Floyd, 1997: 43).

From the discussion above, it is evident that the South African Government implemented important legislative mandates, in favour of the disadvantaged citizens of the country, but the main concerns of the researcher at this stage were:

- The perceived increase in the workload of nurses arising from the

high turnover of patients in the health facilities.

- The perceived problem of attrition of specialized nursing staff from South Africa to other countries, leaving the few overburdened nurses.
- The problem of HIV/AIDS pandemic which was already taking its toll over the patients as well as health professionals, including nurses. Alluding to the above statement, Mngomezulu, the Deputy Secretary of DENOSA, was cited by Luring (2002: 2) as she said:

“We are smacked in the middle of a national epidemic. The last thing we need now is people jumping the ship, as already many hospitals which come face to face with dying patients are understaffed and ill equipped.”

- The perceived imbalance between the output of the nursing academic institutions and patient population demands
- The perceived unavailability of other support personnel that would decrease the burden on nurses by assisting with non-nursing duties.
- The possible decline in the standards of nursing care
- The perceived unavailability of accurate statistics on the problem

of brain drain of nurses, that would be used by the Health Departments and the government in addressing the problem (Floyd 1997:43) (Simon 1997: 89) (Nevidjon & Erickson 2001: 92).

3.1 Problem statement

In spite of the concerns raised in the preceding paragraph, speculation was rampant that the Department of Health did not have any effective mechanisms or strategies in place to address the problem of attrition of nursing staff.

Lauring (2002: 36) maintains that accurate statistics on the problem of brain drain are not available. The South African Medical Association estimates that at least 5000 doctors had left South Africa by early 2002, whilst the Democratic Nursing Organization of South Africa (DENOSA) estimated 300 registered nurses leaving the country every month. Many of these highly skilled emigrants never return home due to the lack of motivation and the opportunities to do so.

A number of factors, for example, economic, social, cultural and educational are perceived to have contributed to this mobility of nurses from South Africa to other countries. They are probably noted through the exit interviews conducted in few health care institutions within the country, but unfortunately none have been empirically proven through the scientific enquiry at a larger scale. It is verbally reported that studies of this nature are still underway, and therefore making it difficult to make scientifically based comments.

Based on this review, and considering that the developed countries have better working conditions, and better remuneration packages compared to the conditions in a developing country, like South Africa, there is a great likelihood that South African nurses would be attracted. A study of this nature would therefore close the gap.

Hellinghausen (1999: 2), argues that policy experts worry that countries attracting nurses from locales facing their own shortages are creating a domino effect of nursing shortages that could be detrimental in the long run. Hospitals in Great Britain, for example, have been

recruiting nurses from urban South Africa, which in turn recruits nurses from other parts of Africa, creating shortages in those areas.

Citing Cheryl Peterson, a senior policy fellow in international affairs with the American Nurses Association, Hellinghauson (1999: 2) had this to say:

“Everybody is robbing Peter to pay Paul.” “We need to do some planning at international levels instead of hurting each other’s human resources.”

Coupled with the figures reflected above, is the need to examine the recommended registered nurse population ratios. The World Health Organization in 1985, recommended 1: 250 for the first world, and 1: 500, for the third world. In 1990, the South African Nursing Council recommended 1: 416. Presently, the total Registered Nurse / Population ratio in South Africa is 1: 460, only less by 40 to be equivalent to the third world countries, yet South Africa is presently rated as a developing, and not the underdeveloped country. Excluding those that are not nursing, the ratio widens to 1: 566, over by 66, for the ratios calculated for the third world. Based on these ratios, the total registered nurses required to raise the manpower levels from 1:

581 to 1: 500 is = 12,001 and from 1: 581 to 1: 416 is = 29,366
(Hellinghausen 1999: 2)

As indicated earlier on, that the Constitution of the Republic of South Africa allowed freedom of movement, and the right to leave the Republic, there has been a remarkable perceived increase in the number of nurses leaving the country to seek employment abroad. According to the South African Nursing Council, the number of registered nurses applying for overseas registration increased (Government Notices, RSA 1996: 7).

1.4 Purpose of the Study

The purpose of the study was to examine attrition patterns of KwaZulu-Natal nurses with specific reference to those that seek employment opportunities in other countries.

The research questions were:

1. What is the attrition rate of the KwaZulu- Natal nurses in relation to seeking employment opportunities abroad?

2. What are the factors influencing the KwaZulu-Natal nurses to seek employment opportunities abroad?
3. What effects does the attrition have on the health care service delivery within the country?
4. What role can the Department of Health play in controlling the attrition rate?
5. What role can the South African Nursing Council, as a watchdog of the public play in controlling the attrition rate?

1.5 Objectives of the Study

The objectives of the study were:

1. To examine the attrition levels of KwaZulu- Natal nurses in relation to seeking employment opportunities in other countries.
2. To identify the factors influencing the KwaZulu-Natal nurses to seek employment opportunities in other countries.
3. To examine the demand versus the supply of nurses through the training programmes supported by the KwaZulu-Natal Provincial Department of Health
4. To determine the effects of attrition on the health care service

delivery within the Province of KwaZulu-Natal.

5. To examine the role-played by the Department of Health in controlling the attrition rate?

6. To examine the role-played by the South African Nursing Council as the watchdog of the public in controlling such attrition.

1.6 Significance of the Study

It was believed that the results and the recommendations of the study would:

- It is believed that this study makes a contribution to nursing research by increasing the body of knowledge concerning the attrition of KwaZulu-Natal nurses.
- Assist the Department of Health and the government to focus directly on the problems affecting nurses and nursing as an occupational class on it's own
- Assist the Department of Health to prove through the scientific enquiry whether the perceptions around the problem are true or not true.
- Assist the Department of Health to design the effective staff

retention strategy for the nurses in particular, bearing in mind their special significance over other scarce skills' occupational classes.

- Assist the Department of Health in dealing with other factors which might be compounding the problem of shortage of nursing staff.

1.7 Definition of Concepts.

Attrition. McLeod & Hanks (1985: 48), defines attrition as the act of wearing away, or the state of being won away by continuous weakening. It is used interchangeably with "the Brain Drain" concept, which is defined by Adaars, (1968: 42) as a one-way permanent migration of skilled people mostly from the less developed countries to the developed countries. For the purposes of this study, both concepts shall be used interchangeably to describe the continuous decrease in the quality and quantities of nurses in health care institutions as a result of the imbalance between recruitment and turnover.

Nurse: In this study, a nurse shall refer to an individual who has successfully undergone a programme of study leading to registration as a nurse (general, psychiatric, community)and midwife in terms of the South African Nursing Council Regulation R425 of 22nd February 1985. training in South Africa.

Nursing. Henderson (1996: 66) defines nursing as a unique function of a nurse to assist the individual sick or well in the performance of those activities contributing to health or it's recovery, (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge, and to do this in such a way as to help him gain independence as rapidly as possible. In this study, nursing shall refer to the duties of the nurse as defined above.

Health service delivery: In this study health services delivery shall mean shall mean all the systems and processes engaged in by the Department of health both at national and provincial level in order to

realize the vision of the Department which is to achieve the optimal health status for all the people of KwaZulu-Natal.

KwaZulu-Natal nurses: In this study KwaZulu-Natal nurses shall refer to the nurses registered with the South African Nursing Council and employed in the health facilities within the Province of KwaZulu-Natal.

1.8 Structural Outline of the Study

Although the details of the structural outline of the study is given under each chapter, a general outline is worth giving at this stage

Chapter 1: Orientation to the Study

- 1.1 Introduction
- 1.2 Background to the Problem
- 1.3 Problem statement
- 1.4 Purpose of the study
- 1.5 Objectives of the study
- 1.6 Significance of the study
- 1.7 Definition of concepts

1.8 Structural outline of the study

1.9 Summary

Chapter 2: Literature Review

2.1 Introduction

2.2 The Emergence and progress of professional nursing in South Africa and over the Years

2.3 A Brief overview of health services in South Africa / KwaZulu-Natal

2.4 The Expected management environment

2.5 The types of health worker migration

2.6 Challenges facing health worker migration

2.7 The international magnitude of brain-drain

2.8 The “Push factors” from the country of origin

2.9 Global strategies to address the problem

2.10 Theoretical framework

2.11 Summary

Chapter 3: Research Methodology

3.1 Introduction

3.2 Research design

- 3.2.1 Target population
- 3.2.2 Sampling technique and sample size
- 3.2.3 Preparation for data collection
- 3.2.4 Pilot study
- 3.2.5 Data analysis
- 3.2.6 Summary

Chapter 4: Data Analysis, Interpretation and Discussion of Findings

- 4.1 Introduction
- 4.2 Analysis, interpretation and discussion of findings

Chapter Five: Summary, conclusions, and recommendations

- 5.1 Summary
- 5.2 Research Findings
- 5.3 Conclusions
- 5.4 Recommendations
- 5.5 References
- 5.6 Annexures

Summary.

The introductory chapter highlighted a number of landmarks, and important variables that have influenced the brain drain problem in South Africa as a country, and in KwaZulu-Natal as one of the provinces in South Africa.

Firstly, it was noted that South Africa has been experiencing the inflow / outflow of it's intellectuals and professionals as far back as three to four decades. Notably was the fact that these movements followed the political crises of different eras. It was also noted that, even in the absence of accurate data around the problem, it is acknowledged that the situation has not improved even after taking over of the democratic government in 1994, and most concentration of these South Africans in the Diaspora, is only in six countries abroad.

The problem of the lack of accurate data was attributed to a number of factors including the non-disclosure of the correct reasons to emigrate, the common reason recorded being around tourism.

Secondly, it was noted that the migration patterns of intellectuals and professionals globally, is from the less developed countries to the developed countries.

Research generally indicates that the studies of the problem under review have not been done to completion, specifically related to the brain drain of nurses, as an occupational class on it's own. A few of these studies were reported to be underway in the United States, but the final results have not been communicated in literature. For this reason, the researcher will to a greater extent in the subsequent chapter refer to the literature that focuses mostly into the brain drain of intellectuals and professionals in Africa as a region to a greater extent, and international brain drain to a lesser degree.

Thirdly, the compounding factors to the problem were identified to be the effects of HIV/AIDS, in South Africa, the highest figures noted in KwaZulu-Natal, the province under study, the increased workload aggravated by the implementation of the policy on free health care services at the Primary Health Care level, decreased numbers of the

nursing support staff at operational levels, and the decreased enrollments into nursing education programmes versus the ageing nursing workforce.

CHAPTER TWO LITERATURE REVIEW

2.1 Introduction

The purpose of this review was firstly, to examine the accumulated body of literature on the international as well as the South African perspective of professionals' braindrain. Secondly it was to trace the evolution of nursing as a profession in South Africa, with emphasis on the different types of training programmes, and how these programmes have been amended with an aim of putting in place an effective / cost effective nursing programme. As a point of departure, particular attention was given to (a) the emergence and progress of professional nursing in South Africa, (b) a brief overview of the health care services in South Africa, and in KwaZulu-Natal, (c) the types of health-worker migration, (d) the challenges in measuring migration (e) the international magnitude of the brain drain (f) the "push factors," from the country of origin and (g) the "pull factors" to the country of intended destination.

Thirdly, it was to examine the global strategies to address the problem. Journal articles, newspapers, presented papers, media and textbooks were used as literature sources.

2.2 The Emergence of professional nursing in South Africa

Nursing education in South Africa started when Sister Henrietta Stockdale started a training programme of nurses at the Carnarvon Hospital in Kimberly in 1877. Admission requirements were not formerly laid down at that time, except that prospective students should be “cultured young women” who had read widely, knew Latin and could possibly play some musical instruments. (Mellish & Brink, 1990: 88)

Nursing students were supernumerary and paid a tuition fee. The first training course lasted for one year, the knowledge being tested by written examinations. The students had to serve another year as staff nurses before they gained recognition as trained nurses. Subjects included anatomy, physiology, practical nursing, and cookery for the sick, surgery and ethics. A second course of lectures was included in the second year, while nurses were serving as staff nurses, and the

second course examination was conducted towards the end of that year. (Mellish & Brink, 1990: 88).

According to Denny (1999: 26), South Africa led the world in the establishment of nursing as a profession, by being the first country in attaining statutory recognition, when it obtained state registration for nurses by act of Parliament in 1891. This was as a result of the efforts of Doctor John Tremble who made all the efforts towards the successful recognition of nursing.

The three year and the three and a half -year diplomas.

The purpose of the three year diploma was to raise the status of basic nursing education by, (a) uplifting the criteria for admission to standard ten, in line with admission requirements to tertiary education in all other fields of professional education, (b) enriching the curriculum by incorporating other courses for example, social sciences in order to enable the diplomates to cope with clients' social problems that have an influence on health (Mashaba, 1995: 45).

The strengths of this programme were that, (a) it led to the recognition of nursing education by Parliament through the enactment, in 1891, of a law which provided for state registration of nurses and midwives, (b) Sister Henrietta and Dr. Mackenzie recognized the need for the scope of practice of Nursing and Midwifery in Africa to be far more extensive, and (c) student nurses had enough clinical nursing practice exposure, and thus were perceived as clinically competent post graduation. It's weakness was that the programmed proved to be too costly since the period of three years was exhausted on learning only general nursing (Mascara 1995: 34).

The purpose of the three and a half –year diploma programme, known as the integrated course was to overcome problems identified with the three year diploma, that is cost-versus product. In the light of the rapid medical and technological advances which required increasing specialization in the nursing field, as well as population explosion with it's consequent increased demands for more comprehensive health services, the South African Nursing Council realized that the future nurses had to be prepared for their extended roles. It would therefore

be necessary to prepare nurses for integrated nursing services and for community services (Mellish and Brink 1990: 46).

Subject matter would be presented on an integrated basis. These courses were not offered at every training school, but many larger centers did train nurses according to this formula (Mellish & Brink, 1990). As the name suggests, this course combined general nursing with either midwifery and / or psychiatric nursing. It was first introduced in the early 1970's. The perceived strengths of this programme were related to, (a) prevention of duplication of lectures, (b) prevention of wastage of lecturing manpower, (c) partial answer to the nursing manpower shortage problem (Mellish & Brink 1990: 89). Concurring with the perceived strengths of this programme, Potgieter (1992, p.164) had this to say:

"The integrated courses were the answer to the modern concept of nursing care, namely the approach and treatment in totality of the patient. This prepared the nurse for her extended role in preventive, promotive, curative and rehabilitative services."

According to Williamson (1983: 56) Most of the students were trained at Provincial hospitals. Unfortunately the programme was unpopular, and was later abandoned by a few schools of nursing that offered it. It's perceived weaknesses outweighed the strengths, for example, (a) the period of clinical exposure was too limited, and it's products thus perceived incompetent post graduation, (b) the senior nurses at clinical practice settings had a negative attitude towards the students and the products of the course, and (c) the principle of service for education instead of education for service had become fully entrenched, contributing to nursing students being viewed as the main component of the working force. This resulted in a very high rate of student's wastage.

The Four-year comprehensive basic nursing programme.

In order to bridge the gap in the knowledge and skills identified with the programmes previously discussed, through a cost effective programme, the South African Nursing Council (SANC) in 1985, passed the regulations that would enable a new graduate to cope with the society's health needs from before birth, to death at an advanced, and

to do so in all fields of nursing and midwifery, for all those conditions that occur as a constant factor in the South African community. Furthermore, this regulation aimed at integrating nursing education within the tertiary education system of the country, and the programme is offered at diploma level by Colleges of Nursing, and at a degree level by the Universities (Mellish & Brink 1990: 89).

Post basic nursing courses offered by South African academic institutions.

Over and above the Basic nursing programmes outlined above, a number of nurses register for a number of post basic programmes that offer them specialty skills in a number of fields. These include, midwifery, critical care, pediatrics', orthopaedics, Primary Health Care, Operating Theatre Nursing, Oncology, Trauma, Gerontology etc. These are all the specialties, which are perceived to be exiting South Africa to other countries.

2.3 An overview of the health services in South Africa.

The overview of the health services in South Africa was done in terms of the availability of the scarce categories of the health care professionals,

the effects of Apartheid prior the first democratic elections, the availability of the training and the health care facilities, and lastly the National health priorities.

South Africa's health care facilities include hospitals, day hospitals, community health centers and clinics. In 1995 about 25,600 doctors as well as 24,500 supplementary health professionals, 160,000 nurses and nurse auxiliaries, and more than 5,100 dentists and dental therapists were registered with the South African Medical and Dental Council (SAMDC) and the South African Nursing Council. In the early 1990's, only about 1,500 doctors nationwide were Black. Wealthy White areas averaged one doctor per 1,200 people, not to mention in the poorest Black homelands with a ratio of one doctor per 13,000 people. Until 1990, apartheid was practiced in most (Country Studies: 1996, 1).

There are eight Medical Schools in South Africa, and six provide dental training. Nurses are trained at several universities, Nursing Colleges affiliated to universities, public and private nursing schools. More than

300 hospitals are managed entirely or partly by provincial departments, out of which 63 hospitals are serving KwaZulu-Natal population. 255 hospitals are privately operated. There are an estimated 108,000 hospital beds nationwide, and almost 24, 800 beds in psychiatric hospitals. The South African Red Cross renders emergency, health, and community services, operates ambulance services, senior citizen's homes, and air rescue services across the nation, but primarily in urban areas. Some areas have also the 24hours poison control centers, child assistance phone services, rape crisis centers, and suicide prevention programs.

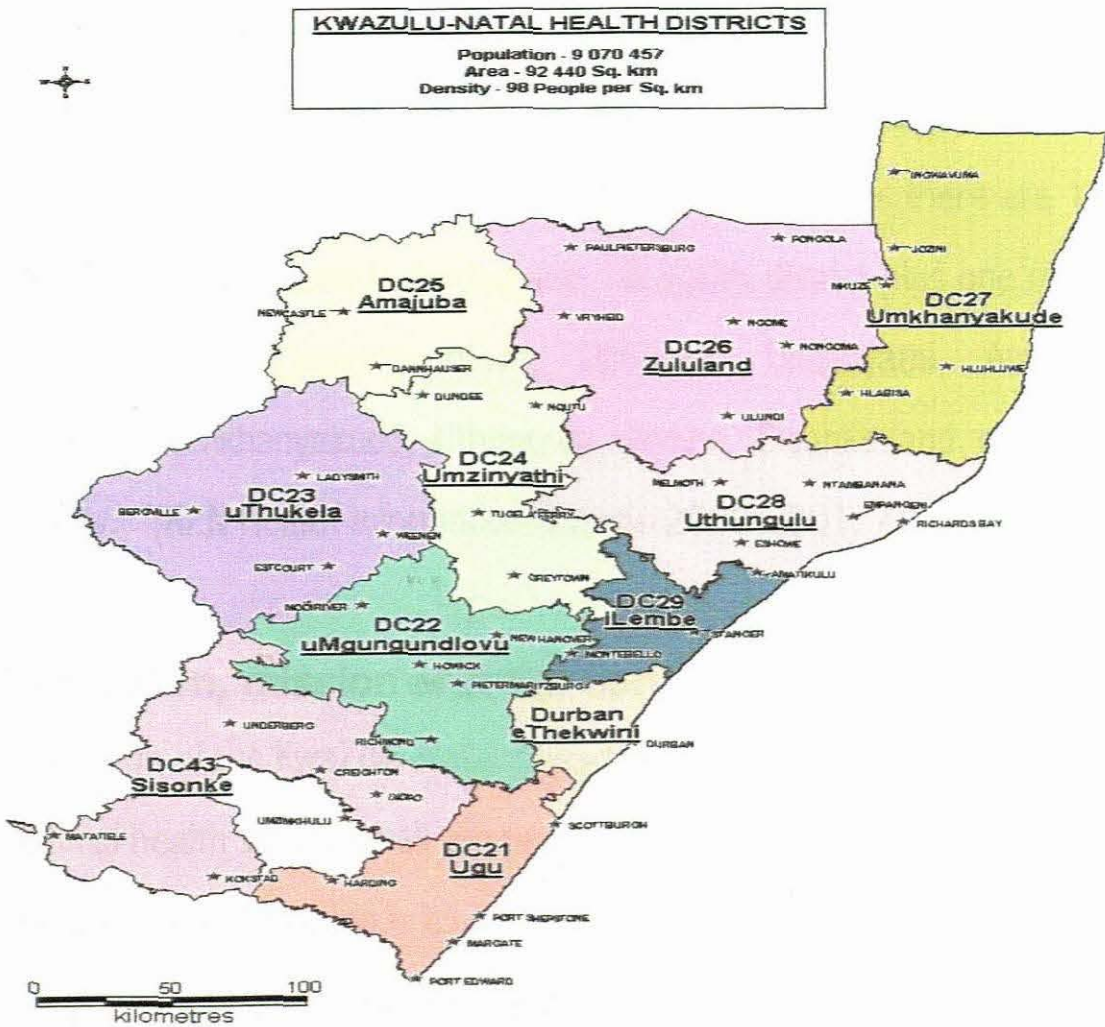
One of the interim government's highest priorities in the mid 1990's was the prevention of childhood deaths and diseases through nationwide immunization programs as well as the implementation of the Integrated Management of Childhood Illnesses (IMCI). The incidence of tetanus, measles, malaria, and other communicable diseases was high, especially in the former African Homelands. For this reason, one of President Mandela's first actions after assuming office in May 1994 was to implement a program of free health care for children under the age

of six. By early 1996, reports revealed that at least 75% of all infants had been immunized against polio and measles (Country Studies 1996: 1).

2.4 An overview of the KwaZulu-Natal province.

This review was done in terms of the (a) population and its demographics, (b) the vision, mission, core values of the KwaZulu-Natal Provincial Department of Health, (c) the package of health services at the institutional level in KwaZulu-Natal, and lastly, (d) the expected management environment.

Figure 1: A Map reflecting the health districts in KwaZulu-Natal.
 Adopted from KZN Department of Health's website:
<http://www.kznhealth.gov.za/Mainmap.htm>



The KwaZulu-Natal population and its demographics.

The KwaZulu-Natal is the most highly populated province in South Africa, and it houses 20.5% of the total South African population.

The mid-year estimated population for 2001 was 9 070 457, which were 8 407 920 in October 1996. The estimate was based on 1996 census, considering the growth rate of 1.5834% with additional deaths due to HIV/AIDS. There are fewer males than females, 47 and 53% respectively. On an average, for every 100 males there are 113 females. The Province is divided into 10 health district plus one metro, namely, Ugu, Umgungundlovu, Uthukela, Umzinyathi, Amajuba, Zululand, Umkhanyakude, Uthungulu, Ilembe, Sisonke and eThekweni Unicity. (KZN Health Information Bulletin 2000-2001: 7)

The vision, mission and the core values.

The vision of the KwaZulu-Natal Department of Health is to provide optimal health status for all the persons in the province of KwaZulu-Natal, whilst it's mission is to develop a sustainable, co-coordinated, integrated and comprehensive health system at all levels of care, based

on the Primary Health Care approach, through the District Health System. The core values are (a) trust built on truth, integrity and reconciliation, (b) open communication, transparency and consultation, (c) commitment to performance, and (d) courage to learn, change and innovate (KZN Health Strategic Plan : 2002- 2003: 7).

The Package of services at institutional level in KwaZulu-Natal

The White Paper on the Transformation of Health Services in South Africa has proposed a new system of hospital service delivery, which contributes significantly towards achieving the vision and the mission of the KZN Health Department. The system clearly identifies a hierarchy of hospital service delivery through an appropriate referral system and implies the core business of the hospital sector.

Furthermore, it emphasizes that hospitals should concentrate on providing high quality compassionate inpatient care and outpatient care on a referral basis and on supporting the development and sustenance of the Primary Health Care sector (Package of Services, KZN 2003: 30)

The hierarchy of hospital service provision is characterized by the district hospital services providing the basis for hospital care and therefore being the most accessible to the surrounding communities. These hospitals normally receive referrals from and provide generalist support to community health centers and clinics. Most of the care is delivered by general practitioners, medical officers or Primary health care nurses in the absence of the specialist other than the Family Medicine Specialist. Each District Hospital has a minimum of 30 and a maximum of 400 beds, and any other facilities with less than 30 beds are classified as community health centers or clinics (package of Services, KZN 2003:30).

The Regional Hospitals receive referrals from and provide specialist support to a number of District Hospitals. Most care at this level is classified as level II care requiring the expertise of the general specialist-led teams. This includes general surgery, orthopedics, general medicine, paediatrics, obstetrics and gynaecology, radiology and anaesthetics. Within most regional hospitals, however, there is also some of the level I services. The Provincial Tertiary Hospitals

receive referrals from and provide sub-specialist support to a number of regional hospitals. Most of the care at this level is classified as level III, care requiring the expertise of clinicians working as sub-specialists or in rarer specialties such as in surgery, for example, urology, plastic-surgery and cardio-thoracic surgery (Package of Services, KZN 2003: 30).

The specialized hospitals provide care only for specialized groups of patients. They include chronic psychiatric and TB hospitals, as well as specialized spinal injuries and acute infectious disease hospitals. The last group high in the referral hierarchy are the National Central Hospitals (Package of services KZN 2003: 30).

There is presently one hospital in KwaZulu-Natal falling into this category, namely Inkosi Albert Luthuli. It consists of the very specialized referral units which together provides an environment for multi-specialty clinical services, innovation and research. These services are generally of a high cost and low volume and require high technology, and or multi-disciplinary teams of people with scarce skills

to provide sustained care of high quality. (Package of Services, KZN 2003: 30)

The expected management environment.

In terms of the Hospital Service Package for South Africa, there are two important National Policies that define the context for hospital management. They are the Batho Pele programme and the Patients' Charter. The principles of the Batho Pele programme are consultation with the public, the setting and communication of service standards, equal access to services, courtesy to the public, full accurate information about services to the public, openness and transparency, redress if promised standard of services is not delivered, and lastly, value for money, meaning that services shall be rendered economically and efficiently (Government notices RSA 1997: 15).

The Patients' Charter lists the responsibilities of both the providers and the patients. According to this policy, every patient has the right to a healthy and safe environment, access to health care, confidentiality and privacy, informed consent, referral for a second opinion, exercise choice in health care, continuity of health care, participation in decision

making that affects his or her health care, to be treated by a named health care provider, to refuse treatment, to be informed about his or her health insurance, and to complain about the health services she or he receives (Package of Services, South Africa 2002: 9).

Over and above the rights that the charter provides for patients, the patients in turn have to fulfill certain responsibilities, which include living a healthy lifestyle, caring for and protecting the environment, respecting the rights of other patients and health staff, utilizing the health system optimally without abuse, knowing the health services available and what they offer, providing health staff with accurate information for diagnosis, treatment, counseling and rehabilitation purposes, advising the health staff on his or wishes with regard to death, complying with the prescribed treatment and rehabilitation procedures, and lastly asking about management costs and to arranging for payments (Package of Services, South Africa 2002: 9).

The overview of health services in South Africa as a country revealed that the effects of Apartheid had a negative impact on the health

system as a whole, for example, the inequitable distribution of health services. In order to address the health care problems, resulting from the health system of the Apartheid era, a number of programmes were begun, including the free health services at the Primary Health level. This programme alone, added an enormous amount of workload emanating from the high patient turnover.

Looking at KwaZulu-Natal as a province, it appeared that it is the mostly populated province with the highest incidence of epidemics including Tuberculosis, malaria, cholera as well as HIV / AIDS. The vision and the mission of the Provincial Department of Health, the package of health services, and the expected management environment, clearly indicated the commitment and the determination of the health authorities to do their utmost best in the delivery of quality services. (KZN Department of Health 2001/2002).

The biggest challenge is the perceived shortage of manpower, arising from the perceived exodus of the very important category of health workers, the nurses, at the time when they are mostly needed.

2.5 Types of health-worker migration

When studying movements of health workers, literature distinguishes three types of migration. That is, the internal, international, and the “cross industry” migration of people leaving the health system to work in areas not related to health (Diallo 2004: 602).

Internal migration describes movements of health personnel within national borders, across subnational administrative units, or between rural and urban areas. In most countries, health workers move from poorer settings and rural areas, faster than the rest of the local population, leaving such areas understaffed in comparison with wealthier regions and cities. If not regulated, this type of migration tends to increase geographical imbalances and inequities in access to health care (Diallo 2004: 602).

International migration describes the movements of health workers who temporarily or permanently settle abroad, mainly because of problems in their home country, such as poor working conditions, low remuneration and lack of incentives, or insufficient availability of

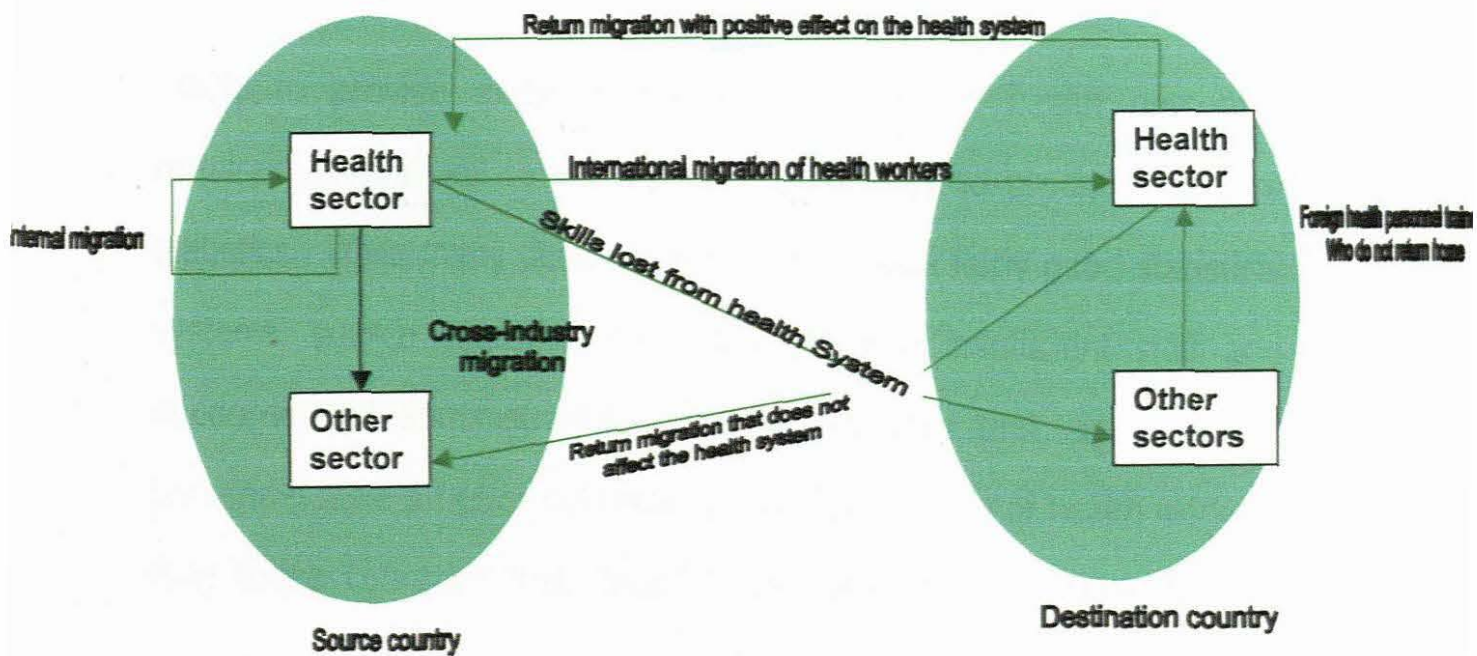
training and avenues for professional development. International migrants include those who are no longer working in health in the host country, and migrants who return and continue to work in health care.

Studies of the international movement of health workers usually distinguish between the countries that send health personnel (the source country) and those that receive them (the destination countries). Diallo (2004: 602) recommends differentiating between those source countries that send their health personnel voluntarily, and those that involuntarily lose their health workers. This differentiation is important because the impact is different. The effect of migration on service provision with the first group is small. These countries usually have the sufficient stock of health workers and “export” health workers mainly to benefit from the remittances.

In the Philippines, for instance, the remittances from physicians working abroad were estimated to compensate for the costs of training and emigration. The impact on service provision in countries that are losing health workers and are already suffering from shortages is more

severe because migration of highly skilled health workers limits access to health care and erodes the quality of care. Health personnel who leave their usual activities for more attractive activities in non-health related fields are counted as “ skills lost”, and this can have the same impact as migration. :Cross-industry migration, “ is another type of internal migration, and has an impact on service provision because vacancy rates in the health-care sector increase (Diallo 2004: 602).

Figure 2: A diagram depicting types of migration of health workers. Adopted from Diallo (2004: 602)



2.6 Challenges in measuring migration

Given the constraints discussed above, any assessment of the scope of international migration and its impact on a country's health-care system will remain an important challenge. Many countries cannot afford the financial burden of producing reliable statistics, and therefore finding ways of reliably recording international movements and information on occupations (to allow identification of the main occupations of health personnel) is difficult. Moreover, because data are collected and processed at different times in different places, it is difficult to ensure the comparability and timeliness of data (Diallo 2004: 605).

Ability to provide evidence on the migration of health personnel requires political will to strengthen the capacity to produce and use statistics. While many destination countries have fairly good statistical systems, source countries often struggle with insufficient staff and uncoordinated administration. Source countries that export health personnel have a better potential to monitor the flow of health workers than those countries that "lose" health workers who are in transit.

Statistics from these destination countries may therefore overestimate the number of health workers.

Another important challenge is to identify the factors that push health workers to leave their home country; source countries often have difficulty monitoring the phenomenon, and qualitative information is sometimes required. Migration information is considered sensitive, and many governments do not collect or share, even between administrations in the same country. Governments need to be aware of the importance of collecting and sharing data on migration so that migration can be better managed. However, in poorer countries there are many other priorities that must be met from scarce resources.(Diallo 2004 : 605)

2.7 The International magnitude of the brain drain.

Literature reveals that All Africa News (1999:2), McVeigh & Hill (2001: 4), Tsukudu (2002: 53), Sison (2002:31), & Tettey, (2003: 49) have aired their political as well as the economic overviews in relation to the brain-drain both internationally and within the South African context. All

writers concur that the political aspect of brain drain cannot be divorced from the economic aspect. They emphasize that it is in contradiction with the great international economic and political objective, namely the narrowing of the gap between the developed and the under-developed countries. It expresses at the same time the complexity and the inter-dependence of different societies, through a complicated interplay of the “push and pull factors.”

All writers, that is All Africa News (1999:2), McVeigh & Hill (2001: 4), Tsukudu (2002: 53), Sison (2002:31), & Tettey, (2003: 49) concur that the largest percentage of skilled workers in the developed countries has been drawn from the developing countries.

Such professionals were not just academicians employed by the universities and top notch centers. They included computer experts, corporate lawyers, doctors, schoolteachers, nurses, engineers and business executives, all with tertiary education amongst their varied professions. Furthermore, they concur that the developed countries save their pounds and dollars on professional education and training,

and in the process obtains the services of trained doctors, nurses, engineers, etc. who earn very much more than their counter parts and have more comfortable styles of living. (McVeigh & Hill: 2001, 3) in particular goes further to examine the brain drain in the context of the age factor of emigrants. They argue that as emigrants enter the developed countries, they are often in the most productive phase of their professional life, and by the time they return back, if they do, they are often spent force with wrong ideas not suited even for their underdeveloped countries.

Furthermore, McVeigh & Hill (2001: 3) have identified the main characteristics of brain drain as follows: (a) there are numerous flows of skilled and trained persons from the developing to developed countries, (b) they are characterized by large flows from a comparatively small number of developed countries and by small flows from a larger number of developing countries, (c) in these flows the engineers, medical & nursing personnel, and scientists usually tend to predominate, (d) the above flows have grown with increasing rapidity in recent years, (e) the higher the level of skill / training, the greater the

susceptibility to migration tends to be, (f) the flows respond increasingly to the changed economic complexity of world societies and to legislation which reflects the demands of the new era, (g) the migratory trends are stimulated by both the character of national education systems by lack and inadequate planning for the training of students from the developing countries, in developed states as well as the proper utilization of their skills in their home country, and (h) there are no signs that the migration of talent is decreasing and there are fairly definite signs that it's increase will, under the present conditions, continue to accelerate. Ghosh & Ghosh (1982: 18) maintain that brain migration is a consequence of dualistic world economy.

They view the world to be having a dualistic structure. One part of such an economy is dominated by the technologically / advanced industrially developed rich countries (DCS) and the other part being represented by capital poor agricultural economics (LDCS). The point of differences that cause brain migration between such countries are shown below:

DEVELOPED COUNTRIES (DCS)	LESS DEVELOPED COUNTRIES (LDCS)
Wage level high	Wage level low
Absorptive capacity high	Absorptive capacity low
Labour shortage	Labour surplus
Demand labour high	Demand of labour low
Education very costly	Education cheap
Population growth low	Population growth high
Mass consumption stage of development	Primary stage of development
Opportunity cost of labour high	Unemployment / underemployment prevailing
Marginal productivity of labour high	High quality manpower not so essential
Labour more / less fully employed	
Rate of profit very high as a whole in the economy	Rate of profit very low as a whole in the economy
High rate of economic growth	Low rate of economic growth

Tettey, (2002: 37) in particular maintains that there are no systematically collected, consistent and verifiable statistics about the monetary cost of brain drain to Africa. In line with Tettey (2002: 37)

Diallo (2004: 604) argues that there are rigid rules governing the recruitment and employment of migrant health personnel in many destination countries, and therefore the international migration of health workers is more likely to be legal migration. As a result many sources can be used to capture and analyse this migration. Potential sources include registries of work permits, records of entry visas, registries of professional associations, population registries, facility surveys, population censuses, and economic censuses. Different types of visas and work permits are issued depending on the agreements between countries, the occupation of the migrant and the intended duration of stay.

Statistics from entry visas and work permits can give an insight into the annual flow of migrants by occupation, country of origin or residence. They may also give information on some other characteristics of health personnel who migrate. Some countries, for example, the United States, require foreign health workers to take examination before filing an application for a work permit or visa. Data from these examinations could be used as indicators of the intention to

migrate but they do not tell us how many successful candidates have left their home country (Diallo 2004: 603).

Other limitations of these statistics are that there is no way of knowing whether migrants meet the conditions of their visas or work permits, for example, by working in a specific place or job. In addition, because different agreements exist between different countries, migrant health workers will need work permits for some countries and not for others. Proxy measures have, however been adopted to give a sense of the value of the human capital that the developed countries, in particular, are gaining at the expense of Africa and the repercussions for the continent. (Tettey 2002: 56) (Diallo 2004: 604).

It is estimated that there are about 100, 000 highly educated African professionals currently working in the United States alone, and the biggest migratory flows from Africa to the United States are Egypt, Ghana, South Africa, Nigeria, Sierra Leone, Kenya and Uganda. Furthermore, researchers are worried by the outflow of immigrants from the rest of the Sub-Saharan Africa to South Africa, a country that

has the highest number of immigrants to the United States of America. (Tettey 2002: 37). The outflow of these highly educated people from many countries in Africa is now a phenomenon that policy makers cannot ignore as numbers continue to rise (Tettey 2002: 37).

McVeigh & Hill (2001: 3) maintains that the highest percentage of nurses who migrate, are those with experience in operating theatre, or casualty trauma. (Tsukudu (2002: 12) in particular has studied the economic implications of the transition of South Africa from the Apartheid to the democratized country. He holds that after many years of apartheid rule, South Africa has become a full and equal member of the international community and a player in the global arena.

The negative implication is that firstly, globalization has meant that South Africa is increasingly feeling the pressure of the global labour market, of fighting in the world war of talent. During the Apartheid era South Africa actively spent a disproportionate amount of money and other resources in skilling and equipping a small section of society

(white) as opposed to being inclusive of the Black people
(Tsukudu 2002: 13).

South Africa presently faces a shortage of skilled labour, including nurses. It is a situation that is compounded by what is called by some a “brain drain” or by others a “white flight” as it is mainly white skilled people who emigrate. Secondly, emigration hurts the South African economy. Foreign companies that invest in South Africa struggle to find suitably qualified locals to run their operations. South African companies struggle to pay distorted salary packages in direct competition with the US dollar or British pound-based offers from abroad. (Tsukudu, 2002: 36).

Sison (2002:23) goes further to highlight the effects of the nursing brain drain on the quality of health care delivery. In particular she reiterates that, most of the specialized and experienced nurses have left the country, and stating that South Africa is left with the novices. To support the statement by Sison, Benner (1984), describes nursing practice in the continuum of levels, from novice, advanced beginner,

competent, proficient and expert. Benner (1994: 18), holds that novices are mostly dependant on rules, which limit their scope of action. Their approach to problem solving remains rigid and solely dependent on prescribed rules. When abnormal situations emerge at a work situation, nurses at this stage remain very apprehensive, that they may not be able to handle the situation correctly.

Proficient nurses, according to Benner (1984: 22) understand the situation as a whole, and perceive it's meaning in terms of long range goals. They learn from experience what typical events to expect in a given situation, and they are able to modify their care plans in response to the prevailing events. Their experiences help them to practice situational leadership, and they keep calm even in cases of emergencies. The expert nurse no longer relies on analytic principles to connect his or her way of understanding the situation. She or he possesses an intuitive grasp of different situations from an enormous background of experience, which enables him or her to take wise decisions without any waste of time. The expert nurse is no longer aware of features and rules, but his or her performance becomes fluid

and flexible (Benner : 1984: 65). Citing Borromeo, Sison (2002:3) further states that departure of experienced nurses directly affects the quality of health care because the health care institutions depend upon them to interact with patients, and she has this to say:

“It is frustrating because the ones you have trained already know what to do and they learn how to anticipate your needs which, in turn, makes your work efficient, and then they leave, he sighs.”

The international magnitude of the braindrain and it's effects on service delivery, has also been looked into with particular reference to other compounding factors, for example, (a) the declining enrollments into nurse training programmes, (b) drop outs (attrition during training) and (c) the effects of HIV / AIDS. (Sison 2002: 3).

One of the Government's biggest successes in health delivery since 1994 has been to increase the facilities available to the people at community level. Quantitatively, they can claim success in getting more services to the people. However, staffing of these clinics is often the problem. The decreased numbers of nurses contributes to compromised patient care and a high level of burnout, because very few nurses have to cope with the increased demands for patient care.

Partly, this stems from the problematic issues around the issues of (a) recruitment into nursing education programmes, (b) retaining the recruits to programme completion.

All Africa News (1999:2), McVeigh & Hill (2001: 4), Tsukudu (2002: 53), Sison (2002:31), & Tettey, (2003: 49) have aired their views in relation to the declining enrollments as a compounding factor. They have further reiterated that the employers are demanding more professionally prepared nurses for hospitals and the speciality nurses for intensive care units, operating rooms, emergency rooms, and other specialized areas of acute care.

All writers concur that for about a decade or two, the number of recruits into all forms of basic nursing education programmes have been declining in relation to the highest demand for health care. This is partly attributed to (a) the increased negative publicity about hospital closures, layoffs, (b) inadequate delays in training new nurses to replace those that have left, (c) the fact that women have many choices today when selecting a post high school education career,

(d) documented poor working conditions, such as evening, night, and weekend shifts, or exposure to contagious elements are cited as persuading many potential nurses to pursue other careers. All Africa News (1999:2), McVeigh & Hill (2001: 4), Tsukudu (2002: 53), Sison (2002:31), & Tettey, (2003: 49).

The problem of recruitment of candidates into nursing education programmes stems from a number of reasons. For example, (a) women who have traditionally filled the field, have many other career options today, (b) colleges have not expanded because nursing education is more expensive to provide than other programmes, (c) enrollment in baccalaureate nursing programmes has declined for the five consecutive years. This recruitment state of affairs in California may have influenced the country, to have no other option but to recruit trained nurses from other countries, including South Africa. Almost similar to the conditions in California, very small numbers of candidates are admitted into nurse training programmes in South Africa. Numbers attracted appear incongruent to the extent of populations served. One of the colleges situated within the radius of at least 480, 000

population in Northern part of Kwa-Zulu Natal has only produced not more than 100 diplomates, in the past five years. (Dobson 2001:3).

Attrition during training, is another area of concern. In the United States, the introduction of the lottery system into community college admissions has allowed under prepared learners to enter. Attrition rates (due to drop out and failure) have risen from 10 percent to 40 percent.

HIV/AIDS pandemic has also been looked into by a number of researchers, writers, speakers and agencies, both locally and internationally, to mention but a few, Floyd (1997: 23), Mangena (2001: 2), Mdladlana (2001:1) Mashishi (2000: 2) Mngomezulu (2002: 1) & Itano (2002:1) as another compounding factor mentioned above. They all maintain that that the sick patterns have been worsened by the AIDS pandemic affecting both the adults and the children, exerting unrealistic demands for the nursing manpower. The families cannot effectively take care of the famine in many parts of the Sub-Sahara Africa and some homesteads have closed down, some leaving only underage children at their own fate.

Mangena (2001: 2) in particular holds that the latest national estimates of HIV / AIDS infection rate is around 4.7 million South Africans, (more than 10% of the population) with 1 500 additional cases a day. The combined effects of poverty related health issues, infectious diseases, and AIDS have lowered the life expectancy to 54,7 years, and this figure is expected to drop to 47 years within the next ten years or so. In acknowledging the problem as it physically affects the total labour force in South Africa, including the small percentage that chooses to remain in South Africa. has this to say:

“HIV / AIDS is making profound inroads into education and training. It is ravaging our national human resources. It is reversing many of the gains of human resources’ development. In fact for families, communities, business and learning institutions throughout the land, the epidemic is changing the “D” in “HRD” from development to destruction. Futhermore, he maintains that business leaders warned that the companies might have to train three people for every one job because of the expected death toll.”

Based on the above review, it is worth to summarise that the magnitude of the problem under review is wide in terms of the estimated figures of emigrants, exacerbated by the caliber of professionals in terms of their skills and age, the failure to produce

more graduates, the AIDS pandemic affecting communities as well as the remaining human resources. Conclusions can also be drawn that the highly skilled are much more mobile than the less educated.

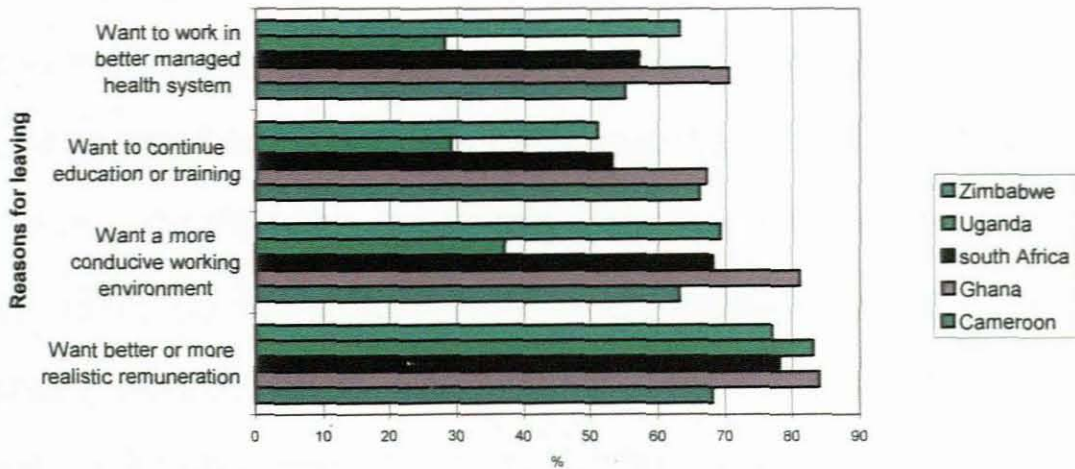
2.8 The “Push factors” from the countries of origin

McVeigh and Hill: (2001: 2) maintain that the causes of Brain Drain are often seen in a bi-polar model of “pulls” exerted by the immigration countries and the “push” exerted factors operating in the emigration countries. They define the push factors as the depressing characteristics in the country of origin, which produce emigration. On the other hand, pull factors are the attracting features in the country of destination, which induce immigration.

The discussion on the international magnitude of brain drain focused on the general picture of political / economies migration trends as influenced by the different characteristics of the developed countries versus those of the less developed countries (McVeigh & Hill 2001: 3).

The discussion on the push factors will pay particular attention to researched literature influencing the professionals to migrate. These factors will be classified into (a) political, (b) economic, that is, all forms of compensation, for example, wage and salary, incentive plans, employee benefit programmes, and additional privileges,(c) occupational, for example, stress related to problems around institutional socialization, placement, orientation, professional guidance and support, and lastly workload. Figure 2 below depicts the factors affecting health professionals' decision to migrate from five African countries.

Fig.3. Factors affecting health professionals' decision to migrate from five African countries: adopted from Stillwell et al 2004. pg 597



2.8.1 Political factors.

Crime

Amongst all the push factors recorded in literature, crime appeared to be the most prominent factor. For the purposes of discussion, crime will be looked into in terms of (a) the general overview during the pre and post democratic era, (b) factors influencing crime levels, (c) risk of victimization, and (d) the significance of the statistics (Schonteich & Louw 2001: 3).

The web's premier conservative news discussion forum (1999:2) Migration News (2001), Schonteich & Louw (2001:1), Crush (2000: 2), and Tettey (2002: 4), have explained crime as a push factor. All writers concur that (a), crime in South Africa is perceived to be a significant threat to the country's overall stability, and to the welfare of its citizens (b) the levels of politically motivated crime has decreased since 1994, (c) the general crime which includes, assault, sexual offences, murder, violent and property crime for example, armed robbery, car high-jackings, muggings, "smash and grab" has increased dramatically, and affecting the tourists as well.

The high crime levels and violence in South Africa, and in KwaZulu – Natal have played a part in fuelling negative perceptions, and fear of crime has itself now become a major cause of loss of skills.

Factors influencing crime

Schonteich & Louw (2001: 4) hold that there is no one satisfactory explanation for South Africa's high levels of crime, especially the high and increasing levels of violent crime, however, they offer a number of issues which help to explain South Africa's consistently high levels of

crime since the country's first non-racial democratic elections in 1994. The two authors have given the period of transition, culture of violence, proliferation of firearms, organized crime, youthful population, rapid urbanization and the weak criminal justice system as factors influencing crime levels. Each factor will be briefly discussed.

The period of transition

Schonteich & Louw (2001 : 4) reiterate that there is a link between South Africa's political transition over the last decade and the increase on the levels of crime. The two writers further maintain that the increases in crime over the last ten years are consistent with the experiences of other countries undergoing transitions to democracy, which are followed by attempts to consolidate new democratic institutions. As change and democratization process proceed, society and its instruments of social control are reshaped, and as a result, new areas for the development of crime open up (Schonteich & Louw 2001: 4).

The South African transition brought about a restructuring of the criminal justice system, the abolition of a number of laws and the promulgation of the new ones. This resulted in the weakening of many criminal justice functions. Schonteich & Louw (2001 : 5) further hold that experienced personnel working in the system, who were trained in policing methods of the old authoritarian order, are now unsure how to function effectively within a new legal framework based on the rule of law, and a constitutionally entrenched bill of rights.

Culture of violence

Sometimes the high rate of crime is attributed to South Africa's political history, in that the families suffered from "institutional violence" for decades through the disruption of their lives by mass removals and migrant labour policies of apartheid. Political violence compounded the disruption of family life, resulting in the weakening of the family unit, and parental control over children, which may prompt criminal behavior amongst the youth. "Culture of violence" theories argue that the effects of apartheid coupled with years of political violence and the continued exposure to violence in the home, and in the neighbourhood produced a destructive culture which manifests itself in what Nedcor

Project on Crime, Violence and Investment called “murderous intolerance”. This means that South Africans quickly resort to violence as a means of solving conflicts whether in the domestic, social or work environment. (Schonteich & Louw 2001:5)

Proliferation of firearms

Citing the Central Firearms Registry, Shonteich & Louw (2001 : 5) maintain that in 2001, 3.5 million South Africans legally possessed 4.2 million firearms, of which slightly more than half were handguns, and it was estimated that a similar number of illegal firearms were circulating in South Africa. The situation is compounded by South Africa’s porous borders allowing arms smugglers to bring large quantities of firearms into the country. Because of an oversupply of small arms, these sell cheaply, making them accessible to petty criminals and juveniles in South Africa. As mentioned earlier on, these arms are used to commit crimes and to resolve personal disputes. (Schonteich & Louw 2001: 5).

Organized crime

Although no accurate figures exist, Schonteich & Louw (2001 : 5) argue that it is likely that organized crime has grown considerably in South Africa since 1994. It tends to grow rapidly during periods of

political transition, when levels of violence are high, leading to state resources being concentrated in certain areas only, and gaps emerging in which organized criminal groups may operate. These syndicates are behind a significant number of car hijackings, vehicle thefts, armed robberies, burglaries of homes in upper-class areas and businesses, commercial crimes and shoplifting (Schonteich & Louw 2001 : 5).

Youthful population

South Africa has a relatively youthful population. Research suggests that there is a strong relationship between age and crime, where most of the crimes are committed mainly by teenagers and young adults. According to the last census, a third of the South African population was under the age of 15 years, and 44% was under the age of 20 years in 1996 (Schonteich & Louw 2001: 5).

The numerically largest population segments were those aged 5 – 9 years, and 10 – 14 years, each of which made-up almost 12% of the total population. This means that with the next census, a number of

children will have moved into the crime prone ages of 12 – 19 years (Schonteich & Louw 2001: 5).

Rapid urbanization.

It is a worldwide phenomenon that crime rates are higher in the cities than in rural areas, with the rate generally increasing according to city size. *With the abolition of influx control in the mid 1980s urbanization*

rates increased in South Africa, especially in the country's larger metropolitan areas to which a larger number of people were drawn in the search for employment. Factors which characterize urbanization such as overcrowding, unemployment and increased consumer demands and expectations (Schonteich & Louw 2001 : 5).

Weak criminal justice system.

The poor performance of a criminal justice system should not be interpreted as a cause of crime. The primary aim of the criminal justice system is to process cases and offenders speedily and effectively and to hand down appropriate sentences to the convicted. Nevertheless,

how well the system functions is important for the following reasons: (a) a relatively small proportion of people are believed to commit the majority of serious crimes, and especially organized crime. If these offenders are apprehended and convicted quickly and effectively, certain crimes can be reduced, (b) a functional system helps to deter some potential offenders from committing a crime, (c) an effective and efficient criminal justice system inspires confidence among victims and witnesses and encourages them to participate in the future by reducing secondary victimization and alienation, and (d) criminal justice successes are essential for boosting public confidence in the government's ability to reduce crime and make people feel safer (Schonteich & Louw 2001 : 6).

Statistics reveal that South Africa's criminal justice system is not performing optimally. In 1999, 2.4 million crimes were recorded by the police and 200 000 crimes ended in conviction of the perpetrators. While it is true that not all recorded crimes should necessarily result in a conviction, the number of convictions in South Africa is low. For the criminal justice system to be successful, it must apprehend, convict and

punish most of the core group of offenders. On average, fewer than 9% of recorded crimes result in the conviction of the perpetrators (Schonteich & Louw 2001 : 6).

Risk of victimization

Schonteich & Louw (2001 : 6), hold that crime does not affect all people uniformly. The likelihood of the average person falling victim to crime is strongly influenced by many factors, for example, age, income, place of residence, and circle of friends and acquaintances. Young people are disproportionately likely to be victims of crime, especially young urban males. The national Victims of Crime Survey found that, out of individuals who had experienced at least one violent crime in South Africa in 1997, almost a third were aged between 16 and 25 years.

The level of victimization consistently declines with age. For non-violent crime, the age group 26 to 35 years experienced the highest level of victimization, after which the level of victimization declines rapidly with age. According to the national Victims of Crime Survey, the wealthiest households are at greatest risk of falling victim to household related

property crime. Households with annual income over R48 000 reported levels of victimization greater than the average of 18% in 1997. Some 24% of households earning between R48 000 and R95 999, and 29% of those with annual incomes of more than R96 000 were victims of property crime (Schonteich & Louw 2001 : 6).

The risk of victimization has also been looked at in terms of the place of residence of individuals. Research has shown that areas inhabited by the poor are less likely to have the kind of infrastructural development, such as street lighting and well maintained public spaces, which facilitate personal crime prevention. The incidence of property crime in a certain area is frequently inversely related to the incidence of violent crime. Townships and poorer areas which experience the highest per capita levels of violent crime in a city often have the lowest levels of property crime. The opposite tends to be the case for the wealthier suburbs. City centers experience high levels of property and violent crime, due to the influx of large numbers of non-residents into cities' business districts on working days (Schonteich & Louw 2001 : 6).

Declining Standards

Research has indicated that besides crime, falling standards constitute another factor influencing the professionals to emigrate. Debate, South Africa indicated that 19% of emigrants list declining standards of education, health care, public service and corruption as reasons to emigrate. Shortage of funds and misguided educational policies and initiatives, racial quotas at universities and government threats about correcting a “lack of transformation” at all costs in predominantly white schools, make people fear for their children’s education. A massive decline in the quality of public hospitals, have inadequate funding, mismanagement, theft and generally unhygienic conditions. In addition to bureaucratic incompetence, corruption, nepotism and self-entitlement have added to the woes of the public service. (Debate South Africa 2001 : 2).

2.8.2 Economic Factors.

A number of writers have examined compensation and its relationship to the global market place. Amongst them are Ezzamel & Willmot (1998:26), Coleman (1999: 20), and Muchinsky, Kriek & Schreuder (2002:19).

Citing Ezzamel & Willmot (1998), Muchinsky et. al (2002:43) hold that emergence of the global marketplace is having a profound impact on the traditional ways of managing work, and compensation of employees thus raising the issue of the global pay.

More and more companies are doing business internationally, which implies that they have employees in various countries, but also implies to a squeeze on profits caused by intensive local and global competition. Rather than focusing in each country individually, all writers advocate for all organizations to look at the issue of compensation along the global marketplace, and to seek synergistic approaches that maximize the best compensation practices, and apply them to the highest degree possible in the local markets.

Leap and Carino (1993: 368-369) provides a working definition of compensation, as a broad term pertaining to the financial rewards received by persons through their employment relationships with the organization. Generally speaking, compensation is financial in nature

because a monetary outlay is made by the employer. Such monetary outlay may be immediate (payable within a short period of time or deferred (payable at a later date).

An employee's weekly or monthly salary is an example of an immediate payment, whereas a pension, profit sharing, or bonus plan typifies a deferred payment. Compensation can be direct, where money is placed into the hands of the employee, or indirect where the employee receives compensation in non-monetary forms or has little discretion as to how the compensation will be spent (expense accounts, use of a company car, group and health insurances).

Deloughery (1995:28) maintains that professional job satisfaction is important to the nurse entering and remaining in the profession. Locus of control (perception of autonomy) has been identified as a vital ingredient in job satisfaction, and stress seems to be the major reason for the dissatisfaction and burnout. Citing the study by Blegen of nurses' work satisfaction and it's variables found no significant correlation between work satisfaction and pay. However this does not

mean that pay is unimportant to nurses. It may mean that nurses like their work, and simply deal with the pay aspect in some other manner.

Furthermore, nurses may well tend to separate their job satisfaction from their pay appropriately, making their clients the beneficiaries of outwardly happy persons, although the worry over financial affairs eats away silently at the nurses. Deloughery (1995:34) further asserts that odd hours and long shifts place extra stresses on their marriages, and thus plays a part in the comparatively high rate of divorce among nurses. As a result many of them are single parents, and thus have sincere concerns over money matters, yet they enjoy their work so much that they tolerate the stress of financial problems. It is more likely that nurses as a whole have historically been very subtly indoctrinated to give freely of themselves and never to grumble for financial rewards.

2.8.3 Occupational stress

A number of writers have aired their views regarding the factors that can induce occupational stress, from the stage of being novices post

graduation, up to the stage of retirement. Amongst them are Schmalenberg and Kramer (1979: 56). They describe stress in terms of an internal process that occurs when a person is faced with a demand that is perceived to exceed the resources available to effectively respond to it, and where failure to effectively deal with the demand has undesirable consequences. These factors include poor institutional socialization, improper placement, lack orientation, lack of professional guidance and support, and work overload.

Improper placement.

Literature indicates that the new graduate's initial work experience has a critical impact on the formation of their concept of a registered nurse and on their value systems. Similarly, it has been suggested that correct placement influences the ability of qualified nurses to practice efficiently, and it is therefore equally important for nurse managers to consult the qualified nurses about their placement (Schmalenberg & Kramer 1979: 60)(Troskie 1993: 23)

The study revealed that nurses working in their areas of interest were found to be coping well with their work roles. Furthermore, Ntombela, Mhlongo, and Mzimela (1996: 27), and Troskie (1993: 24) maintained that the nurses should be paced in areas of their interests, making sure that responsibilities delegated to them are continuously scrutinized to determine whether they are able to cope, as too much responsibility too soon may cause unnecessary stress.

Poor orientation.

Gillies (1993: 122) defines orientation as the process of acquainting a new worker with existing work environment, so that he or she can relate quickly to his surroundings, the main purpose being to make the employee feel wanted, needed, and to make him or her believe that his or her presence is required for the realization of organizational goals. Citing Schemp and Rompre, Brasler (1993:48) maintains that technological advances, increased knowledge generated by research and new treatment modalities have resulted in an increase of the knowledge base and skills expected of the new graduates in nursing. This results in the new graduates' feeling overwhelmed and unprepared

for the realities of the workplace. To assist the new graduates to quickly cope with the realities of the workplace, different writers have aired their views regarding the influence of orientation in the workplace. They assert that the expanding knowledge in health care and the emphasis on cost containment have greatly influenced the methods used to prepare newly employed professional nurses to perform effectively. These changes have resulted in two distinct approaches to orientation, the traditional programme and the competency based programme. (Flewenyll & Gosnel, 1990; 22) (Tylor, 1992: 39).

Brenner (1982: 41) is one of the proponents of the traditional programme of orientation. Although her work does not outline the clearly defined arguments directly in favour of the traditional programme, she argues that: (a) there are difficulties in developing competency-based orientation programmes that can reflect performance, demands, resources and constraints of the actual practice of new graduates, and (b) lack of pre-existing definition of competency in nursing makes it difficult to develop the competency based programmes. (Flewenyl & Gosnel 1990: 23).

Critics of the traditional programme, maintain that this programme is nurse educator based because it is only he or she who has to (a) decide what content to present, (b) determine the order of presentation of the content, (c) develop the criteria for satisfactory completion of the in-service education requirements. These critiques are in line with Freire's philosophy of education, "The Pedagogy of the Oppressed" as described by Mashaba (1995: 14). The irony is that the dominant group is not aware of it's oppressive role, but neither are the students aware of being oppressed.

Competency based programmes are less structured and allow for flexibility in the use of learning methods and length of orientation. The number of class hours and type of learning experiences vary according to the identified learning needs of individual orientees. Both programmes have their own proponents and critics. To state but a few, Bueno, Monjan, Gassner and Spady (1985: 59) have argued in favour of the competency based programmes, where they indicate as the strengths of this approach (a) involvement of the learner in the

educational process, (b) mastery of skills based on criteria, (c) competency-based primarily on the orientee's demonstrated performance.

Hart, Pollock and Rinke are cited by Flewellyn and Gosnell (1985: 67) as the critics of the competency based programmes and they argue on the following, (a) assessment is based primarily on one demonstrated performance, (b) lack of time limitation for learning will greatly increase the cost of the programme, and (c) the time required for educators to develop the criteria and design learning packages, plus the initial cost of the programme outweigh any savings achieved during implementation of the programme. Proponents and critics concur that the lack of an agreed upon definition of competency makes it difficult to devise measurement instruments, a view supported by Cooney (1992: 28).

Lastly, it has been found that the newly qualified nurses who get employed in their training hospitals tend to be deprived of orientation. This was confirmed by the results of the study by Troskie (1993:22) of

the critical evaluation of the newly qualified nurses to practice (Part-Two). In line with the proponents of the competency- based programmes of orientation, Troskie (1993:28) further advocates that the orientation should be directed at the individual needs of nurses, be given over a long period, and be followed by in-service education. She further emphasizes that even if nurses get employed in their training hospitals, they still require orientation to their new responsibilities as registered nurses.

Lack of Professional Guidance and Support

A number of guidance and support programmes for the newly qualified nurses exist in literature today. The challenge however is how fruitfully utilized they are, especially for the benefits of the new graduates. For the purposes of this review, (a) preceptor ship, (b) mentorship, and (c) support groups will be examined.

Preceptor ship programmes.

Literature reveals that Ashton and Richardson (1992:33), Brasler (1993:48), Clayton, Broom and Ellis (1989:34), Gillies (1993:78) and Horsburg (1989:31) have studied the influence of preceptor ship

programmes on the practice of newly qualified nurses. Firstly, all these researchers concur on their description of the concept of preceptorship as the individualized, one to one relationship of teaching, which is short-lived, and places emphasis on the acquisition of knowledge and skills. Secondly, they concur on their outline of the purposes of preceptorship as to (a) reduce reality shock, (b) to reduce the number of those who leave soon after graduation, and (c) consolidate the learning outcomes achieved on registration. (Ashton & Richardson (1992:23) Brasler (1992:48) Gillies (1993: 78)

Exclusively, however, Ashton and Richardson (1992:23) go further to emphasize the means of ensuring effective preceptorship. They maintain that preceptors should receive specific training over and above their own clinical nursing practice experiences. Citing Piemme, Ashton and Richardson (1992:24) suggest that effective preceptorship requires practitioners to possess a number of personal characteristics, for example, (a) patience, (b) enthusiasm, (c) positive, non-threatening and non-judgmental attitudes, (d) open-mindedness, (e) flexibility, (f) sense of humour, (g) confidence, (h) self awareness,

and (i) ability to demonstrate respect for peers. Furthermore, Ashton and Richardson (1992:24) emphasize the need to provide preceptors with ongoing feedback and support. Just like novice nurses, novice preceptors will need a period of support if they are to become effective in their roles.

Support Groups.

Brasler (1993:25) argues that severe anxiety can cause stress symptoms, which reduce the capacity to concentrate on more than fine detail to the exclusion of other important concerns. Such a state can not be in the interest of patients or the practitioner, so the individuals must take steps to reduce anxiety by carefully planned preparation of new roles and having regular access to support groups whenever necessary.

Findings of the study by Troskie (1993:25), on critical evaluation of the newly qualified nurses competency to practice (Part – Two), revealed that guidance and support played a much more important role in the development of the newly qualified nurses. This was especially true in

relation to support by senior personnel in practice setting. However, unlike the findings from the study by Troskie (1993), the results of the study by Brasler (1993:47), on the predictors of clinical performance of graduates, rated the support received from friends higher than any other forms of support, including senior personnel in practice settings. Those nurse friends were likely, the classmates from their nursing education programmes, which then apparently served as a major source of emotional support for the graduates as they moved through their orientation period.

Incentives.

Krech & Cruthfield (1982:175), citing Skinner and his followers have used the term positive reinforcement to refer to any stimulus that increases the probability or strength of the response that preceded it. Likewise, nurses who have been assessed on the job and found to have performed above expected standards need to be rewarded and recognized as a form of positive reinforcement.

Lomurno and Downing-Janos (1990:35) reported about an annual programme that provides the practitioner with continuous incentives from year to year, providing recognition for the practitioner when the level and scope of performance exceeds the expected standards. This programme is “termed” The Professional Advancement and Recognition of Excellence” (PARE). The successful PARE candidate receives both the financial incentive and professional recognition. These researchers maintain that to recruit and retain the calibre of nurses required to provide high quality service demands a commitment of not only a monetary reward, but also a commitment to provide professional recognition. This can be provided as a success acknowledgement in hospital newsletters, and on notice boards of nursing offices

2.9 Global strategies to address the brain-drain problem

A number of researchers, writers, public and private organizations and speakers have examined the strategies to address the brain drain problem. Amongst them are Kaplan (1996:21), Cohen (1997:11), Katz (2000:32), the Bernstein (2002:36), McCormack (2002:38),

Fitzgerald (2002:23), and the New Partnership for Africa's Development (NEPAD: 2002:35), Tettey (2001:35 & Tettey (2002:44). All writers have suggested different approaches in addressing the problem of brain drain, with extensive contributions noted from Kaplan (1996:21) and Tettey (2002:44).

For the purposes of this review, the strategies to address the problem will be categorized into three suggested worldwide models: (a) "Remain option," (b) "Return option," and "Diaspora option." The remain option relates to the conditions within the home country that will make it worthwhile for its highly trained professionals and intellectuals to stay. The return option is geared towards the adoption of measures and the strategies that will convince professionals abroad to return to their countries of origin and contribute towards the development there.

Diaspora. According to the Cambridge International Dictionary of English Language (2002: 135), the term Diaspora refers to the spreading of people from one original country to other different countries. The usage of the term originated in Israel, to describe the

Jews living in different parts of the world, outside Israel, (*Jews in the Diaspora*). The term is commonly used in Africa to refer to the Africans that have migrated to other countries, outside the African continent (*Africans in the Diaspora*). For the purposes of this study, the term shall be used to describe the same.

The diaspora option relates to the negotiated processes between the two countries to utilize the skills of the emigrants for the benefit of the country of origin, without them having to physically relocate back to the country of origin.

2.9.1 The "Remain option"

As it has been stated in the operational definition of the remain option, that it relates to the conditions within the home country that will enable its intellectuals and professionals to stay, it is an option with both economic and political challenges. The greatest percentage of work that will influence the remain option positively, is the responsibility of government, ministries of public service, labour at policy making level, and the managers of the institutions at the work settings, including

hospitals, in the case of medical and nursing professions. Governments, according to Tettey (2002:8) have to transform plans for socio-economic reconstruction from the level of rhetoric to that of concrete action. Citing the Economic Commissions for Africa, in relation of the perceived failure of governments to create enabling conditions within the home countries of professionals, Tettey (2002:9) has this to say:

“It is an indictment on African governments that the African Capacity Building Foundation holds some of them responsible for difficulties in accomplishing its goals.”

In the preceding discussion the push factors were categorized into political, economic, and occupational. The same pattern will be followed when discussing the conditions within the home countries that would convince the professionals to stay.

Legislative proposals.

Bernstein (2002:36) have suggested different legislative proposals that would contribute positively in convincing nurses, specifically to stay in their home countries. The first legislation is the Nurse Reinvestment Act (S. 1597). This American Act was introduced in October 2001, by Senator John Kerry, with the purpose of: (a) providing incentives for more young people to enter nursing, (b) establishes the National Nursing Corps, which would extend the loan repayment program for nurses in exchange, for at least two years of service in a faculty where there is a severe shortage, (c) encourages specialty training and mentoring through an internship and residency program designed to fill vacancies created by nurses leaving the profession, (d) supports the development of nursing school curricula, (e) provides funding for initiatives to improve the image of nursing as a career, (f) provides tax breaks for individuals and institutions involved in nursing.

The second legislation introduced by Senator Tim Hutchinson in the Senate was the Nursing Education and Employment Development Act (S.721). The bill provides: (a) support for scholarships and loan

repayments for nurses who work in shortage areas (b) supports career ladder programs, (c) supports public service announcements to promote nursing and nursing faculty development.

(Bernstein :2002:36).

Combining the key elements of S.721 and S. 1597, Senator Barbara Mikulski introduced S. 1864, approved by the Senate in December 2001. As mentioned, the bill contains much of the content of S. 721 and S. 1597, including the establishment of a National Nursing Corps, nursing scholarship programs for students who agree to work in underserved areas, scholarships for graduate-level education, and grant programs to improve the workplace, increase nurse retention and recruitment (AHA Trendwatch : 2001;26); (Bernstein : 2002:36).

The third regulatory and policy issue related to extensive nursing documentation. Nevidjon & Erickson (2001:43) hold that a number of regulatory and policy issues may also be exacerbating the shortage of nurses. These include state and federal law, regulation by accreditation/ certification organizations, licensure and nursing practice

acts, requirements from reimbursement organizations, private organizations and the government. Some issues are factors in causing nurses to leave and others may be barriers for recruiting nurses if not attended to.

Specifically, the author looked at the complexity of documentation resulting from regulatory agencies, federal and state support to nursing programs, employment of foreign nurses, and the role of state Boards of Nursing. In all sectors of patient care delivery, nurses complain about the amount and complexity of paperwork. This dissatisfies nurses who want to have interaction with patients and families. Nevidjon & Erikson (2001:44) suggests that within an organization, aggressive process improvement initiatives can help standardize and streamline paperwork, with frontline staff driving the process in consultation with internal experts in patient documentation, risk management and reimbursement.

The fourth regulatory framework worth discussing are those of the State Boards of Nursing / Nursing Councils. These regulatory bodies according to Nevidjon & Erikson (2001: 22) have an important

contribution to make during this uncertain time regarding both the recruitment and retention of nurses. They reiterate that undoubtedly, there will be pressure to lower licensure standards to increase the number of graduate nurses. This would be a mistake as the Boards are responsible for protecting the public from unsafe, illegal or unethical practice. During times of shortage and stress, the potential for unsafe practice may be increased. However, Boards need to review also their policies and procedures to determine whether those policies are contemporary or out of date, contributing to nursing shortage.

Provision of adequate compensation

Nevidjon & Erickson (2001:22) argue that retention of nurses begins with how the organization does or does not value the staff. Rhetoric notwithstanding, most health care executives view staff as an expense and in times of financial constraints, as is currently the state, watch personnel budget line very closely. Rather than viewing staff as an expense, seeing them as an asset on the balance sheet will drive different decisions about the work environment.

Similar to the views by Nevidjon & Erickson (2001:22), AHA Trendwatch (2001: 26) reiterates that while increased compensation is not a long term solution, it does provide an immediate incentive for new and current staff. In addition some hospitals are using signing bonuses based on experience or length of commitment to attract nurses. Although increased reimbursement is not designed to completely solve nurse's dissatisfaction and the shortage, short-term incentives can bring part time or retired nurses back to the workforce full time.

Focusing on new recruits (hires).

Proponents of this strategy emphasize on the development of a structures orientation program that combines classroom and practical learning for creating specialty expertise. New recruits screened through behavioral interviews and inputs from other nurses. This has to be followed by provision of additional support in adjusting to the new job demands (Bennewick (2001:33).

Addressing the priorities of hospitals.

Studies have shown three factors of overwhelming importance to nurses. They are compensation, scheduling options, and work intensity. Retention efforts must address these three areas to prevent dissatisfaction. Some hospitals have started providing nurses with detailed information about their compensation packages on a regular basis. Performing ongoing compensation reviews will help to ensure competitive salaries of nurses. Policies for timely evaluation of individual scheduling requests should be provided along with promoting a self-scheduling process. (Bennewick: 2001:33).

Scheduling flexibility

Scheduling flexibility remains a high priority in the nursing field. Hospitals must make good faith efforts to meet each nurse's preferences regarding scheduling. Established policies should ensure that an individual's preferences are noted and considered when scheduling all shifts. Intensity of work is the third most important concern for nurses. Unfortunately, long hours of work and hectic pace of the nurse's workday is unlikely to change in the near future.

Measures should be taken to recognize and provide programs for dealing with stress. Hospitals may conduct focus groups to identify the root cause of stress within the individual nursing units, and then develop a wide range of programs that may provide relief from job stress. (Bennewick: 2001:33).

Lastly, it should be mentioned that managers would need to make retention a part of their overall management style and responsibilities.

Their task in this area would include identifying roles and activities that lead to retention, customizing staff responsibilities, identifying the sources of dissatisfaction, and providing regular performance feedback. Some managers are working with the human resources and finance departments to provide additional tools to help in the area of staff retention. A tracking system should be in place for evaluating managers' performance on their retention plans and strategies. Poor managers could increase the risk of nurses' dissatisfaction whereas good managers would contribute positively towards the retention of their nursing staff.

2.9.2 The "Return option"

Chapter one of the study explained that South Africa started to witness the inflow/outflow of professionals and intellectuals three to four decades ago, as far back as the Sharpville uprisings of 1961, the Soweto uprisings of 1976, the declaration of the state of emergency in 1985 and the period leading to, and following the change to a government of National Unity from 1993 to date. (Kaplan: 1996:45).

One characteristic, more difficult to specify precisely or quantitatively substantiate is that of the political disposition of many of those in the South African intellectual diaspora are likely to be of a "liberal" persuasion. The term "liberal" here is used loosely by Kaplan (1996:46) to denote an opposition to the previous apartheid regime and a likely broad support or at least, sympathy for the "new" South Africa. Kaplan (1996:46) further argues that the political disposition is important if the intellectual diaspora is to be mobilized in support of local developments. Many of the emigrants counted in the above stated political era were, in very general terms, opposed to governmental policy at the time, and in Kaplan's terms, "voted" with

their feet. (Kaplan : 1996:46). There are indications that those who left South Africa more recently have less political and more pragmatic motivations. Those who left since the advent of the new government of the National Unity (1994), are less likely to be liberal and more likely to be unsympathetic to the new government. Nevertheless, overall, it is very likely that among many in the intellectual diaspora, there will be a broad sympathy for the new dispensation and among some, notably those who left or were forced to leave because of their opposition to apartheid, there remains a strong commitment to supporting the new dispensation. (Kaplan: (1996:48).

Research suggests a stepwise process that has to be followed if the emigrants are to be successfully convinced to return to their country of origin. They include (a) establishing a database for emigrants, (b) maintaining better statistics on health worker migration' (c)improving the conditions within the country of origin that will make emigrants to return.

Establishing a database for emigrants

The report on New Partnership for Africa's Development-Part 3, Kaplan (1996:46), and Tettey (2002:34) advocate for the establishment of a reliable database on the brain drain both to determine the magnitude of the problem, and to promote discussions and collaboration between the experts in the country of origin and those in the Diaspora. Specifically the database should reflect the quantity or figures, the location, as well as quality or qualifications, of the intellectual Diaspora.

Kaplan (1996:46) presents a South African model of establishing a database of the other dimensions of the intellectual Diaspora, through data collected from the alumni associations of five major South African Universities, which the researcher felt worth outlining for the purposes of this review. The university alumni associations have the task of maintaining contact with the graduands, wherever they reside. All have a regular magazine with news about the university and other matters of interest are sent to all graduands that the alumni office is able to locate.

The five universities from which data were obtained were Cape Town, Witwatersrand, Natal, Rhodes and Stellenbosch. The database in terms of the size of the intellectual diaspora revealed 21,485 graduates from these five South African universities, resident abroad with their addresses known. Moreover, it is clear that the overall numbers of South African graduates resident abroad is larger than the given figures for the following reasons. Firstly, there are many graduates known to reside abroad, but who were not contactable, that is 4, 187 from Rhodes and Cape Town universities alone. Secondly, in some cases, graduates resident abroad utilized their local home addresses. Thirdly, the figure excluded other universities and tertiary institutions, but it is likely that the intellectual Diaspora is well in excess of 50, 000, and it is probable that that over 30,000 would, with a little further effort in acquiring the address lists, be readily contactable (Kaplan: 1996:48).

For the five universities, for which data was available, more than 63% of contactable graduates were at that time just in six countries, that is, Australia, New Zealand, Canada, Israel, the United Kingdom and the

United States of America, with the latter two having particularly large concentrations. The geographical concentrations are significant in facilitating the operations and management of the network. While the detailed and comprehensive statistics were not available, an indication of the quality of graduates was the high number and high percentage of students who graduated with the highest degree conferred by the university, namely the doctorate. Out of 379 students who graduated with doctorates from the university of Cape Town, 28% and contactable were resident abroad. (Kaplan: 1996:48).

Maintaining better statistics on Health workers migration

Diallo (2004: 605) maintains that better statistics on the migration of health workers can be obtained by standardizing, collecting and analyzing data on a regular basis. Other specific actions which may also improve knowledge on the migration of health workers include:

- Using existing data more effectively. Many countries claim that they lack data on health personnel migration, but many sources could be used to analyze the phenomenon, even if the primary

aim was not to collect data on the migration of health workers. This would enable policy makers to formulate policies on the basis of limited data than on anecdotal information.

- Improving the quality and the comparability of data. Compared with some areas of statistics, such as the occupation, there is little international standardization of migration statistics. Diallo (2004: 605) holds that data should be collected on the basis of established principles and methodological standards. Developing a minimum data requirement for tracking the movement of specific health professionals including nurses could be helpful. Building the statistical capacity of the developing countries that have poor statistical systems should be part of the process.
- Implementing a permanent follow-up system. The main purpose is to connect all stakeholders so that those who use the information can better explain what type of data they need and those who gather data can advocate for better use of it, and get support for more data collection activities.
- Networking between source and destination countries. This is important in order to harmonize their data collection instruments

so that migration data on health workers can be compared using the same simple templates (Diallo 2004: 606).

Creating enabling conditions within the country of origin that will convince the intellectuals in the “diaspora” to return

Research indicates that the task of creating the enabling conditions within the country of origin in order to attract the returnees is a mammoth one. It requires the collaborative efforts of special committees or commissions to co-ordinate the whole process. Tetey (2002:33) in particular argues that the initiatives at reversing human capital loss must go beyond the verbal appeals to patriotism. He gives an example of Taiwan where the National Youth Commission (NTC), was established with the mandate of co-coordinating efforts at getting the intellectuals to return. The scheme encompasses recruitment drives that will make the return option attractive, as well as taking concrete measures that provide the enabling conditions for the retention of those who return.

The National Youth Commission serves as a repository of information where potential returnees and prospective employers are able to match their interests. Similar to the Taiwan situation, Cohen (1997:43), holds that during 1992, the Pretoria office of the International Organization for Migration (IOM) ran a small programme called “The Return of Talent Programme.” It managed to recruit 52 South Africans abroad, 75-80 of whom have stayed. Because the numbers were very small, the programme was suspended. Nonetheless, the moral-building and demonstration effects of persuading prominent individuals to return to their country may make it worthwhile to reassess the programme. (Cohen: 1997:43).

Presently, the national and international initiatives, under the rubric of the return option are laudable. However, their potential for addressing Africa’s problem of human capital deficit is limited, in view of the size of the Diaspora community, and the rate at which skilled and professional Africans are leaving the continent. The unfavourable political and economic climate in many African countries makes the sustainability of the return option very difficult. The strategy requires a large infusion of

capital to attract the requisite numbers of professionals needed for socio-economic and political development, and to prevent those intending to leave to do so. Such funds are not available to cash-strapped countries on the continent. Furthermore, the same socio-economic factors that pushed people out of the continent in the first place still prevail in most of the countries. This situation compels a significant number of returnee-professionals to embark on new sojourns of economic survival, and it defeats the objectives of the return option. (Tettey: 2002:34).

It has been noted through research that the return option programmes in Africa has a number of weaknesses outweighing the strengths. Firstly, they tend to target a selected category of most urgently needed professionals, mainly in the fields of science, technology and economic management. Secondly, while the limited resources available to the programmes require such selectivity, it is difficult for such returnees, on their own to create the multiplier effects for socio-economic and political development. This can only be engendered through a synergistic confluence of different skills and expertise, making it

imperative therefore, for mechanisms to be put in place for the gelling of a wider spectrum of minds. It is true that science and technology professionals are a key ingredient in Africa's economic rejuvenation. However, they cannot achieve that objective without input from their counterparts in the social sciences and humanities, whose expertise is particularly necessary for the creation of the enabling environment within which technological and economies progress for all can take place. (Tettey: 2002:35).

In addition to the inability of African countries to support the return option at effective levels, it is a fact that there are many Diaspora Africans who, for a variety of reasons, are not willing to relocate to Africa. Tettey (2002: 35), gives an example of Ali Mazrui and Philip Emeagwali, two successful Africans in the United States, who have, for instance made it clear that family considerations in their new country of residence does not make it feasible for them to relocate back to Africa. This reality therefore rules out the possibility of deriving maximum benefits from such individuals by focusing entirely on the return option. (Tettey: 2002:35).

In view of the limitations facing the return option in Africa, many analysts agree that the emphasis on promoting the return of Africans in the Diaspora is not realistic, neither is it enforceable. Africa does not have the means to accommodate the returnees. It must rather explore ways and means of maximizing the contribution of this large human resource resident abroad by adopting appropriate policies and incentives. (Tettey: 2002:35).

2.9.3 The "diaspora option."

Research indicates that there is a wealth of African expertise in entrepreneurship that should be incorporated into schemes directed at channeling Diaspora resources towards African development. Tettey (2002:36) in particular holds that the majority of Africans abroad, if not all, profess a strong commitment towards the uplifting of their countries' socio-economic-political status. As it has been indicated previously that many Africans are running successful businesses in Europe and North America, for example, and their skills in negotiation, investment, and customer service can provide tremendous assistance to the development of the enhanced entrepreneurial culture in Africa.

The attraction of the diaspora option emanates partly from the theoretical conception that sees human capital, not exclusively in terms of an individual's abilities, but as a product of the synergies between those abilities and the professional environment in which the individual is located. Based on this conception, advocates of the Diaspora option see migration to the developed countries as a potential asset for Africa, rather than a liability. They contend that by being in the host countries, African professionals are able to enrich their skills and expertise in a way that they would not had done in their countries of origin, because of better access to professional resources. They are also able to build invaluable networks within epistemic communities that can be utilized for the benefit of their home countries (Meyer & Brown: 1999:46).

Developments in the fields of information and communication technologies bring an added advantage to the Diaspora option. Partners in the development initiatives do not have to be in close physical proximity to engage in collaborative efforts. The internet, for example, makes it possible for them to communicate faster, share ideas and build knowledge pools that are accessible to multiple users and

collaborative. It also helps avoid the tedium and expense of the traditional forms of interaction. In sum, the intersection of information technology and the Diaspora option allows Africa to turn the brain drain into brain gain, from a problem to a potential asset (Tettey: 2002:36).

Areas of specific focus that have been researched, and found worth exploring through the Diaspora option and made available in literature are: (a) use of collaborative research, (b) selling Africa on the world wide web, (c) distance education, and (d) co-ordination of schedules, A brief outline of each focus are is given below:

Use of Collaborative Research

Among the uses to which zonal networks can be put are collaborative research, which can benefit particular African countries or the continent as a whole. This can be accomplished by encouraging project specific Internet forums where interested parties can share ideas and design feasible projects and programs. In view of their better access to information technology resources, those in the Diaspora can take the initiative in hosting networks of knowledge exchange with their home

based compatriots, by supporting network subscriptions for local professionals who cannot afford them, as well as developing and maintaining a database of national experts (Cohen : 1997:57) (Tetty: 2002:38).

Selling Africa on the world-wide-web

Tetty (2002:38) argues that the credibility that individual members of the network have garnered in their professional careers, and the contacts that they have established, can also be harnessed to “sell” Africa on the world-wide web, and thus serve as a vehicle for eliciting material, financial, and other support for various projects that they plan pursuing. This can be done through organized collection of easily accessible information that show opportunities and potential, and provide quick access to relevant experts who can respond to inquiries. The success of collaborative projects by these networks could induce further support from other compatriots and external benefactors.

Distance education

Kaplan (1996:43), Cohen (1997:35), McVeigh & Hill (2001:11), and Tettey (2002:36) have examined the role played by the Diaspora option in promoting distance education. They all concur that it is a potential gain especially for the home country of the emigrants. . In view of the shortages of academics that bedevil the developing countries, including the African institutions of higher learning, it would be possible to make use of many African intellectuals in the Diaspora to offer distance or correspondence courses to universities, polytechnics, professional bodies, and public servants.

Over the years, various initiatives for distant education have been developed, introduced, some more successful than others. Global support and peer review are important issues to consider, and closer ties with the international community have to be promoted as distance education is extended in Africa. Many such initiatives are developed with a “foreign” input and design. This brain migration may be in the form of scholars, lecturers, and students for the purposes of mutual

benefits in the form of knowledge, expertise and training, including the use of medical specialists in periodic return visits. (Tettey : 2002:35).

Co-ordination of schedules

The other advantage that the network can offer is to allow the intellectuals in the Diaspora, for example, the Africans to co-ordinate their schedules in a way that enables a number of them to return periodically to the continent to offer their services for short periods of time. The terms of such service provision can be worked out with local institutions and state agencies. Doctors, for example, can come down in groups and offer medical assistance in selected communities. North American academics, for example can offer instruction during the spring and summer months, when most of them are not teaching, but when African institutions are still in session. (Tettey : 2002:38).

2.10. Theoretical Framework

Adam's equity theory of work motivation

Polit & Hungler (1991: 123) maintains that when research is performed in the context of a theoretical framework, it is more likely that its findings will have lasting significance and utility. It was noted that, none amongst the nursing theorists has explicitly detailed the theory directly related to human resources and work motivation. For the chosen theory to bear relevance to the topic under study, the researcher based the study on Adam's Equity Theory of work motivation, which is one of the psychological behavioral theories.

As a point of departure in explaining the basis of Adam's equity theory of work motivation, Linder (1998: 18) holds that at one time employees were considered just another input into the production of goods and services. The major postulates of this theory are that:

- the perceived inequity creates tension in the individual,
- the amount of tension is proportional to the magnitude of the perceived inequity,

- the tension created in the individual will motivate him to reduce it,
- the strengths of the motivation to reduce inequity is proportional to the perceived inequity.
- furthermore, they concur that the concept of equity is most often interpreted as a positive association between an employee's effort on the job and the pay he or she receives.

Similar to other employees, it is perceived that the nurses regard their inputs to be more than the outputs. The Adam's equity theory of work motivation describes the inputs in terms of effort, loyalty, hard work, commitment, skill, ability, tolerance, determination, heart / soul, enthusiasm, trust in the bosses and supervisors, support of colleagues, support of subordinates, and personal sacrifice (Adams 1965: 47).

It was stated earlier on that the work of nurses in health settings is highly demanding due to the compounding factors, for example, HIV / AIDS pandemic, that has taken it's toll over both patients and staff, as well as high patients turnover after the declaration of free health

services in Primary Health care facilities. Arising from the effects of these factors, the nurses are left with no option but to double their efforts, resulting in the long hours of work without rest. Furthermore, most of the nurses have specialized skills, for example, the critical care, theatre and obstetrics / gynaecological expertise. These are the major inputs that nurses bring with them as they deal with the diverse patient situations in clinical settings.

Like other employees, nurses compare their own situations with other “referents” in the market place, influenced by colleagues, friends and partners in establishing these benchmarks. Communicating with their colleagues who bring the same inputs in the workplace in other countries, it is perceived that the nurses in South Africa, perceive the inputs to be incongruent with the outputs, a view supported by Munchisky, Kriek & Schreuder (2002: 45) as they reiterate that when two parties exchange goods or services, it is possible that one of them may feel that the exchange was unequal, inducing a certain level of demotivation.

Adam's equity theory of work motivation describes outputs as typically all financial rewards including salary, expenses, perks, benefits, pension arrangements, bonus, commission, recognition, reputation, praise, interest, responsibility, stimulus, travel, training, development, sense of achievement, advancement and promotion. He holds that if employees feel that their inputs out-weigh the outputs, they become demotivated, and respond to this feeling differently.

Adams (1965:46), in particular distinguishes between two types of equity, that is distributive equity, and procedural equity. Distributive equity deals with how fairly employees feel they have been rewarded for their contribution, by comparison with others. Procedural equity has to do with employees' perception of the fairness of the organization's procedures in areas such as performance appraisals and promotions.

In line with the view of Adams (1965: 55), Muchinsky, Kriek & Schreuder (2002:45) hold that when two parties exchange goods or services, it is possible that one of them may feel that the exchange was unequal, inducing a certain level of demotivation. Generally the extent

of demotivation is proportional to the perceived disparity between inputs and expected outputs, for example, some employees reduce effort and application and become inwardly disgruntled, or outwardly difficult or even disruptive, whilst others seek to improve the outputs by making claims or demands for more reward, or seeking an alternative job, a view supported by Chapman (2001:35).

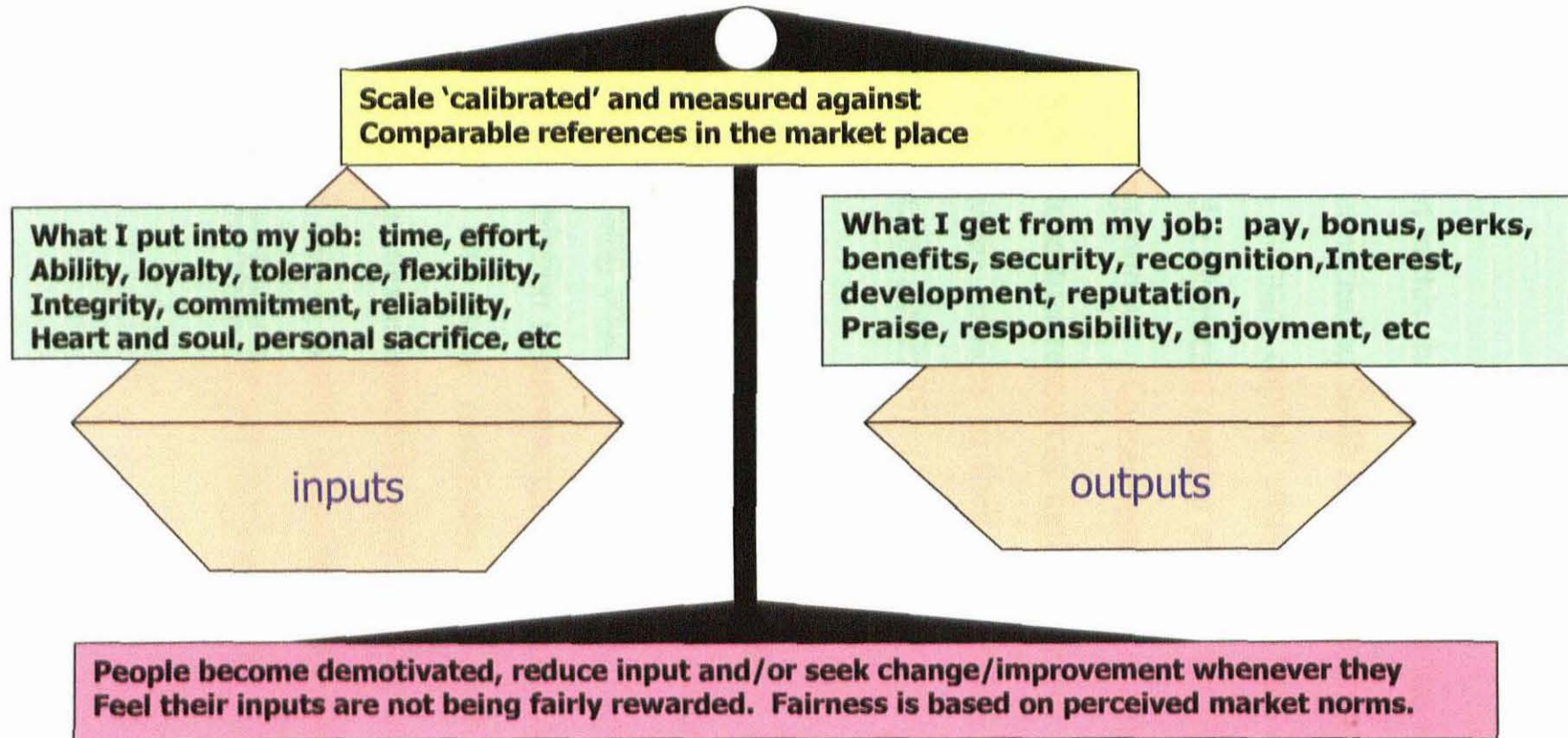
Inequity on the other hand exists when an employee's outcome / input ratio is perceived to be noticeably unequal to that of a relevant comparison person. The comparison person may be a co-worker, a person doing a similar job for a different employer, or it may be the person himself or herself at some other time or in some other job situation.

Adam's Equity theory further explains that good compensation can give rise to the individual increasing the quantity and quality of his work, but under compensation may result in one of the following reactions, (a) the individual may produce less by reducing his efforts (b) may attempt to exert a restrictive influence on the performance of others, and (c)

leave the situation, either by resigning or applying for a transfer to the different position (Adams 1965: 44).

Figure 4 : Diagram Reflecting the input / Output patterns, of Adams' Equity Theory of job evaluation. Adopted from Chapman (2002).

Adams' Equity Theory - job motivation



Summary

Based on the review provided in this chapter, it is clear that the whole region of Africa as a continent, including South Africa as a country, are confronted with a serious human capital crisis that has been exacerbated by the outflow of a significant number of their most highly qualified nationals, including nurses. Consequently, the countries' capacity to develop their intellectual resources further, manage their institutions, and provide needed services to their communities have been immensely impaired. (Tettey 2002: 35)

From the emergence and the progress of professional nursing in South Africa, it was noted that Sister Henrietta Stockdale played a major role on the evolution of basic nursing education in South Africa. She was able to (a) lay down the admission requirements for training, (b) set examinations, (c) organize and issue certificates, (d) emphasize professional behavior and high moral standards, and (e) advocate for nursing education to become part of general education of the country. This clearly indicates that her ideas formed the foundation of basic

nursing education. Today nursing education is part of the mainstream of professional education (Potgieter, 1992:20).

It was further noted that a number of basic nursing education programmes have been tapped over the years, with an attempt of eliminating the weaknesses identified with the implementation of the former programmes, until 1985, when the South African Nursing Council passed the regulations that provided for the affiliation of nursing colleges to universities (R425, 22nd Feb. 1985). All the attempts mentioned above were made with an objective of producing efficient and effective nursing workforce, that would be able to face all the health care challenges of the country, instead the majority of that human capital was perceived to be leaving the country, to seek employment opportunities abroad.

The overview of health services in South Africa and in KwaZulu Natal revealed that the effects of Apartheid had a negative impact on the health system as a whole, for example, the inequitable distribution of health services. In order to address the health care problems,

resulting from the health system of the Apartheid era, a number of programmes were begun, including the free health services at the Primary Health level. This programme alone, added an enormous amount of workload emanating from the high patient turnover. Looking at KwaZulu-Natal as a province, it appeared that it is the mostly populated province with the highest incidence of epidemics including Tuberculosis, malaria, cholera as well as HIV / AIDS.

The magnitude of the problem under review is wide in terms of the estimated figures of emigrants, exacerbated by the caliber of professionals in terms of their skills and age, the failure to produce more graduates, the AIDS pandemic affecting communities as well as the remaining human resources. Conclusions can also be drawn that the highly skilled are much more mobile than the less educated, a view supported by Helliwell (1999: 15).

The push factors were mostly attributed to the highest levels of crime within the country, the declining economic and educational standards, stress resulting from work overload, and perceived poor compensation systems

The developed countries, where the vast majority of these professionals are domiciled, have become the beneficiaries of the continent's extensive human capital crisis. The benefits that Africa has tended to derive from the exodus has generally been in the form of individual level remittances and some concomitant spin offs into the informal sector. Until very recently, not much has been done at the state level to harness conscientiously and in a sustained manner, the intellectual, fiscal, and material resources of the Diaspora for socio-economic development at home. Whatever attempts have been made to attract professionals were based mostly on appeals to the patriotic sensibilities of individuals. In those cases where systematized mechanisms were devised, the strategies tended to be premised on a model that emphasized incentive packages aimed at wooing particular categories of professionals to return. While the return option seems to have worked relatively well in some wealthy developing countries, and the desire of many professionals to remain in their host countries for a variety of reasons, constraints their ability to effectively make use of it. Amongst the strategies to address the brain drain problem, the three models, namely, "Remain, Return, and the Diaspora" options were

examined. It became evident that presently, Africa as a continent does not have the capacity to address all the problems categorized as push factors, that would convince it's intellectuals to stay. This means that the remain option can not be effective overnight, instead it is going to be a process that probably will be debated in the forums, for example, NEPAD, at a regional level of Africa as a continent.

It came out again that the return option has been explored, but at a very small scale. The challenge, as stated earlier on is that the conditions that forced the emigrants out of their home countries need to be addressed at their utmost in order to convince the expatriates to return. In summary, it is the option with a number of limitations for a developing country like South Africa.

Consequently, there is a shift towards the Diaspora option as a way of making the resources of Africans in the Diaspora without facing the problems of the return option. The conclusion that can be drawn from the foregoing discussion is that the Diaspora option coupled with the

potential that the information technology provides, offers tremendous opportunities for socio-economic development in Africa. The continent has a chance to transform its serious brain-drain problem from a spectre to a source of positive human capital mobilization that can be channeled into development at home.

The realization of the potential that the intersection of the Diaspora option and technology provides however requires the commitment of multiple agents. Commitment from professionals in the Diaspora to work towards the development of their countries of origin, the ability both local professionals to cooperate with their compatriots in this effort, and the support of governments and donors, constitute the foundation upon which the potential of technology can be realized most efficaciously (Tettey 2002:37).

Lastly, the theoretical framework of the study indicated that the nurses bring with them a number of variables that assist them as attributes in successfully dealing with the diverse patient situations. These inputs are described in terms of effort, loyalty, hard work, commitment, skill,

ability, tolerance, determination, heart / soul, enthusiasm, trust in the bosses and supervisors, support of colleagues, support of subordinates, and personal sacrifice. In exchange of inputs listed above, they expect the outputs in terms of salaries and other forms of remuneration and recognition to be equivalent to their inputs. Failure to strike a balance between the inputs and outputs, results in different reactions, for example, others may decide to resign in order to work for better paying employers.

CHAPTER THREE RESEARCH METHODOLOGY

3.1 Introduction

In this chapter, the nature of the study design, population, sampling procedure, instruments, methods of data collection, validity and reliability issues will be described.

3.2 Research design

A descriptive survey design involving registered nurses at practice level, the deputy directors responsible for all the nursing service and nursing education issues at the levels of the Health Districts in KwaZulu Natal and the South African Nursing Council through the office of the Registrar was used. The research design was both quantitative and qualitative in nature.

3.2.1 Target Population

The target population was three dimensional. The first dimension was that of the registered, practicing nurses employed in regional hospitals within the province of KwaZulu-Natal. Those that were employed in regional hospitals were specifically targeted because regional hospitals

receive referrals and provide specialist support to the district hospitals. Most care at this level is classified as level two care, requiring the expertise of the specialist-led teams of both doctors and nurses. Although the specialized nurses are also needed in district hospitals and the primary health care facilities, their expertise become very critical in the regional hospitals, because even the cost per patient is calculated based on the fact that patients would be given specialist care.

The second dimension was that of the Deputy Directors for Nursing in all the eleven (11) health districts in Kwa-Zulu Natal namely Ugu), Umgungundlovu, Uthukela, Umzinyathi, Amajuba, Zululand, Umkhanyakude, Uthungulu, Ilembe Sisonke, and Ethekwini (Durban Unicity). The health districts had been recently established in order to ensure effective decentralization of management from Head Office. These officials were targeted because they were responsible for all the nursing service and nursing education matters within the districts.

The third dimension was that of the South African Nursing Council, represented through the office of the Registrar. The Registrar is the most senior manager in charge at the South African Nursing Council, responsible for the maintenance of the standards of nursing and nursing care within the country.

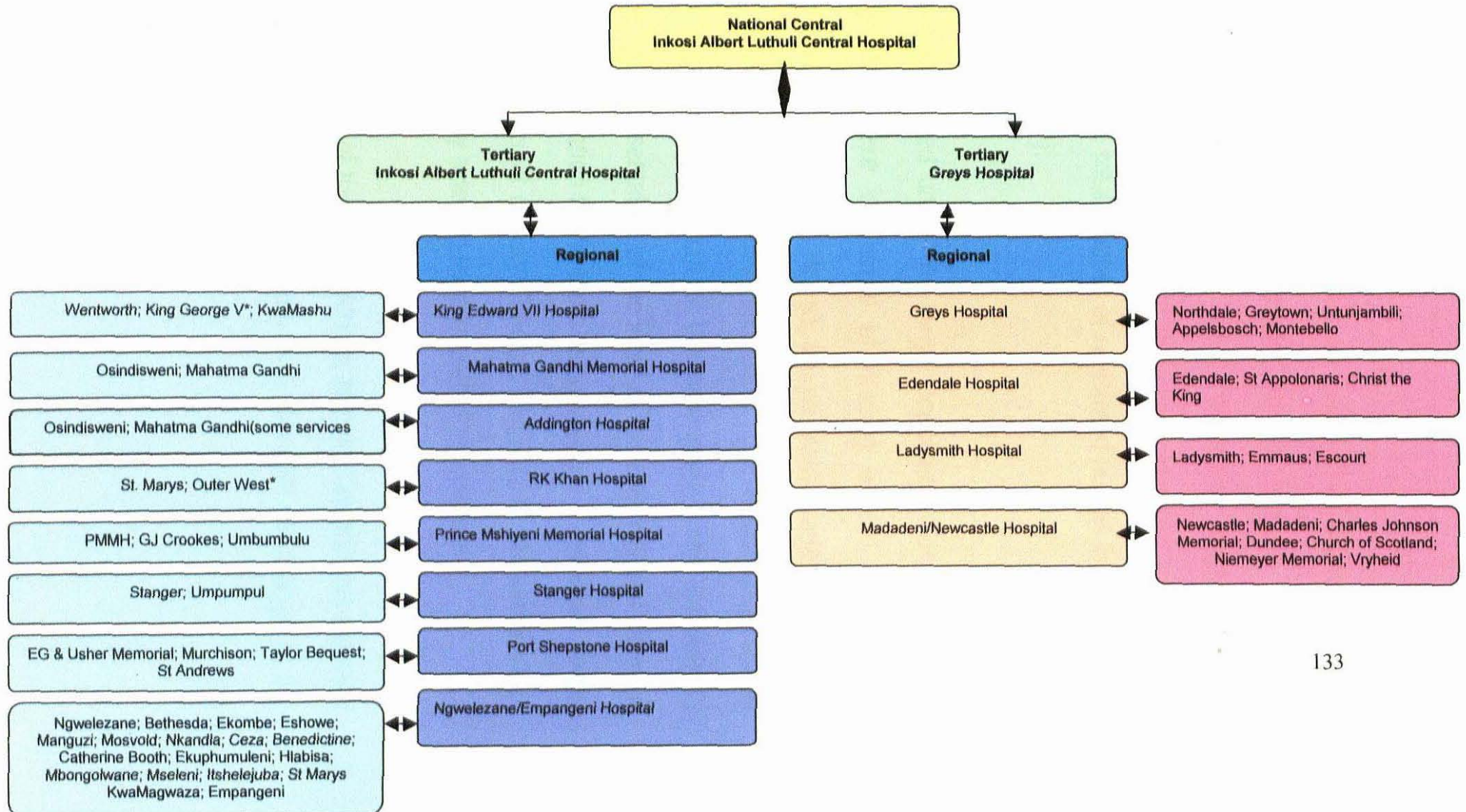
3.2.2 Sampling technique and sample size

The aim was to select at least one regional hospital per district, which would make the total of eleven (11) regional hospitals. Due to the maldistribution of health facilities within the province, there were some health districts that did not have regional hospitals at the time of data collection.

For those health districts without the regional hospitals, the district hospitals were included in the sample. Out of twelve (12) regional hospitals within the province of KwaZulu-Natal, seven were selected using the simple random sampling technique.

From the districts without regional hospitals, the names of all the district hospitals within each health district were also written down, and only one hospital per district selected through the simple random sampling technique. In total, ten (10) hospitals made up of seven (7) regional hospitals and three (3) district hospitals were selected.

Table 1: A framework for hospital service delivery in KwaZulu-Natal: Adopted from the 2001/2002 Annual Report for KwaZulu-Natal Department of Health



From the ten (10) hospitals selected to form part of the sample, sixty (60) registered nurses were included in the sample. They were selected conveniently, as they were submitting applications of resignations with the indication that they were intending to migrate to other countries. The total number of registered nurses included in the sample was sixty (60).

As it has been stated under the target population that eleven (11) deputy directors were in charge of nursing service and nursing education matters within each district, the researcher selected nine (9) using the simple random sampling technique. The remaining two out of eleven were going to form part of the pilot study. The aim was to ensure the full representation of the input of the authorities of different health districts in relation to the topic being studied. It therefore meant that the total number of deputy directors included in the sample was nine (9), conveniently selected to form part of the sample.

Lastly, the Registrar of the South African Nursing Council was selected purposively since she was targeted as a manager in charge of the

South African Nursing Council. This licensing body was selected because of the role it plays in controlling nursing education, nursing practice, and the protection of the public through ensuring safe, and competent care, in accordance with the Batho Pele Principles and the Patient's Rights' Charter.

In the opinion of the researcher, the Registrar would be a relevant respondent to give reliable information by virtue of her position and the attached responsibilities. In total, the sample size included nine (9) deputy directors, sixty (60) registered nurses, and one (1) registrar making a total of seventy (70) participants.

Based on the explanation around the sampling technique and the sample size given above, the researcher was convinced that the sample was representative of the population being studied.

3.2.3 Preparation for data collection

In preparation for data collection, a number of ethical issues were considered from the inception to the completion of the study. Firstly,

the proposal to undertake research was submitted and approved by the ethics committee of the University of Zululand. Secondly, the researcher requested for the permission to undertake research at different levels. It was done in a written form from the Kwa-Zulu Natal Human Resources Development Directorate. Having obtained the written permission from the Human Resources Development Directorate at Provincial level, other authorities at different levels were approached to request for their own permission at local levels. Those were the Hospital Managers as heads of health institutions selected for inclusion in the study, the District Managers to whom the deputy directors for nursing report at the health district levels and the registered practicing nurses in respective health institutions.

Confidentiality of information was guaranteed throughout the project. Participants were informed of their right to withdraw even after consenting to participate. No form of identification of participants was asked. Participants were informed that participation was voluntary , and they were assured that the health service authorities would not have any access to the names of those who consented or did not

consent to participate, a view supported by Polit & Hungler (1991:36), as they reiterate that a good research problem conforms to the moral and legal standards of the scientific enquiry.

After the permission was granted by the other authorities mentioned above, the researcher started to develop the instruments for data collection. As data was to be collected at three levels as previously stated, the researcher consulted some research experts in developing valid and reliable tools for research. Three out of eleven deputy directors of the health districts were also requested to give their input in the development of the data collection instruments. Both the questionnaires and the interviews were to be used to collect data. The integration of qualitative and quantitative data within single studies or coordinated clusters of studies, according to Polit and Hungler (1991 : 517), is an emerging trend, and the one that is gaining momentum in recent years. Questionnaires were to be used to collect data from two areas. That was from the deputy directors of the health districts, and from the registrar of the South African Nursing Council. Despite the limitations attributed to questionnaires as data collection instruments,

they were utilized in two out of the three areas of data collection for the following advantage: (a) less costly and requiring less time to administer, considering the size of the sample. Furthermore, it was believed that the intended participants were the officials in management positions who would fully understand the necessity to complete and return the questionnaires bearing in mind the significance of the study. For purposes of clarity, the questionnaire directed to the deputy directors of the health districts was identified as research instrument one

The questionnaire directed to the deputy directors of nursing in the health districts was identified as research instrument one. It comprised of both closed and open ended questions, and required the Deputy Directors of the Health Districts to give information on (a) the

classification of the district either as urban, peri-urban, rural or deep rural. Catchment population of the total district, (b) the total catchment population for the districts, (c) the number of health facilities within their districts. These would include the central hospitals, regional

hospitals, district hospitals, established clinics, community health centers. The information on the number of these health centers would assist the researcher to estimate the health care workload of the particular district in relation to the human resources available, as well as to note the challenges faced by rural over urban health facilities (c) the number of nursing education academic institutions. These would include the colleges, and the nursing schools, (d) the number of nursing students that had enrolled in the past three years as well as those that had graduated in each of the academic institutions in the past three years. This data would assist the researcher to estimate the number of potential recruits for the health care institutions in accordance with the demands of the catchment populations and the disease profile of the Province of KwaZulu-Natal. The subsequent questions were open ended seeking information on the (a) the reasons for the attrition of nurses in the opinions of the deputy directors for nursing within their own districts, (b) the opinions on the effects that the attrition had had on the delivery of health services, (c) the strategies they were using to cope with the problem, (d) whether the Provincial Department of health was giving them any form of support in

order to cope with the problem, and (e) whether the South African Nursing Council, in the opinions of the deputy directors, had any role to play in dealing with the problem. The information on the above questions would assist in getting into the roots of the problem so that effective strategies to address it would be put in place.

The questionnaire directed to the registrar of the South African Nursing Council was identified as research instrument three. It was the shortest instrument requesting for data on the total number of KwaZulu-Natal nurses registered with the South African Nursing Council for the past three years under study, that was 1999, 2000, 2001. The data expected would differentiate the number of those that were employed in public versus private practice, and therefore estimate the ratio of registered nurses per population, measuring these against the norms

of the World Health Organization as stated in chapter two. The second question was seeking data on the total number of nurses who had applied for overseas registration within the period under study. This data would yield information on the actual attrition levels of KwaZulu-

Natal nurses, and therefore qualify and quantify the extent of the problem. The third question was seeking data on the number of nurses recruited to South Africa from other countries. It would assist in estimating the balance or the imbalance between the loss and the gain. The last question was open ended requesting the registrar to explain the role played by the South African Nursing Council in controlling the attrition of nurses.

Research instrument two, was different from the previously discussed instruments in that it was a structured interview, the purpose of which was to conduct in-depth structured interviews, on the six registered nurses per hospital, excluding the ones who would form part of the pilot study. The information on the interview data would assist the researcher to get the actual feelings of the respondents about the *problem in question*. The total number of nurse respondents intended to be interviewed was sixty (60). The interview schedule comprised of the first few questions related to the sample characteristics of age, gender, length of service post graduation, area of placement and qualifications. This type of data would assist the researcher to ascertain

whether brain-drain was in any way attributed to age, gender, experience and specialization. The subsequent questions were seeking the respondents to explain in details their reasons for leaving, the effects that their leaving would have on the delivery of the health services within their hospitals and within the Province, and whether they intended coming back to South Africa or not. This would yield relevant information attributed to the push factors from the country of origin.

3.2.4 Pilot study

It is imperative that the instrument for data collection be as accurate and as reliable as possible. Criterion validity was tested by determining whether the questions formulated would be able to yield information regarding the problem under study. This was achieved through the pilot study, which was carried out at different levels of data collection. Research instrument one was piloted on two deputy directors of health districts that did not form part of the main study. Research instrument two was piloted on two registered nurses employed at two regional hospitals, that were not going to form part of the main study

The analysis of data from the pilot study convinced the researcher that the two instruments were valid and would be reliable during the actual collection of data. Research instrument three could not be practically piloted since the country has only one Nursing Council with only one registrar. It could only be piloted outside the borders of the country, and was not feasible for the researcher to do so. It was however believed that the research experts as mentioned earlier on gave the valuable input into the instrument. Concept validity was tested against the theoretical framework of Adam's equity theory of work motivation.

3.2.5 Data collection

Having convinced herself that the instruments for data collection were valid, the researcher engaged in the actual data collection. The questionnaires were mailed to the deputy directors in charge of nursing, as well as to the registrar of the South African Nursing Council, after making telephonic contacts with all the intended participants, preparing them to await for the questionnaires, and thanking them for granting the permission to undertake research. The envelopes for returning the questionnaires were included.

The researcher went on to commence interviewing the registered nurses employed in the regional and district hospitals that formed part of the sample. The interviews were conducted in the quiet environments, and participants' permission to use the tape recorder was sought, and was granted. Each interview took thirty five to forty minutes.

The researcher probed the participants for clarity and understanding, by using, (a) the recapitulation probe, in order to take the respondents back to the beginning of the experience described during the interview. Citing Gordon, Sorrel and Redmond (1995: 47), maintain that when respondents are asked to retell parts of their stories by returning to the beginning, they often add new details the second time through.

The silent probe, whereby periods of silence were introduced periodically by the researcher, in order to establish a comfortable pace during the interview, encouraging the participants to follow their paths of associations by the relating the stories their own way. Since some ideas or feelings of the participants can not be captured in words, it

was thus important for the interviewer to be comfortable with silence, in order to listen to the powerful silence that may speak louder than words, a view supported by Sorrel & Redmond (1995:50). The interviewees were allowed to talk freely for as long as they wanted to. The participants verbalized a number of issues, to quote but a few who had this to say:

"I have two teenage boys, both at their tertiary level of education, the house to pay for, I have even stopped to further my own studies because my husband is presently unemployed."

"The only option I have now is to give this marriage a break, go to London, work for about two years, and perhaps after that come back to fetch my children, my husband has been unfaithful for too long."

"We are paid nothing in South Africa, when I get to the United Kingdom, I will probably double or triple the salary that I am getting now."

"I am certainly sure that I will never come back, coming back for what, my parents are both late, and I am not even married, I do not even have a child, I do not see any problem in staying for ever in London, I am just going."

“To tell the truth, I am afraid and scared to leave my country, but I have no option. I can imagine when I am nicknamed as a foreigner, people referring to me as Kwerekwere, and I have heard that sometimes you have to work overtime in order to make more money. My ticket is ready.”

“I love my country, I will miss even my patients, and I am aware that there is shortage of nurses, but I have a lot of responsibilities that I can not cope with presently.”

“You are never taken as a person, I have worked for eight years without any promotion, I am still a junior nurse. When you ask those people in staff office, they always say something about PERSAL. I am sick and tired of PERSAL!!! PERSAL!!! PERSAL!!!”

“It is not clear how you get selected for study leave, but I am not even interested. With my midwifery I will get enough money somewhere else.”

The response rate was good in that six out of nine deputy directors responded, (75%), and fifty for registered nurses out of sixty (88%) were interviewed, and registrar of the South African Nursing Council responded.

3.2.6 Data analysis

Research produces rich amounts of data which needs to be systematically analyzed in a logical fashion. Computer programs were used to analyze quantitative data, which was then presented in the form of graphs and tables.

Qualitative data was analyzed manually, according to the identified themes or occurring regularities. The unit of analysis for the open ended question statements was the whole statements, rather than the single words or sentences. Credibility of qualitative data analysis was ensured by means of data triangulation with the purpose of cross-checking representation of reality. Patton (1990:46) citing Denzin identifies four kinds of triangulation that contribute to verification and validation of qualitative analysis, namely: (a) investigator triangulation, (b) analyst triangulation, (c) data triangulation and (d) theory or perspective triangulation. In investigator triangulation, multiple individuals are used to analyze single set of data whereas in methodological triangulation multiple methods to address a research problem, for example, observation and interviews. In other words, by

using multiple methods and perspectives, it is hoped that true information can be sorted out from error information, a view supported by Polit and Hungler (1991: 383).

One experienced researcher was requested to counter check and analyze the same data obtained from both the questionnaires and the interviews. The results from his analysis were congruent with the interpretations of the researcher, thus giving an assurance that the results of the study were reliable.

This process ensured interrater reliability, defined by Polit & Hungler (1991: 466) as the degree to which two raters operating independently, assign the same ratings or values for an attribute being measured.

Based on the triangulation approaches described above, the researcher was able to guard against the accusations that the study findings might be simply an artifact of a single source, and single analyst (Polit & Hungler 1991: 466)

Summary

From the methodology above, it was noted firstly, that the research design was a descriptive, cross sectional type that involved three areas of data collection. Those were the registered nurses themselves, the deputy directors in charge of nursing service and nursing education within each district, and the South African Nursing Council as the licencing body and a watchdog of the public.

Secondly the integration of both the quantitative and qualitative data through the use of both questionnaires and interview eliminated some of the weaknesses attributed to each of the data collection instruments. Furthermore, the successful pretesting of the instruments further assured the researcher that data from the two areas would provide a comprehensive picture of the problem under study.

CHAPTER 4

DATA ANALYSIS, INTERPRETATION AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter presents data analysis, interpretation and discussion of findings of the study which includes (a) sample characteristics, (b) the attrition rate of KwaZulu- Natal nurses in relation to seeking employment opportunities abroad, (c) the factors influencing the KwaZulu- Natal nurses to seek employment opportunities in other countries, (d) the effects attrition has had on health service delivery within the Province of KwaZulu-Natal, (e) the role played by the Department of Health in controlling the attrition of nurses, and (g) the role played by the South African Nursing Council, as a watchdog of the public in controlling the attrition. Firstly the results from quantitative data are presented followed by the results from qualitative data.

4.2. Analysis and interpretation.

As it was mentioned in chapter three, that the research design was both quantitative and qualitative, the results from quantitative data will be analyzed, interpreted, discussed, followed by the results from the

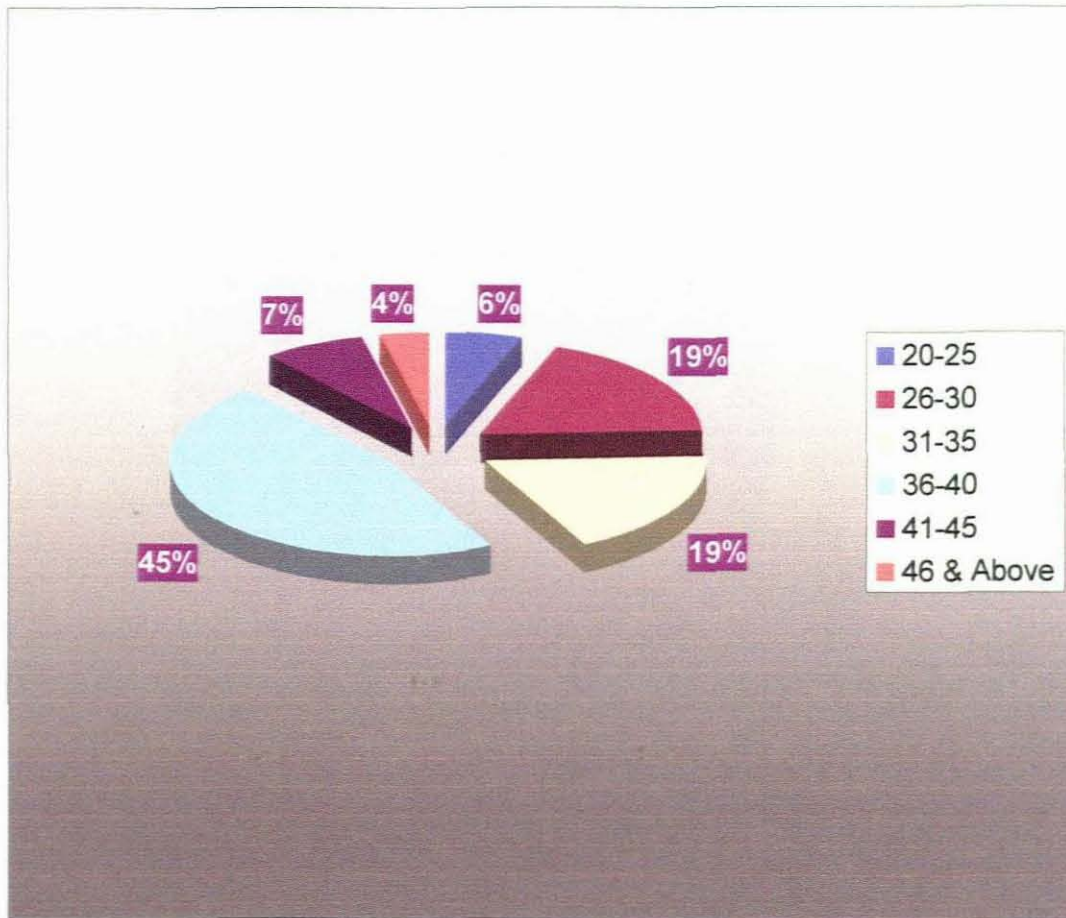
qualitative data.

4.2.1 Sample characteristics

The intended study sample consisted of (a) sixty (60) registered practicing nurses employed in different health institutions within the Province of KwaZulu- Natal, nine (9) Deputy Directors for Nursing employed in different Health Districts within the Province of KwaZulu- Natal, and (c) the Registrar of the South African Nursing Council. In the actual study, fifty four (54) registered nurses, nine (9) Deputy Directors for Nursing, and the South African Nursing Council through the office of the registrar of the South African Nursing Council participated.

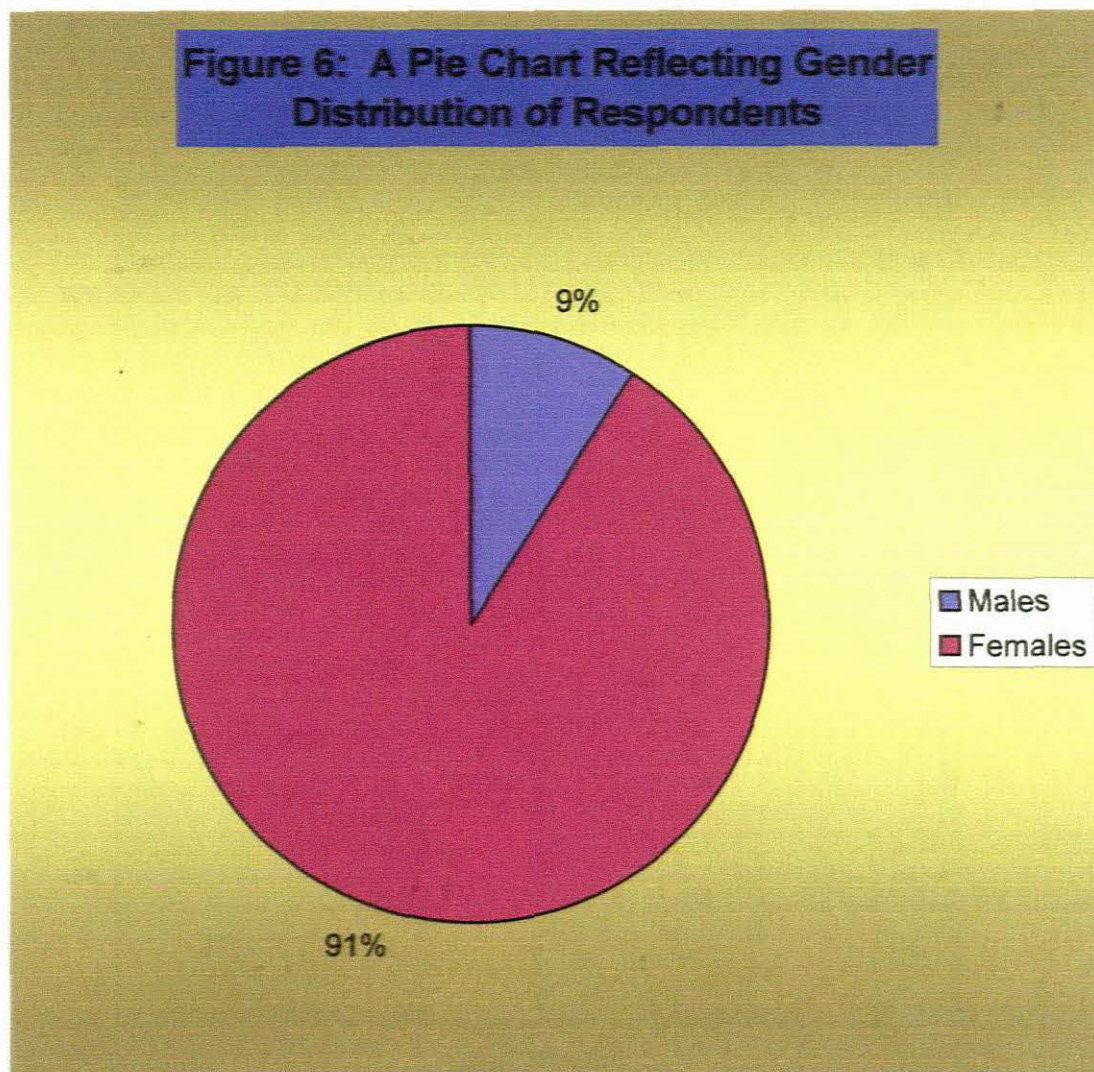
Age Distribution

Figure 5: A Pie chart indicating age distribution of respondents



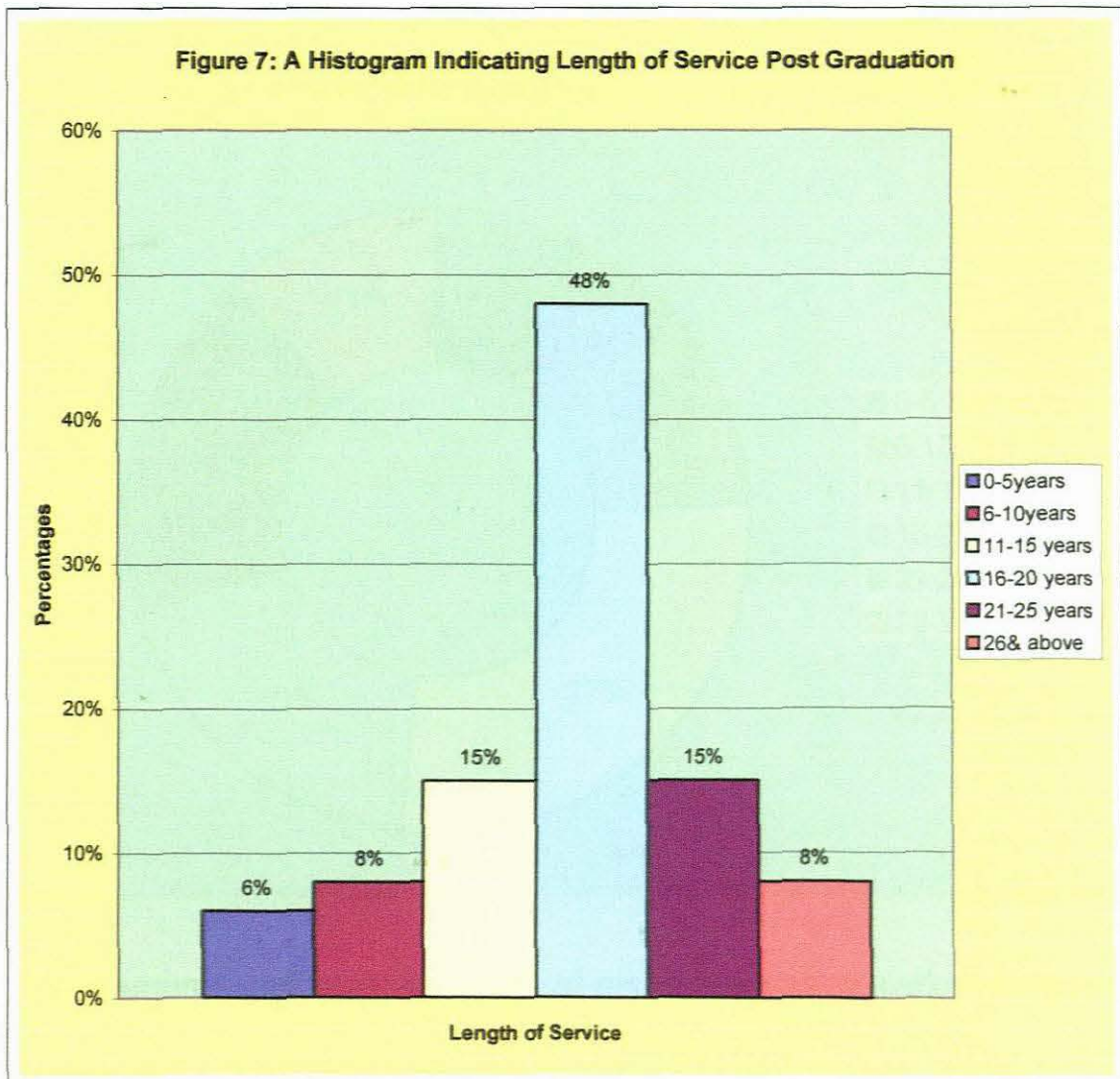
The pie chart above indicates that 45% of respondents were between the ages of 36-40 years of age, whilst only 4% were from 46 years and above.

Gender Distribution



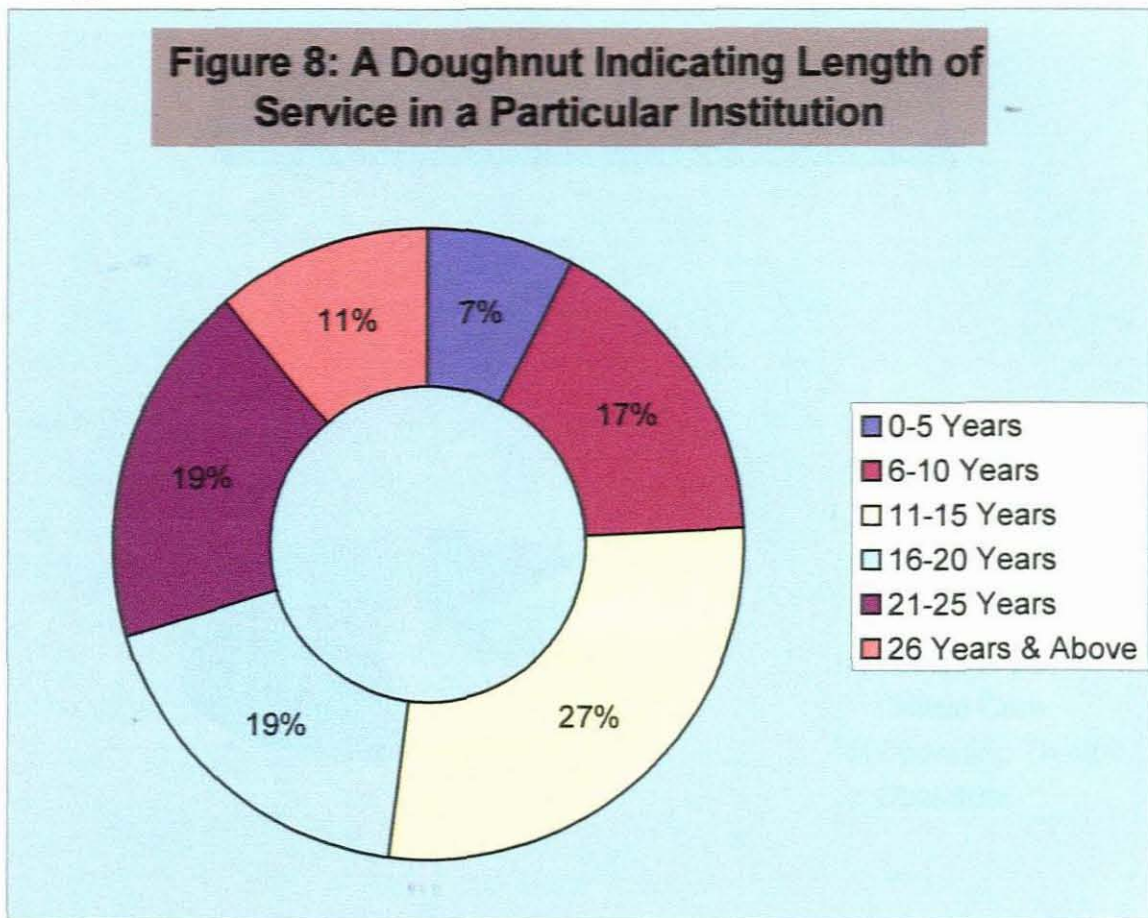
The pie graph above reflects that 91% of respondents were female nurses whilst only 9% were males.

Length of Service Post Graduation



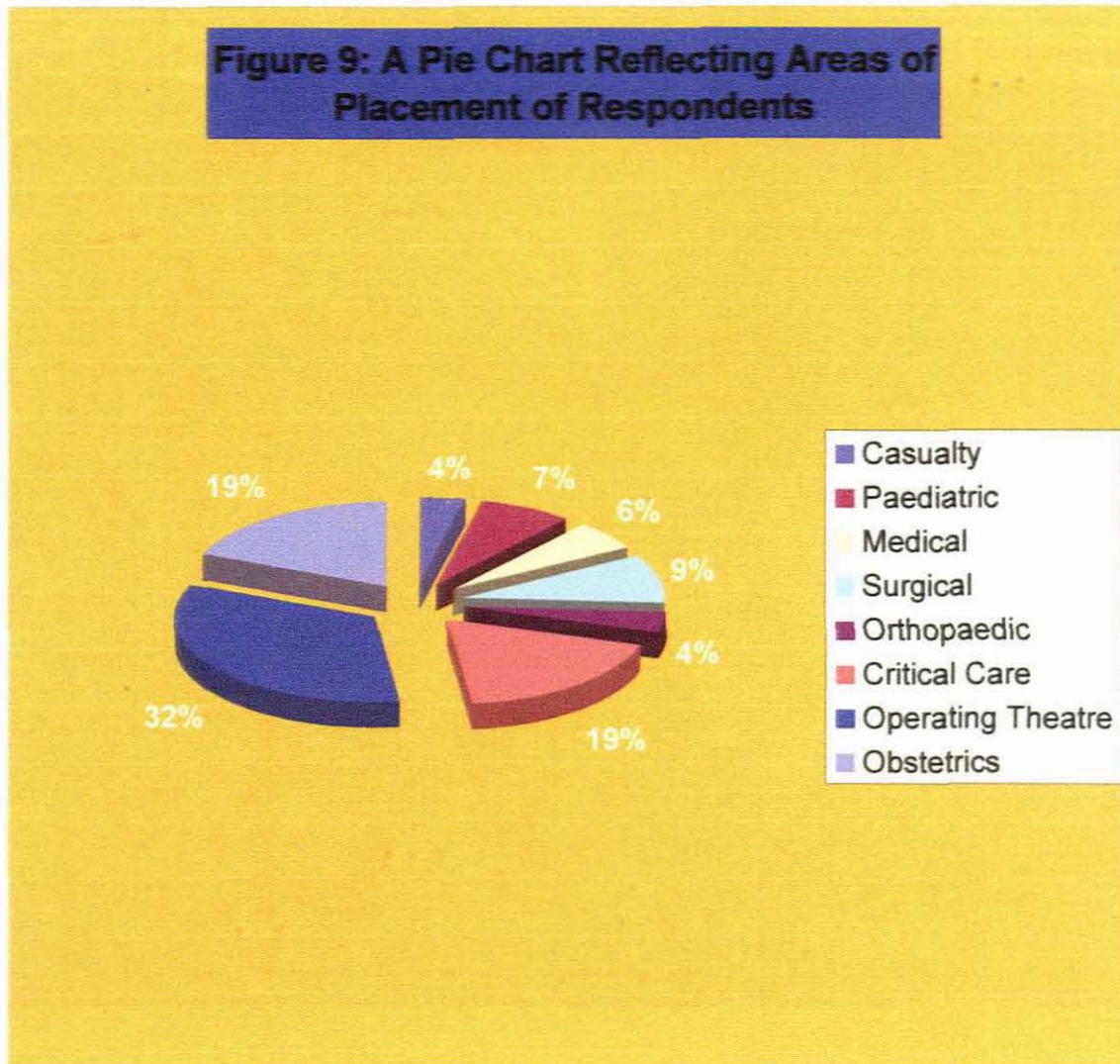
The histogram above reflects. The histogram indicates that 48% of respondents had between 16-20 years of service, followed by 15% per category who had spent 11-15 years and 20-25 years respectively. Only 6% of respondents had spent 0-5 years service post graduation.

Length of service in a particular institution



The doughnut indicates that 27% of respondents had worked between 11-15 years in the particular institution, 19% had worked between 16-20 years and 21-25 years respectively. 17% of respondents had worked for a period of between 6-10 years, 11% between 26 years and above. Lastly, only 7% had served those particular institutions for a period between 0-5 years.

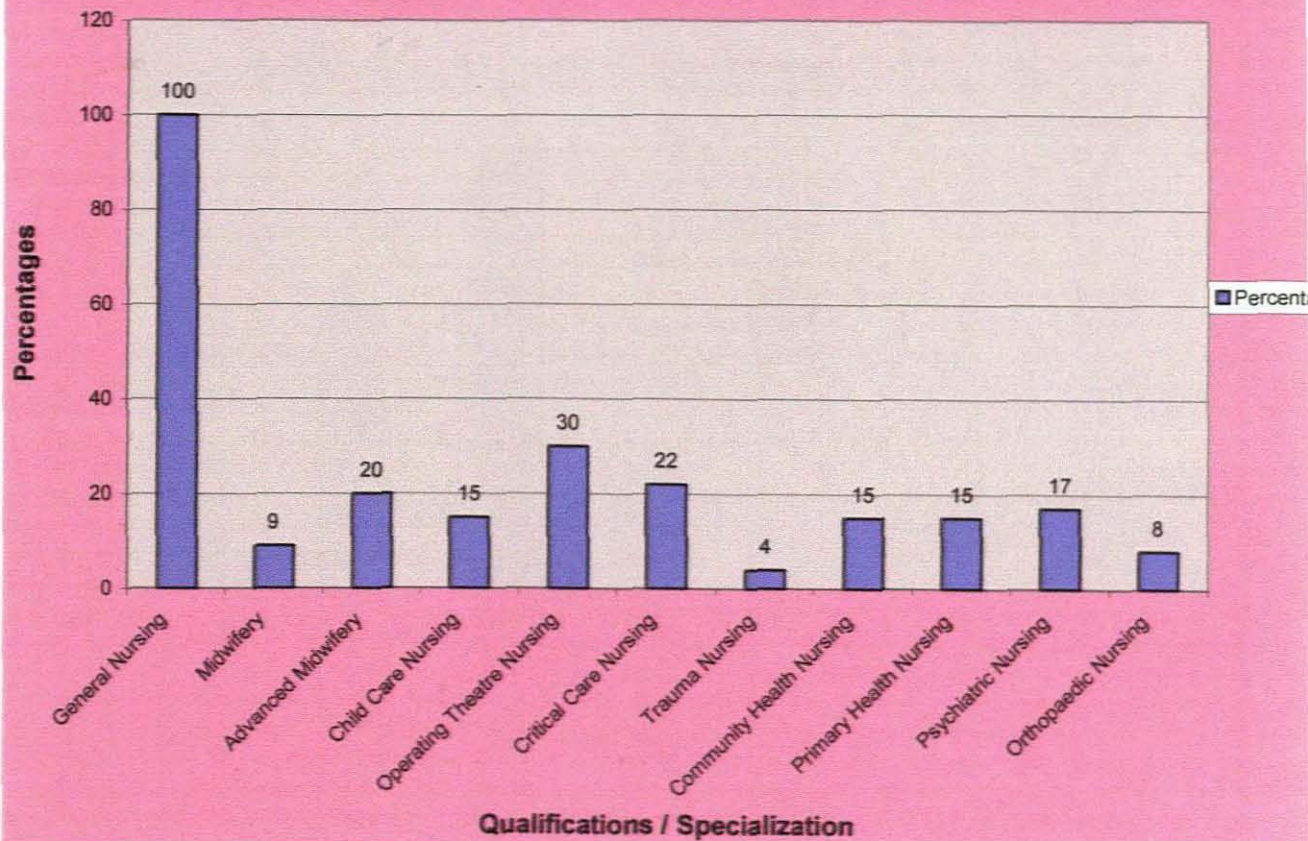
Areas of Placement of Respondents



The Pie chart above indicates that 32% of the respondents were allocated in operating theatres, 19% in critical care and obstetrics respectively, 9% in surgical units, 7% in orthopaedic units, and 4% in casualty departments.

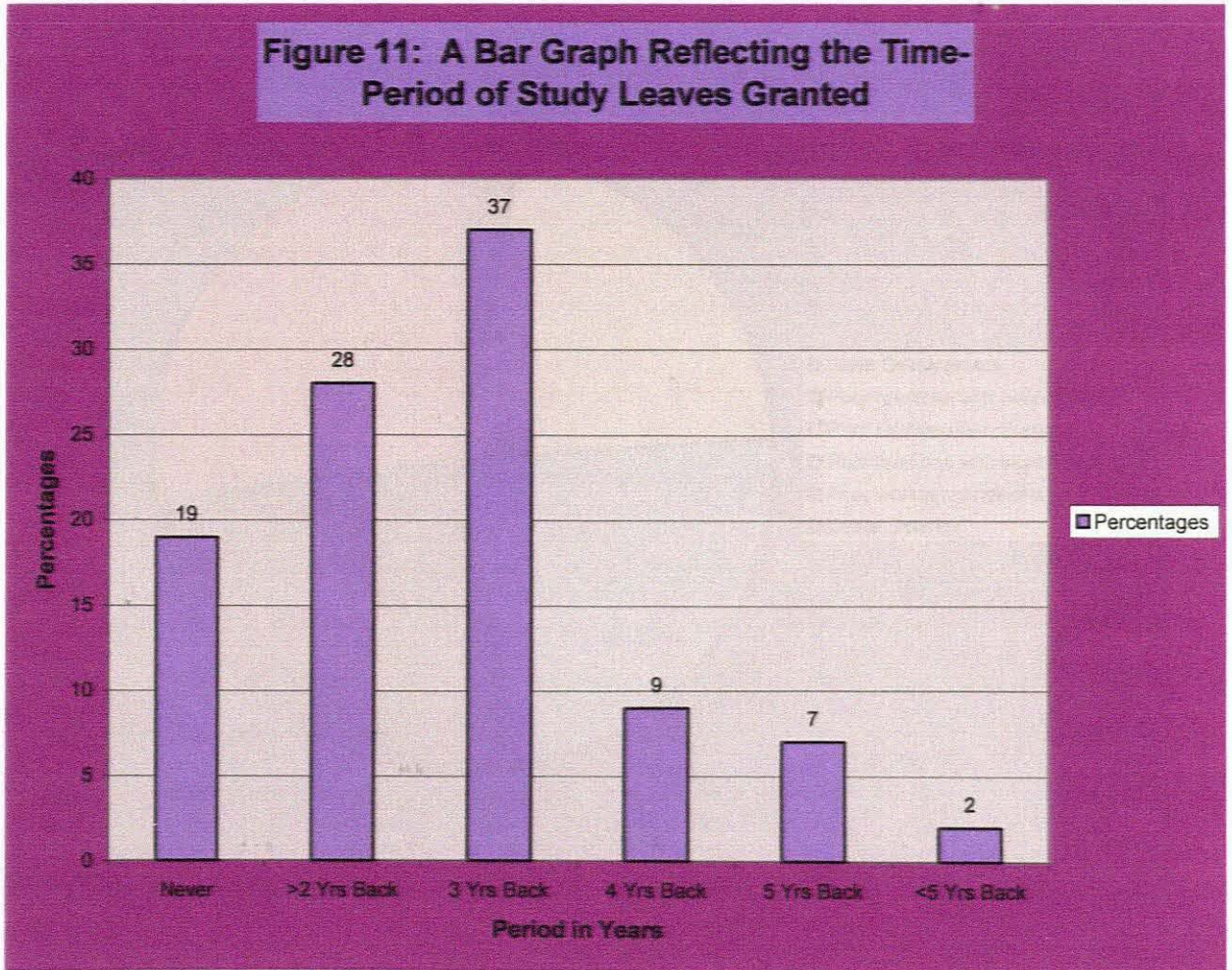
Qualifications / Specialties of Respondents

Figure 10: A BarGraph Reflecting Qualifications of Respondents



The bar graph above reflects that 100% nurses had a Diploma in General Nursing, followed by 30% allocated in operating theatres, whilst those allocated in critical care units, and obstetric units constitutes 22% and 20% respectively.

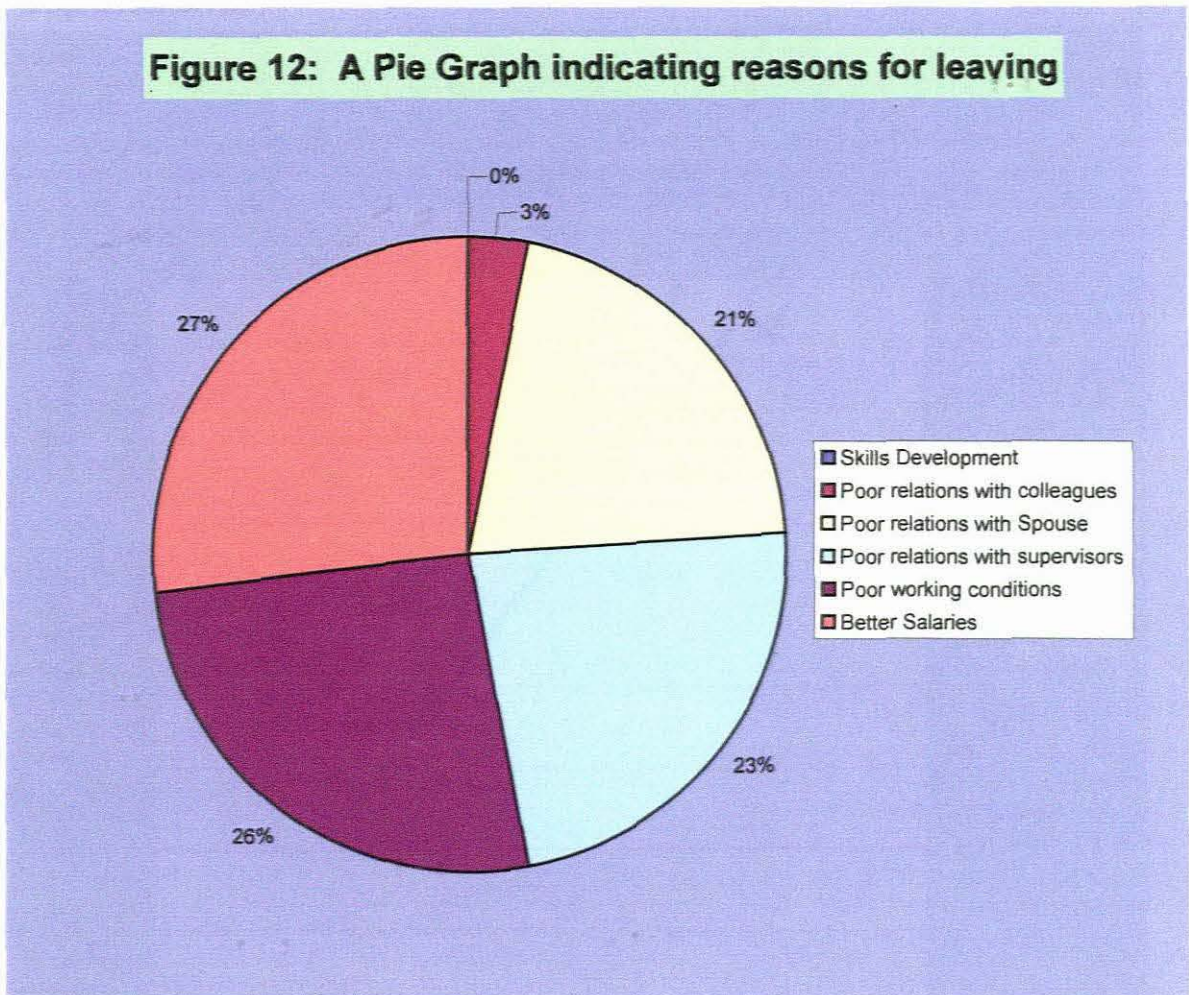
Time-Period within which study leaves had been granted



The bar graph above reflects that 37% of respondents had been granted the study leaves three years back, 28% two years back, 9% four years back, 7% 5 years back, 2% more than five years back, whilst 19% had not been on any study leave.

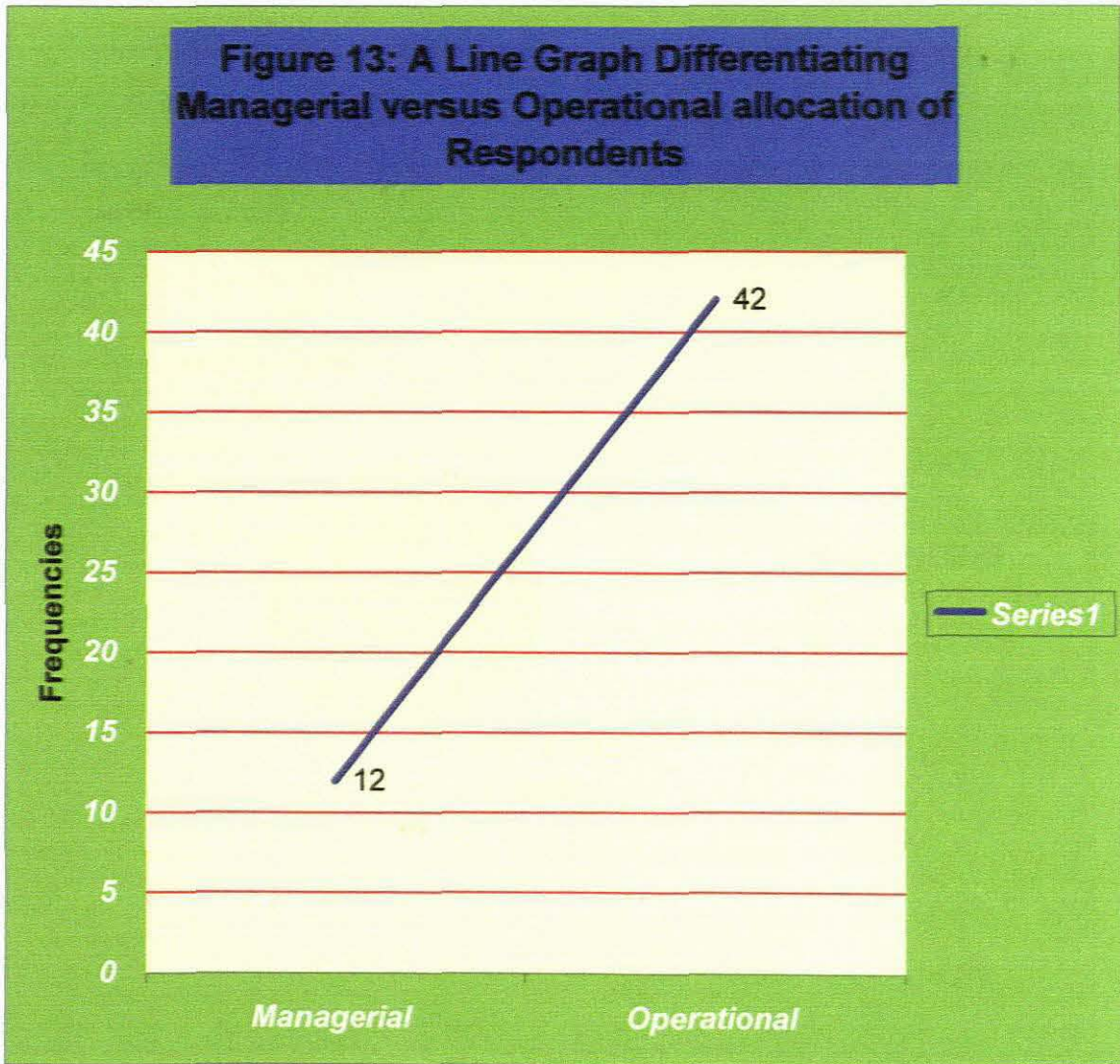
Reasons for Leaving

Figure 12: A Pie Graph indicating reasons for leaving



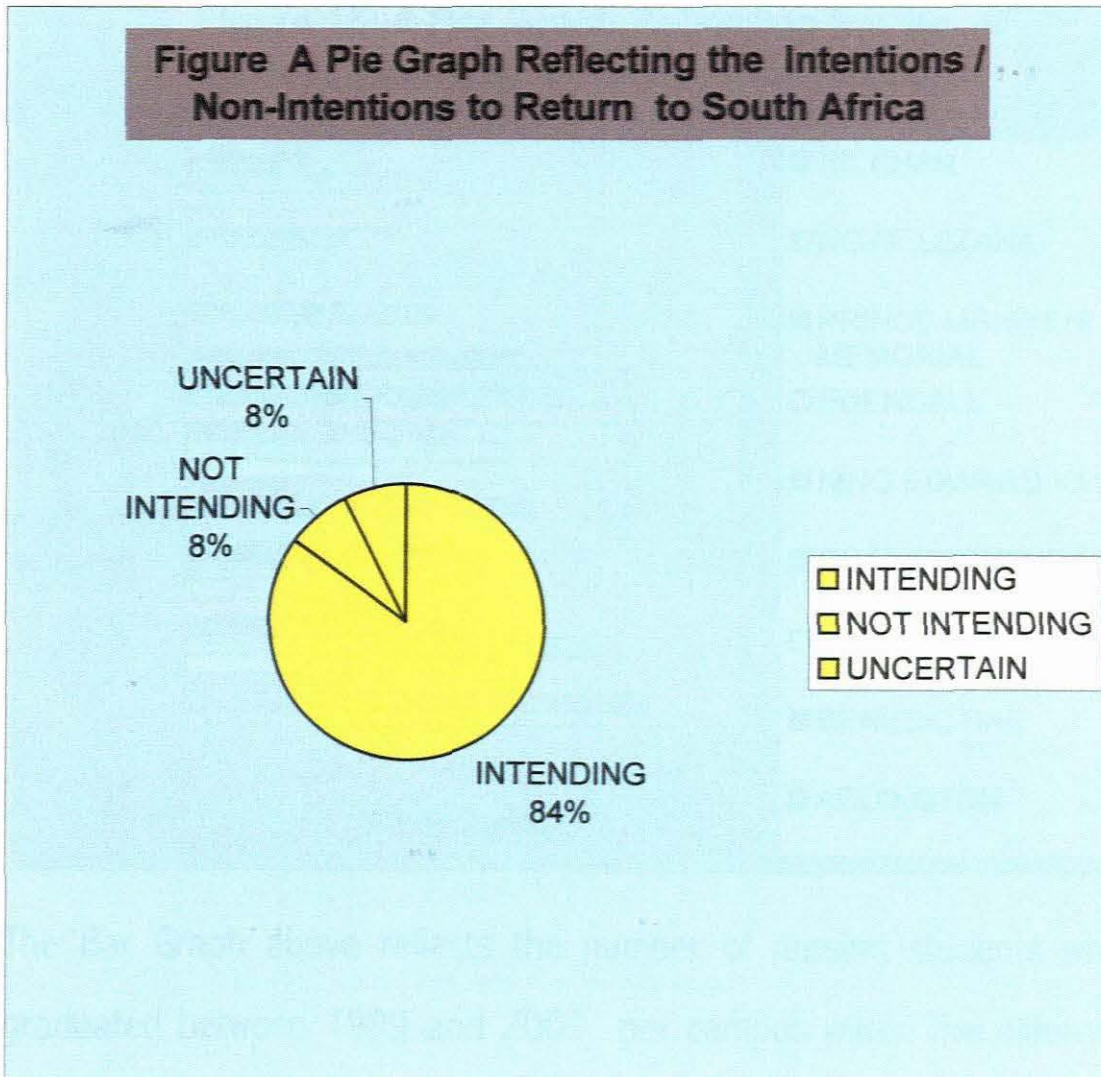
The pie chart above indicates that 27% of respondents attributed their reasons for leaving to the need for a better salary, followed closely by 26% who stated the poor working conditions as the main reason for leaving. None of the respondents attributed their reasons for leaving to the need for skills' development.

Managerial versus operational allocation of respondents



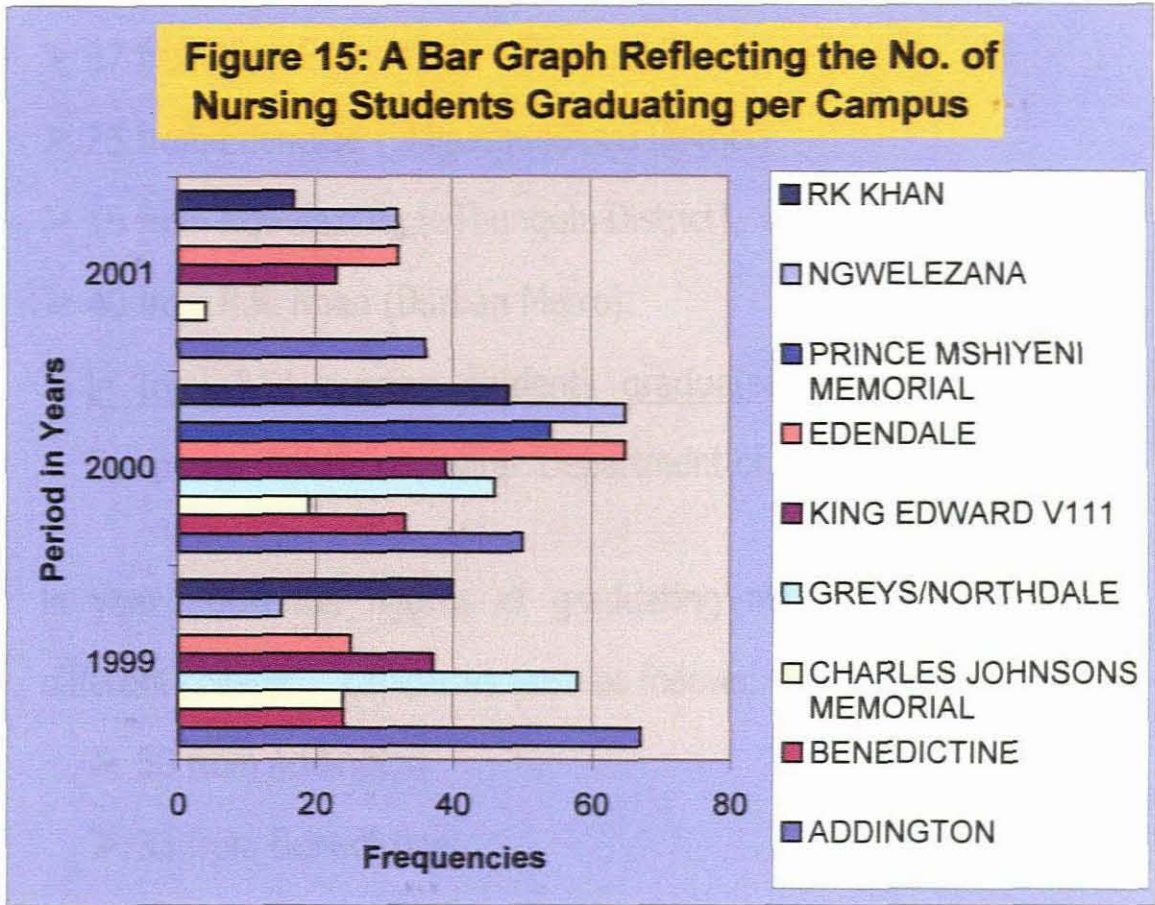
The line graph indicates that 42 (77%) of respondents were allocated to do operational (hands on) nursing duties, whilst 12 (23%) were already in managerial (supervisory posts).

Figure 14: Intentions and Non-Intentions to return



The Pie chart above indicates that 84% of the respondents indicated their intentions to return to South Africa, whilst 8% indicated their non-intentions to return. The other 8% was uncertain.

Students graduating per campus



The Bar Graph above reflects the number of nursing students who graduated between 1999 and 2001 per campus within the different health districts in KwaZulu-Natal. In 1999, the figures of graduating nursing students were as follows:

- 67 graduated from R.K. Khan (Durban Metro)
- 24 from Benedictine (Zululand District)
- 24 from Charles Johnsons' Memorial (uMzinyathi District)

- 58 from Greys / Northdale (uMgungundlovu District)
- 37 from King Edward V111 (Durban Metro)
- 25 from Edendale (uMgungundlovu District)
- 15 from Ngwelezana (uThungulu District), and
- 40 from R.K. Khan (Durban Metro).
- In total 314 nursing students graduated from the College Campuses of KwaZulu-Natal Department of Health in 1999.

In year 2000 the figures of graduating nursing students from different college campuses were as follows:

- 50 from Addington
- 33 from Benedictine
- 19 from Charles Johnsons' Memorial
- 46 from Greys and 9 from Northdale
- 39 from King Edward V111
- 65 from Edendale
- 54 from Prince Mshiyeni Memorial
- 65 from Ngwelezana
- 48 from R.K. Khan

- In total 428 Nursing Students graduated from the college campuses of KwaZulu-Natal Department of Health in year 2000.

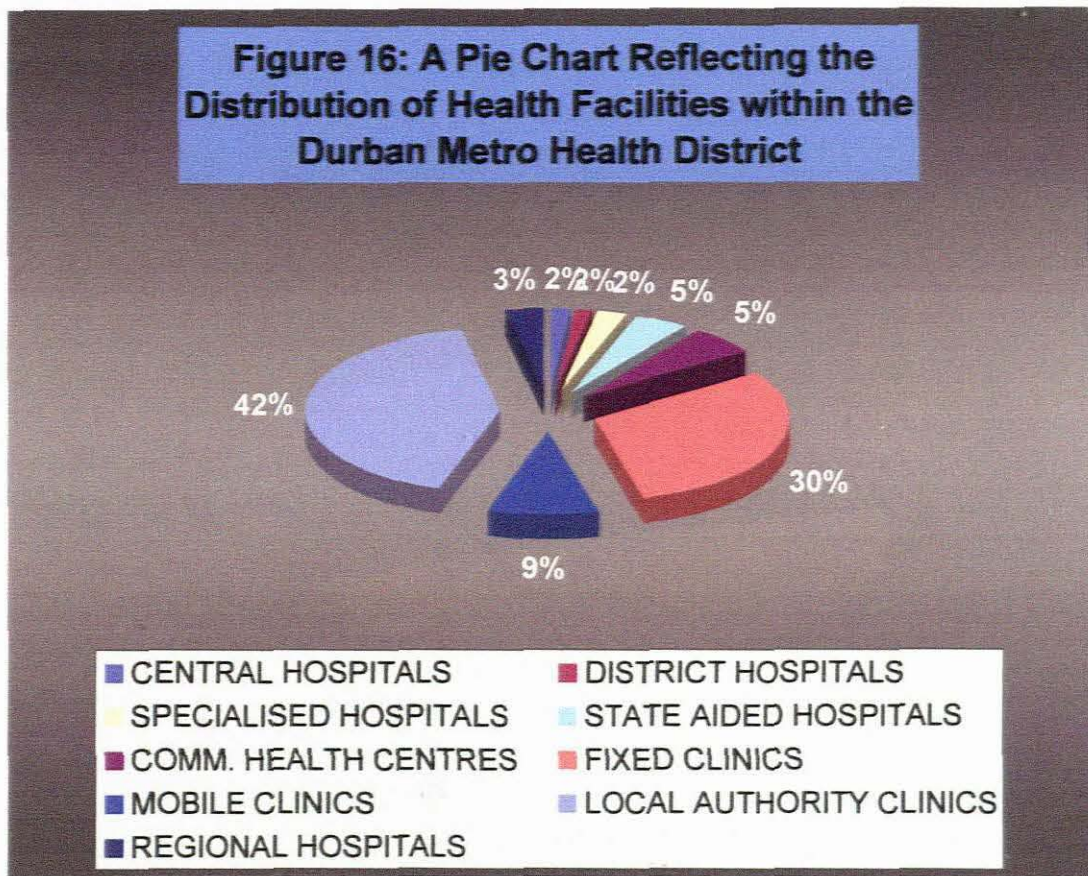
In year 2001 the figures of graduating nursing students from different college campuses were as follows:

- 36 from Addington
- 04 from Charles Johnsons' Memorial
- 23 from King Edward V111
- 32 from Edendale
- 32 from Ngwelezana
- 17 from R.K. Khan
- It would appear that there were no graduating students from Benedictine, Greys/Northdale, and Prince Mshiyeni Memorial respectively
- In total only 144 Nursing Students graduated from the college campuses of KwaZulu-Natal Department of Health in 2001

Distribution of the health facilities

The picture of distribution of health facilities within the province of KwaZulu-Natal was significant for the study of this nature, in order to reflect the issues of equity or non equity in terms of patient populations versus nursing manpower. The picture of the distribution per district is given in the form of pie charts and bar graphs.

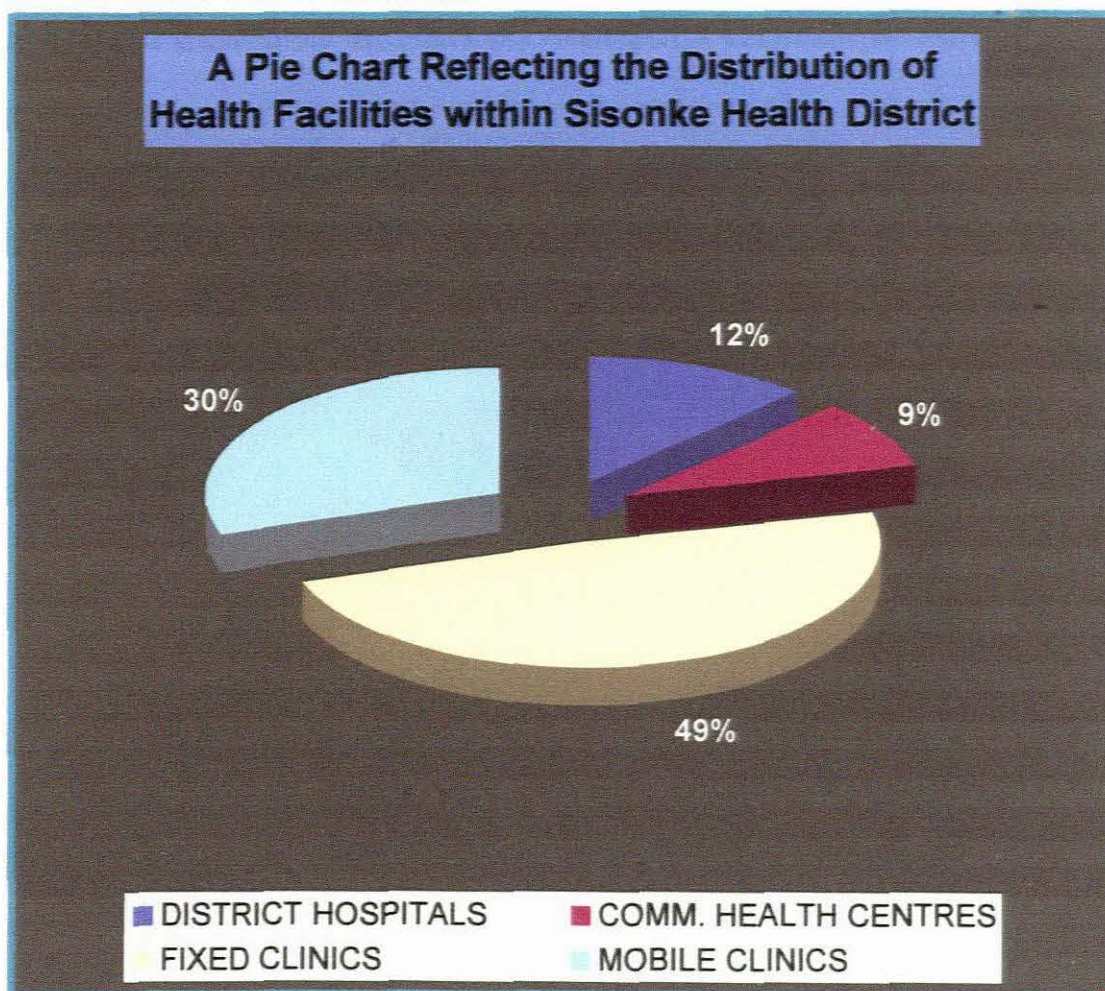
Distribution within the Durban Metro (eThekweni)



The Pie Chart above indicates that there was 1 Central Hospital, 4 Regional Hospitals, 2 District Hospitals, 3 Specialized Hospitals, 6 State Aided Hospitals, 7 Community Health Centres, 39 Fixed Clinics, 12 Mobile Clinics, and 54 Local Authority Clinics distributed within the Durban Metro Health District. The figures reflect the distribution in 2001.

Distribution within Sisonke

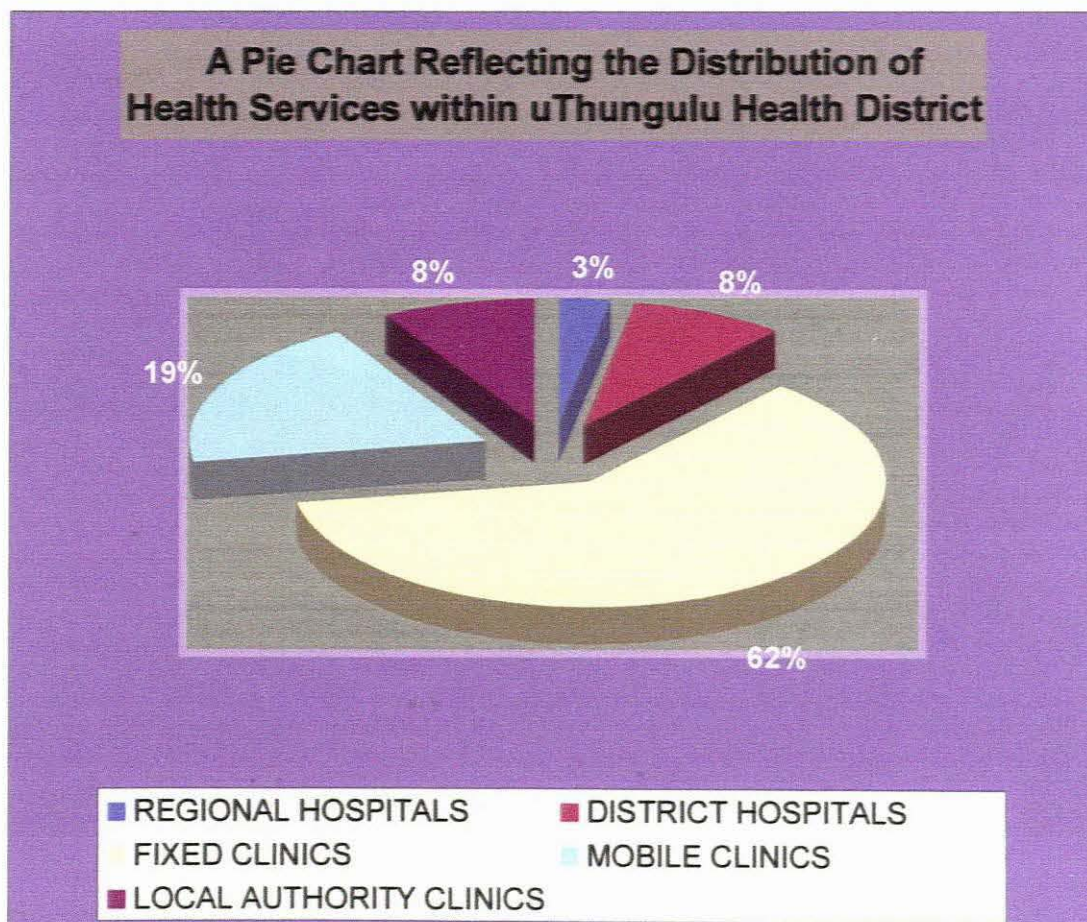
Figure 17: A Pie Chart indicating the distribution within Sisonke district



The Pie Chart indicates that there were 4 District Hospitals, 3 Community Health Centres, 16 Fixed Clinics, and 10 Mobile Clinics distributed within Sisonke Health District. The figures reflect the distribution of health facilities in 2001

Distribution within uThungulu district

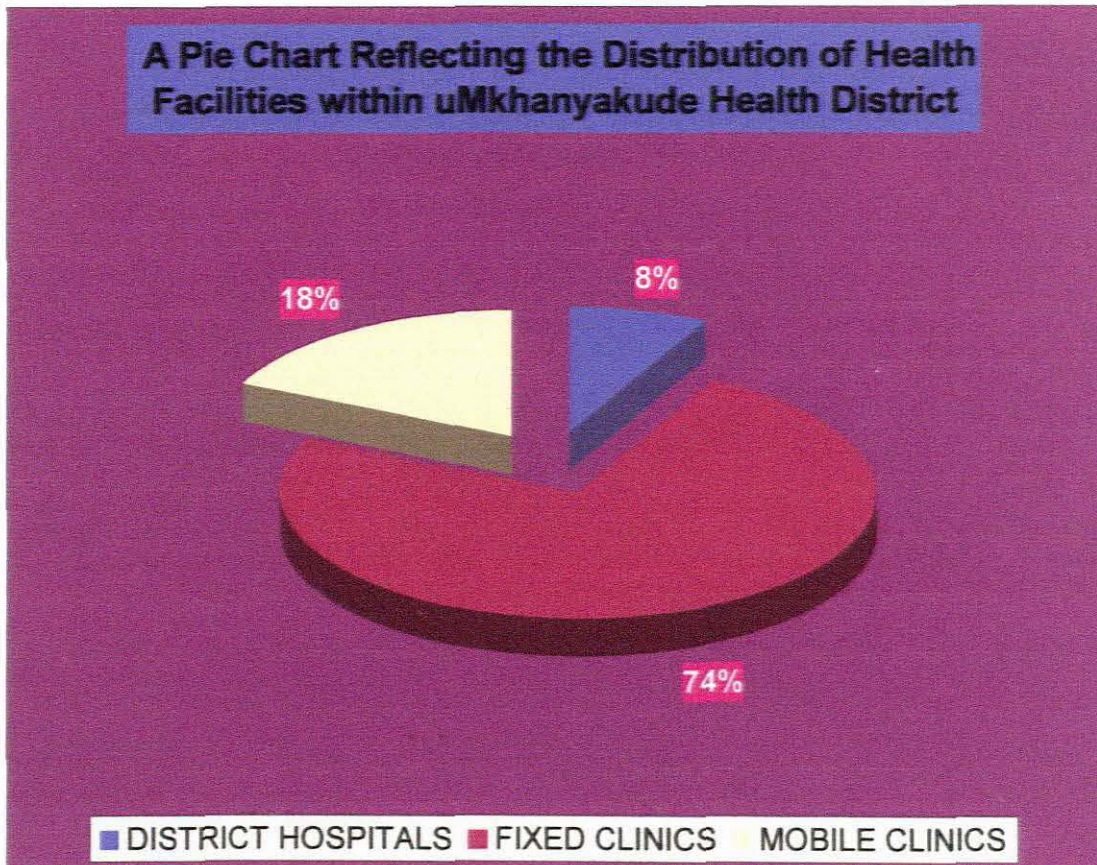
Figure 18: A Pie Chart Reflecting the Distribution of Health Facilities within uThungulu Health District



The Pie Chart above indicates that there were 2 Regional Hospitals, 6 District Hospitals, 44 Fixed clinics, 14 Mobile clinics, and 6 Local Authority clinics distributed within the uThungulu Health District. The figures indicate the distribution in 2001

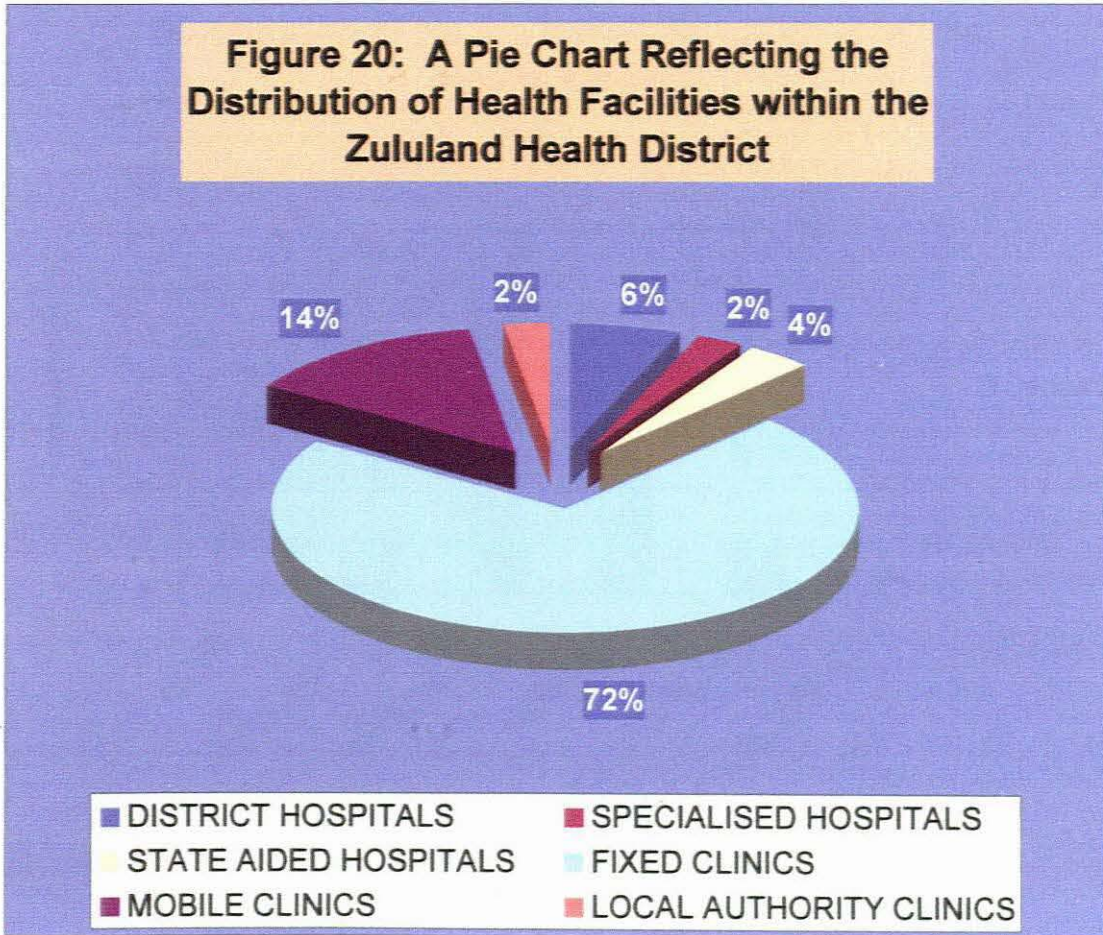
Distribution within uMkhayakude district

Figure 19: A Pie Chart Reflecting the Distribution of Health Facilities within uMkhanyakude Health District



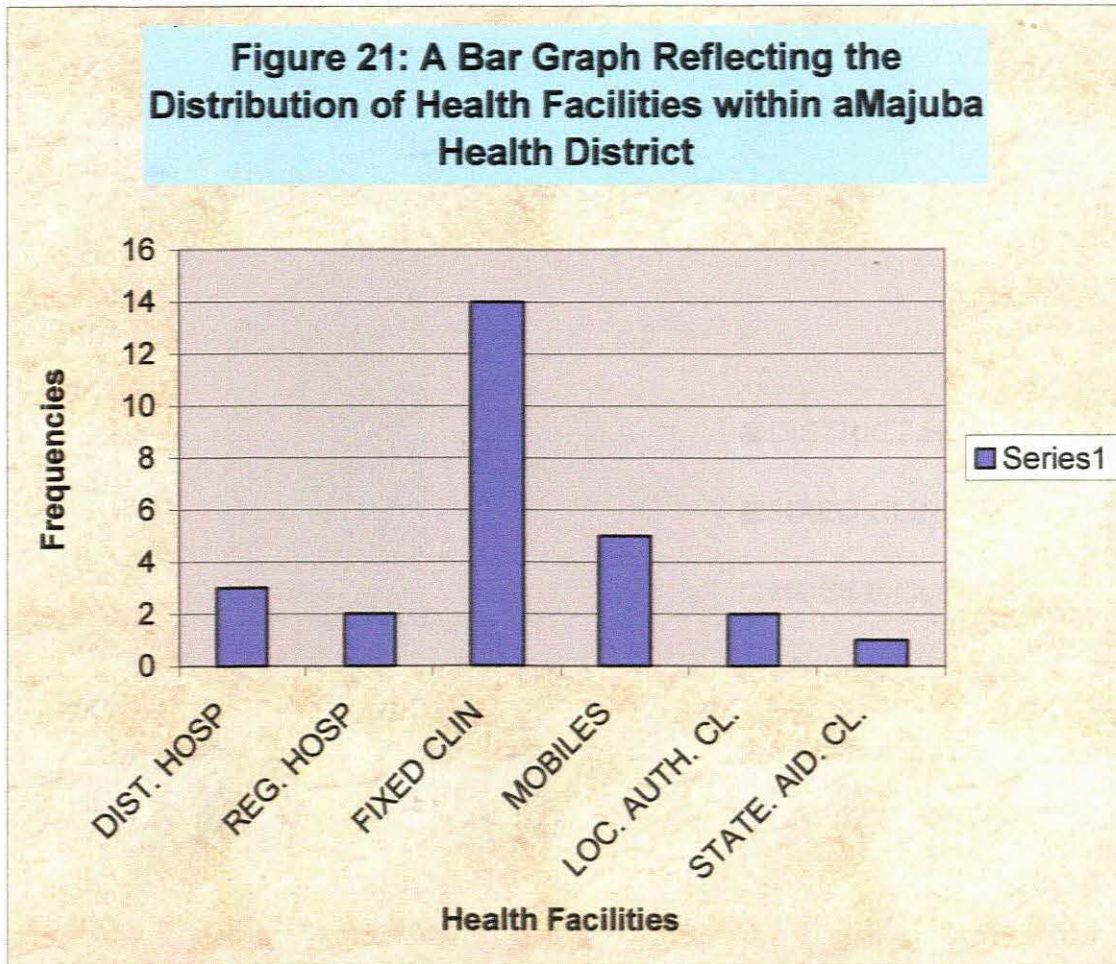
The Pie Chart above indicates that there were 5 District Hospitals, 49 Fixed Clinics and 12 mobile clinics distributed within uMkhanyakude Health District. The data indicates the distribution in 2001.

Distribution of Health Facilities within Zululand Health District



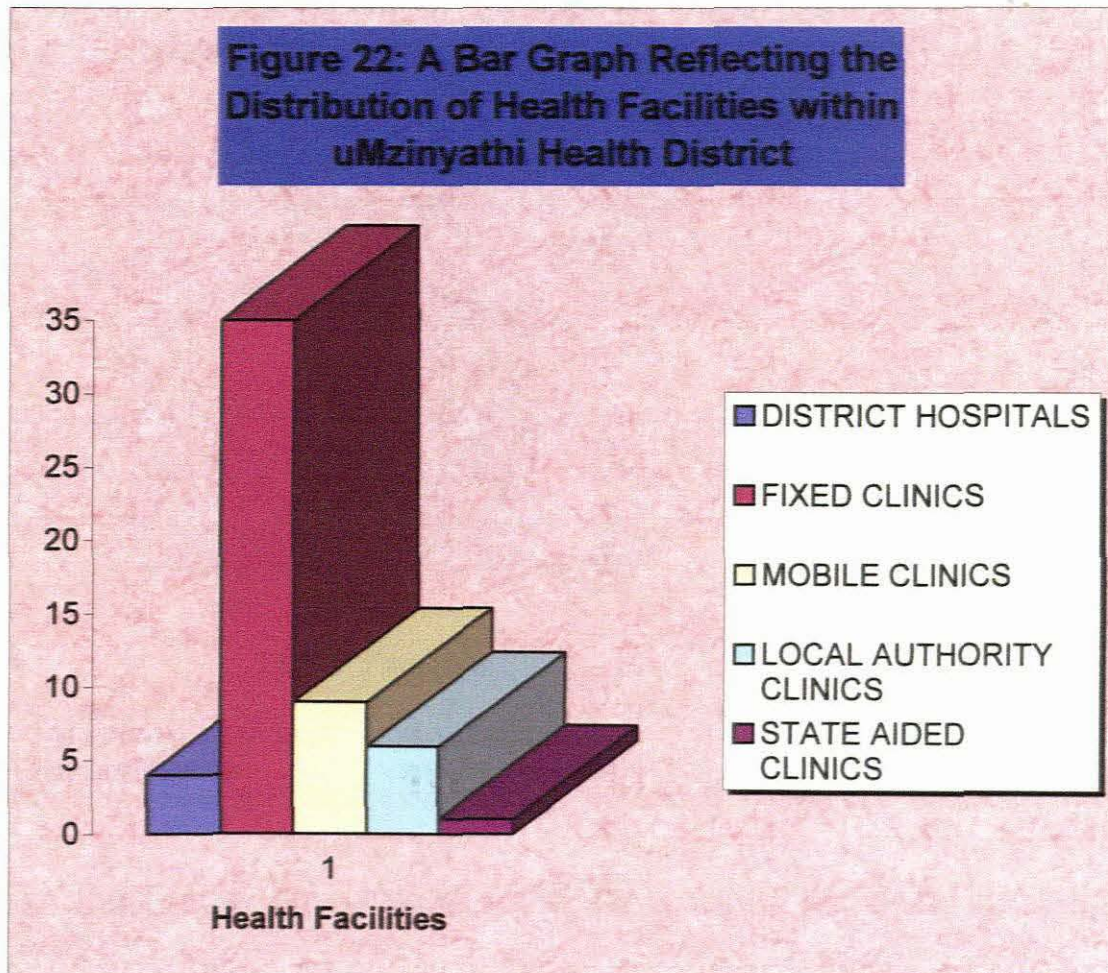
The Pie Chart above indicates that there were 5 District Hospitals, 2 Specialized Hospitals, 3 State Aided Hospitals 58 fixed clinics, 11 Mobile Clinics, and 2 Local Authority Clinics. The figures indicate the distribution in 2001.

Distribution of Health Facilities within aMajuba Health District



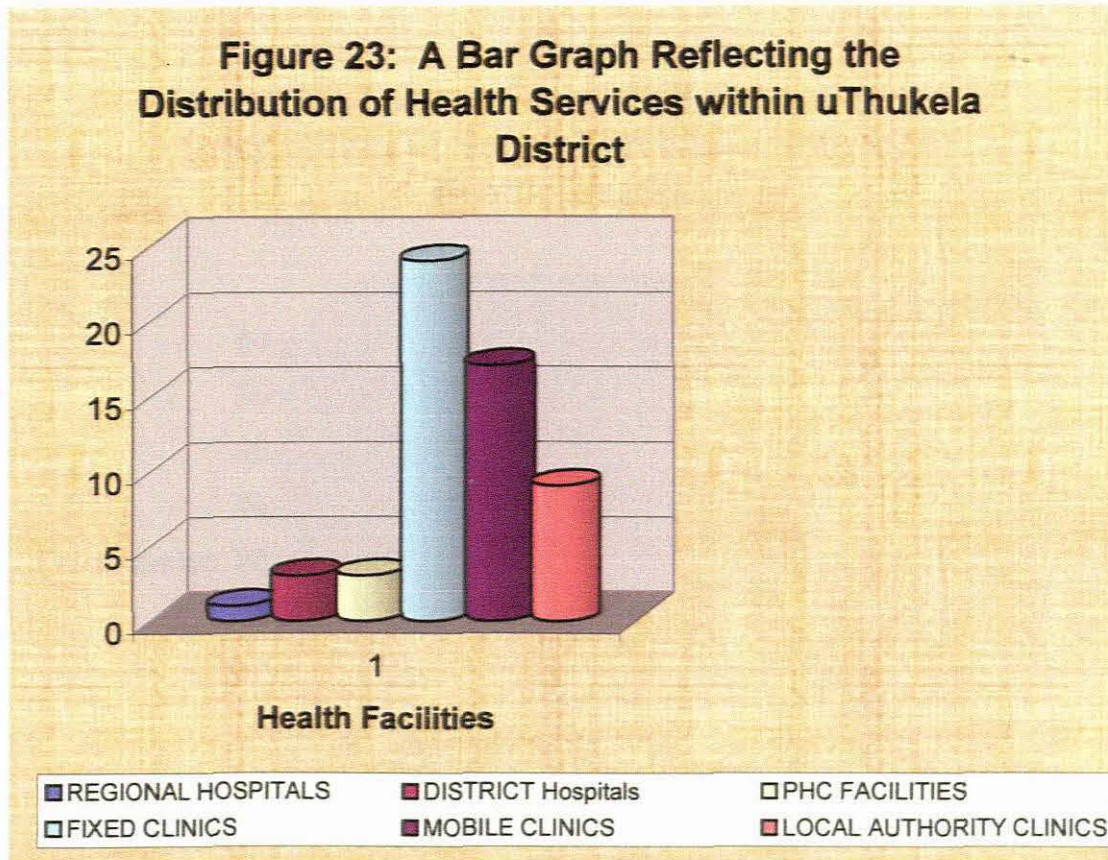
The Bar Graph above indicates that there were 3 District Hospitals, 2 Regional Hospitals 14 Fixed Clinics, 5 Mobile Clinics, 2 Local Authority Clinics, and 1 State Aided Clinic. The figure indicates the distribution in 2001

Distribution of Health Facilities within uMzinyathi Health District



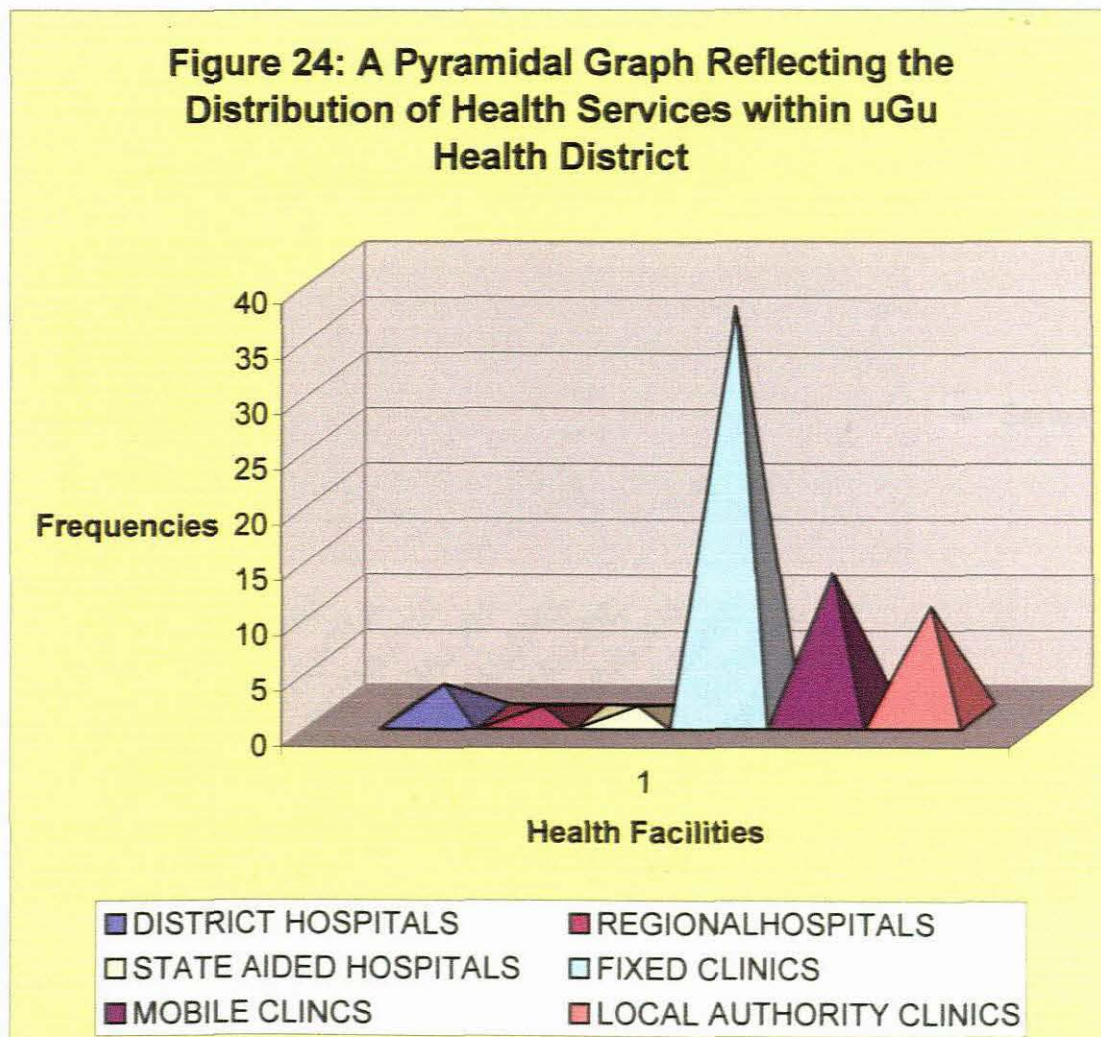
The Bar Graph above indicates that there were 4 District Hospitals, 35 Fixed Clinics, 9 Mobile Clinics, 6 Local Authority Clinics and 1 State Aided Clinic. The figures indicate the distribution in 2001.

Distribution of Health Services within uThukela Health District



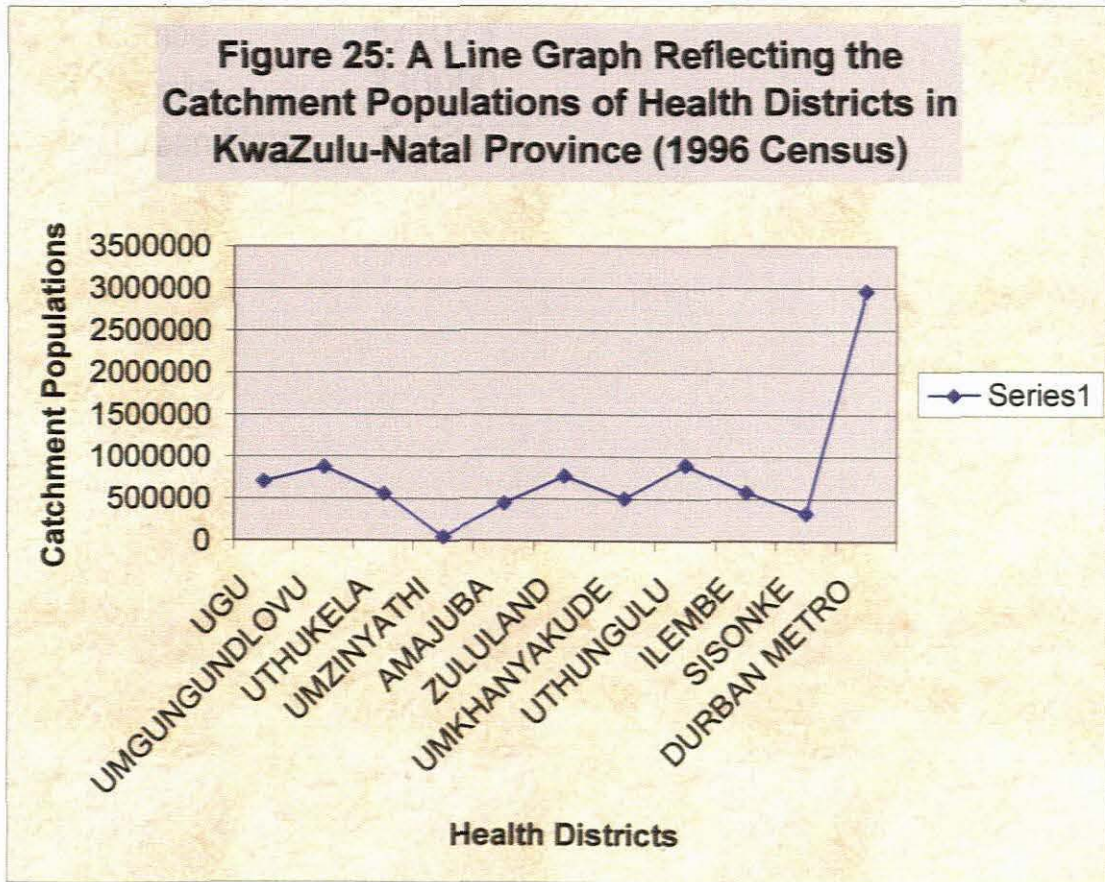
The Bar Graph above indicates that there was 1 Regional Hospital, 3 District Hospitals, 3 Primary Health Care Facilities, 24 Fixed Clinics, 17 Mobile Clinics, and 9 Local Authority Clinics distributed within uThukela Health District. The figures indicate the distribution in 2001.

Distribution of Health Facilities within uGu Health District



The Pyramidal Graph above indicates that there were 3 District Hospitals, 1 Regional Hospital, 1 State Aided Hospital, 37 Fixed Clinics, 13 Mobile Clinics and 10 Local Authority Clinics distributed within uGu Health District. The figures indicate the distribution in 2001

Catchment Populations of different health districts within the Province of KwaZulu-Natal



The Line Graph above indicates that the distribution of the population in terms of the 1996 census was as follows:

- uGu 704141
- uMgungundlovu 875000
- uThukela 553671
- uMzinyathi 46401
- aMajuba 442676

- Zululand 768791
- uMkhanyakude 503760
- uThungulu 898913
- iLembe 577073
- Sisonke 330000
- Durban Metro 2 964227

Table 2: The Geographical distribution of the population of South Africa versus nursing manpower

Province	Population 2002	Nursing Manpower as at 2002/12/31			In Training	
		Registered	Enrolled	Auxillaries	Total	Students
Limpompo						
- Females	3122311	6142	2553	2556	11251	918
- Males	2721540	606	348	280	1234	224
- Total	2843851	6748	2901	2836	12485	1142
North West						
- Females	1863132	5644	1878	3244	10766	685
- Males	1796770	621	189	399	1209	119
- Total	3659902	6265	2067	3643	11975	804
Mpumalanga						
- Females	1620916	3932	1712	1222	6866	362
- Males	1535356	286	176	165	627	60
- Total	3156272	4218	1888	1387	7493	422
Gauteng						
- Females	4001586	25662	6470	12217	44349	1893
- Males	4104604	1072	344	912	2328	322
- Total	8106190	26734	6814	13129	46677	2215
Free State						
- Females	1452496	6415	1079	2725	10219	529
- Males	1406585	721	260	278	1259	91
- Total	2859081	7136	1339	3003	11478	620
KwaZulu Natal						
- Females	4883415	17047	8796	6938	32781	1730
- Males	4328707	711	387	743	1841	300
- Total	9212122	17758	9183	7681	34622	2030
Northern Cape						
- Females	455030	1708	560	818	3086	73
- Males	433360	112	23	46	181	40
- Total	888390	1820	583	864	3267	113
Western Cape						
- Females	2214284	12421	3926	7261	23608	766
- Males	2099675	401	159	424	984	166
- Total	4313959	12822	4085	7685	24592	932

Eastern Cape

- Females	3810171	10912	3534	4774	19220	1664
- Males	3321970	535	101	424	1060	396
- Total	7132141	11447	3635	5198	20280	2060

TOTAL

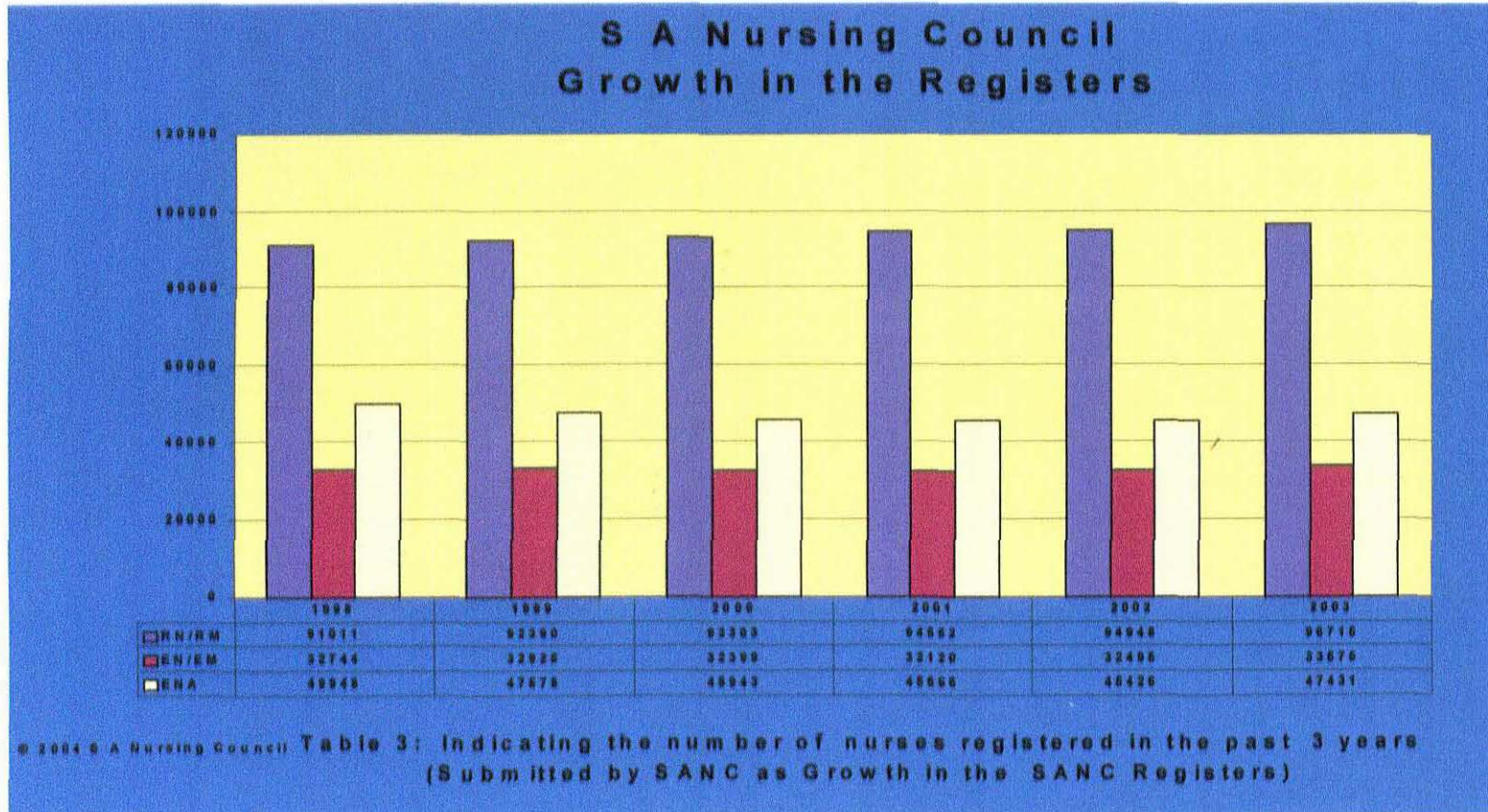
Females	23423341	89883	30508	41755	162146	8620
Males	21748567	5065	1987	3671	10723	1718
Total	45171908	94948	32495	45426	172869	10338

Population per Qualified Nurse (in the same province)

Province	Registered	Enrolled	Auxiliaries	Total
Limpompo	866:1	2014:1	206:1	468:1
North West	584:1	1771:1	1005:1	306:1
Mpumalanga	748:1	1672:1	2276:1	421:1
Gauteng	303:1	1190:1	617:1	174:1
Free State	401:1	2135:1	952:1	249:1
KwaZulu Natal	519:1	1003:1	1199:1	266:1
Northern Cape	488:1	1524:1	1028:1	272:1
Western Cape	336:1	1056:1	561:1	175:1
Eastern Cape	623:1	1962:1	1372:1	352:1
TOTAL	476:1	1390:1	994:1	261:1

***Population figures – Statistics South Africa (mid year estimates)

Table 3: Indicating the number of nurses registered in the past 3 years (Submitted by SANC as Growth in the SANC Registers)



4.2.2 The Levels of attrition

Table 4: Numbers of Registered Nurses Applying for overseas registration between 1999 and 2001:

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
1999	197	234	267	272	490	284	243	393	362	298	349	284	3672
2000	210	199	255	266	367	200	275	266	339	234	300	256	3167
2001	200	210	245	273	276	189	256	269	327	278	254	287	3164
											<u>N</u>	=	10003

The table above indicates that 3672 registered nurses emigrated in 1999, followed by 3167 in year 2000, and 3164 in 2001. The total loss for the whole country in three years was ten thousand and three (10 003) registered nurses.

Table 5: A Table reflecting Number of Registered Nurses Submitting Applications for resignation in KwaZulu-Natal public health institutions with the intention of emigrating.

	1999	2000	2001
UGU	41	41	29
UTHUKELA	36	33	38
UMZINYATHI	39	37	41
AMAJUBA	23	32	24
ZULULAND	29	21	26
UMKHANYAKUDE	31	26	14
UTHUNGULU	55	58	31
SISONKE	-	21	21
DURBAN METRO	144	177	91
Total loss for KZN Province in 3 Years:		N	= 1159

The table above indicates that in total, 1159 registered nurses in KwaZulu-Natal Public health institutions submitted applications to resign, with the intention of seeking employment opportunities in other countries. There were no figures available for Sisonke District in 1999. The highest figures were within the Durban Metro, followed by uThungulu, and uThukela respectively.

4.2.3 Factors influencing the KwaZulu-Natal nurses to emigrate

- Economic Factors: The results of the study indicated that the highest percentage of respondents (31%) rated the need for a better salary as the main reason to emigrate one of the respondents had this to say:

"I have two teenage boys, both at their tertiary level of education, the house to pay for, I have even stopped to further my own studies because my husband is presently unemployed.

- Poor Working Conditions: The poor working conditions were rated as the second most important reason for nurses to emigrate (26%). Specifically, the respondents mentioned among other things, work overload, lack of promotion opportunities,

poor relations with supervisors, and sometimes with their own colleagues, poor or no accommodation facilities.

- Social Factors: Two socially related issues were given as the contributory causes for the nurses of KwaZulu-Natal to emigrate. These included poor relations with the spouses, and poor relations with the in-laws, and one of the respondents had this to say:”

“The only option I have now is to give this marriage a break, go to London, work for about two years, and perhaps after that come back to fetch my children, my husband has been unfaithful for long enough.”

4.2.4 The implications on Health care delivery

The respondents gave various responses on how they viewed the implications of the emigration of nurses from the province to other countries. From their responses, the implications on health service delivery was categorized into the following themes:

Declining standards of health care

All respondents mentioned among others, the declining standards of health care as one that would impact negatively on health care

delivery. The shortage of professional nurses would necessitate that some of the activities normally scheduled to be done by professional nurses, would sometimes be allocated to junior nurses. Furthermore, professional nurses have to fulfil their teaching function in the wards where nurses on training are placed for their clinical experience. To emphasise the situation described above, some of the respondents had this to say:

“Our Nursing Assistants have never been properly trained to do some of the tasks, for example, the taking of blood specimens and the dressing of extensive wounds.” “They are doing all those tasks in spite of the risks because we are short staffed”

Furthermore, nurses on training therefore would miss the clinical guidance of professional nurses, and perceived as incompetent post graduation and to allude to this statement some of the respondents had this to say:

“There is actually no time to teach the nursing students anything”

Poor human relationships amongst health workers themselves, and managers. Interprofessional and intraprofessional relationships play a major role in the strengthening of

the working teams. The shortage of nurses, according to the views of the respondents had already worsened the poor relationships either between nurses themselves, nurses and their supervisors, or nurses and the other health care team members, for example, the doctors. The similar scenario was verbalized by respondents in a study conducted by Ndlovu (1999: 82), on the exploration of clinical nursing practice of the Diplomates of the four year Comprehensive Basic Nursing Diploma. Explaining the state of poor relationships where they were allocated within the first three years of service, some of them had this to say”

“There is absolutely nothing interesting me in this theatre, as I am waiting to be called for another procedure. I am here for scrubbing only. People are given offers that we do not get, like the refunding of hours. Nobody has ever explained when and how these hours are refunded, and most of the time I do not get my lunch.”

Relationships between the service providers and the communities

Members of the community always expect to get the service of a high quality, on time. Respondents reiterated that due the extreme shortage of nursing staff, the clients did not get attended to on time.

As a result the waiting times increased.

The demand to train more nurses.

It was a feeling from a number of respondents that the numbers of candidates to enter into the nurse training programmes would have to be increased in order to cope with the attrition levels within the period under study. In the opinion of the researcher, this would be a positive step, but would have to be coupled with the monitoring of the drop out rate during training.

4.2.5 The Role played by the Provincial Department of Health in controlling the attrition of nurses

Respondents mentioned that although the attempts by the department of Health to curb the attrition were underway, none of them were effective enough at the time of data collection. Those attempts included the following:

- Development of a comprehensive retention strategy for all the professionals categorized under the scarce categories including nurses. Briefly unpacked, the strategy would include:
 - Doubling the intake of learners into the different training programmes

- Developing the contracts that would demand each learner at the end of training to serve the Province the years equal to the years of his or her training programme
- Discussions around the payment of the rural allowance to other categories of clinical professionals including the nurses
- Creating another category of the health workers that would relieve the nurses from doing the non-nursing duties so that the remaining nurses would concentrate on their clinical core functions, for example clinical orderlies and ward clerks.

4.2.6 The role played by the South African Nursing Council in controlling the attrition of nurses

The office of the Registrar of the South African Nursing Council reiterated that the Council does not have any direct strategies to deal with the attrition issue. They leave that to the employers and organized labour. However, a mention was made that as the Council, they support all the initiatives by the government to deal with the problem.

One would assume therefore that, should the above proposals be implemented, it would have a positive effect in improving the working conditions of nurses, and therefore reduce the number of those who leave the province for employment opportunities in other countries

4.3 Discussions

Age Distribution

The distribution indicates strongly that the decision to leave the country is not attributed to the certain age limit. Notably was the fact that the highest number of respondents (45%) were between the ages of 36 – 40 years of age, probably with the vast experience in managing the diverse patient situations. It was also noted that only 6% were between were between the ages of 20-25 years of age. This might be attributed to the implementation of the departmental policy requiring bursary holders to serve within the province for they can leave. It was also noted with concern that nurses that were over the age of 46 years, were also leaving the province. Preparing employees for retirement is one of the important Human Resources Departments' function. It would be assumed that they were financially unstable,

having poorly prepared for retirement. This poses a challenge for the Department of Health to pay particular attention to the welfare of its employees.

Gender Distribution

From the historical background and evolution of nursing as a profession, the picture reflects that nursing is still a female dominated profession. In line with the above statement, Hall & Erasmus (2003:537) reiterate that the majority of South African nurses are females. It is however noted that in recent years, more males are starting to enter the profession. The South African Nursing Council register reflects that in 2001, 15% of all student nurses, and 19% of pupil nurses were males. The challenge for the Department of Health, in line with the employment equity act is to ensure that more males are recruited into the nursing profession, in order to reduce if not closing the gap

Length of service post graduation

Similar to the interpretation of the item of age distribution above, the histogram reflects that the years of service post graduation is not a limiting factor for nurses to emigrate. Furthermore, it indicates that the highest percentage of respondents (40%) had gained vast experience, and probably in their productive years in terms of their age as indicated in the pie chart of age distribution. Benner (1994: 32) in her theory 'From Novice to expert' maintains that after seven years of experience with similar patient populations, nurses perform at their level of proficiency. Furthermore, she holds that they have confidence in their own abilities, and apply their backlog of experience, making them to be able to maintain order even in the midst of chaos. Losing such the calibre of nurses in the opinion of the researcher, was a very costly exercise, in terms of the cost of the training programme itself, as it was explained under the emergence and progress of professional nursing in South Africa. Secondly it was costly in terms of the necessity to orientate new recruits, if the department of health would be able to attract even a few to make up for the loss.

Length of service in a particular institution

The findings indicates that 27% of respondents had worked between 11-15 years in the particular institution, 19% had worked between 16-20 years and 21- 25 years respectively. 17% of respondents had worked for a period of between 6-10 years, 11% between 26 years and above. Lastly, only 7% had served those particular institutions for a period between 0-5 years.

Again it can be inferred that the length of service in a particular institution is not a determining factor for nurses to decide to emigrate or not to emigrate. However, it is noted that the Provincial Department of Health was losing the highest percentage of experienced nurses in terms of the levels of their clinical nursing practice, a view supported by Benner (1984: 39). Within her theory from "Novice to Expert" she (Benner 1984: 33) describes nursing practice in the continuum of levels, from novice, advanced beginner, the competent, the proficient, and the expert nurse. A short analysis shall be given around the competent, the proficient, and the expert nurses below.

According to Benner (1984: 34) competency is typified by the nurse who has been on the same job, and the same or similar situation for two to three years. She or he displays a feeling of mastery, and the ability to manage diverse clinical situations. Benner (1984: 30) further identifies proficient performance from nurses who have worked with the similar patient populations for approximately three to five years. She holds that they learn from experience what typical events to expect in a given situation, and they are able to modify their care plans in response to prevailing events.

Expert nurses according to Benner (1984: 32) function as orchestrators of complex situations, able to single out the problems that need managing, setting priorities quickly and delegating responsibilities to the available staff. They have confidence in their own abilities, and applying their rich backlog of experience, they are able to maintain order in the midst of chaos. They have worked with the similar patient populations for more than seven years.

Referring to the levels of clinical nursing practice as described by Benner (1994: 32) one would assume that most of the nurses who emigrated from KwaZulu-Natal would be classified as competent / proficient / or expert nurses. This would have a cost implication in terms of recruitment processes as well as the orientation process of newly employed nurses.

Areas of placement of respondents

The Pie chart reflects that 32% of the respondents were allocated in operating theatres, 19% in critical care and obstetrics respectively, 9% in surgical units, 7% in orthopaedic units, and 4% in casualty departments.

Operating theatres, critical care and obstetric units, are regarded as the highly specialized units in need of the specialized skills in South Africa. It is very costly to train such nurses and losing them to other countries is more than a mere loss of skills. In chapter two, literature explained that one of the most important reasons for intellectuals and professionals to leave South Africa is the highest levels of crime. Most

of the crimes that have been experienced by South Africa, especially in the transitional period to democracy were the gunshots which kept the operating theatres of both urban and rural hospitals overburdened with major operations, for example, laparatomies, thoracotomies and others. That was and is still where the specialized skills of theatre trained nurses are needed. The route of freshly operated patients after major and complicated surgery is normally from the theatres to critical care units, where the specialized skills of critical care nurses are needed.

Qualifications / Specialties of respondents

The bar graph reflects that 100% nurses had a Diploma in General Nursing, followed by 30% allocated in operating theatres, whilst those allocated in critical care units, and obstetric units constitutes 22% and 20% respectively.

This would be attributed to the fact that this is a basic Diploma that any Professional nurse would attain before registering for other post basic courses. It was further noted that the higher percentages were

amongst those nurses that had specialized in Operating Theatre Nursing 30%, Critical Care Nursing 22%, and Advanced Midwifery 20%. It was noted that a number of professional nurses had more than one qualification, as a result the values or percentages might appear to be more than 100%. Noted with concern was the fact that the specialized nurses allocated in highly specialized units constituted a higher percentage amongst those that were leaving the KwaZulu-Natal Province for other countries outside South Africa, yet their skills were in their highest demand as it has already reflected in terms of violence and other kinds of crime.

Time-Period within which study leaves had been granted

The picture reflects that the pattern of granting study leaves to the nurses within the province of KwaZulu-Natal was satisfactory, and their intentions to seek employment opportunities in other countries would not be highly attributed to the lack of opportunities to improve their skills.

Saravia & Miranda (2004) however hold that higher education is one of the principal conduits of permanent emigration. The majority of skilled workers of foreign origin acquire specialized and postgraduate professional qualifications in the host country. Two thirds of foreign-born scientists and engineers working in the United States earned their doctorates there. Half of the foreign-born graduate students in France, the United Kingdom and the United States remain there after completing their studies.

Reasons for leaving

Tetty (2002: 17) holds that a key driver of the professionals' exodus from Africa is undoubtedly, the harsh economic conditions under which most professionals work, and the perceived lack of appreciation for their work, that is reflected in low levels of remuneration that they get, relative to other groups of employees. Furthermore, he asserts that it is therefore not surprising that that they avail themselves for better opportunities in other countries when the situation presents itself. A detailed discussion will be done under the factors that influence nurses to emigrate.

Managerial versus operational allocation of respondents

Findings indicated that the higher percentage of nurses that left the country were those that were at the actual bedside, twenty four hours a day. Much as the nurses at supervisory levels are also needed at a certain degree, the wards and other clinical units can not survive without bedside nurses. As it was also indicated that poor relationships with supervisors were the other contributory factor for the nurses to leave, it is clear that there was less team spirit for effective teamwork.

Hunt and Weinright (1994:53) maintain that the outcomes of nursing practice are due to the work of a group of nurses. No individual mental powers or personal skills can be a source of a successful outcome, nor does any aspect of good nursing care have to be traceable to an individual. This view supported by Booyens (1993: 125), as he reiterates that what is required of a team, is a set of complementary skills, a group of people whose minds complement creatively and emotionally.

Intentions versus non intentions to return to South Africa

Findings indicated that 94% of nurse respondents communicated their intention to return to South Africa whilst 8% indicated their non-intentions to return. The remaining 8% was uncertain. In spite of the above explanation, nobody would be sure of what these South African Nurses (94%) would actually do at the end of their intended period of migration. In the opinion of the researcher, there might be very less, if any that they would contribute to patient care, even if they eventually come back. This is because nursing has always been a physically and emotionally demanding profession, and most of them had in the past indicated the need for early retirement (that is retirement before the prescribed ages of retirement). This has been alluded to by McVeigh & Hill 2001: 3) as they argued that generally emigrants enter the developed countries, in their most productive phase of their lives, and by the time they return back, if they do, they are almost "spent force" with wrong ideas not suited even for their underdeveloped countries.

Saravia & Miranda (2004: 610) argue that although the migration of talented individuals can affect any country, developing countries face the greatest challenge. Their student emigrants and temporary migrants are most likely to remain abroad. For example, among the doctoral graduates in science and engineering in the United States in 1995, 79% of those from India and 88% of those from China remained employed in the United States. Incentives for migrants to return to developing countries have been insufficient to override the limitations at home, both real and perceived, and the attraction of opportunities found abroad.

Students graduating per campus

Although the output of the private nursing programmes within the province, and the output from the University linked nursing programmes were not part of the sample, it would be assumed that the government supported programmes form the greater percentage of the graduates from the nurse training programmes. From the analysis above, it is evident that in three years, the government supported nursing programmes could only produce 886 graduates, at an average

of 295 per year. Looking at the geographical distribution of the population of South Africa versus nursing manpower, it is reflected that in 2003 KwaZulu-Natal had a population of 9. 761032 and a total of 18 343 registered nurses. This gives the population per qualified nurse of 532: 1 within the province of KwaZulu-Natal. This is far below the World Health Organization norms. (Statistics South Africa-Mid 2003 estimates).

Distribution of health facilities

The discussion on the distribution of health facilities was looked into in terms of the availability of facilities according to the levels of care and the equity or non-equity in their distribution. It would be assumed that the distribution of both the human and material resources would be congruent to the service needs, in line with the catchment populations.

The District Health System outlines that health services would be provided in terms of four levels of care, from the Primary Health Care clinics, up to tertiary level of care. The availability of health facilities within the Province of KwaZulu-Natal within the study period was in line with the District Health System provisions. It reflected four levels of

care. Level one was provided in mobile clinics, established clinics, community health centers and district hospitals. As stated earlier on, these facilities provided the basis for primary health care, and therefore would be the most accessible to surrounding communities. District hospitals received referrals from and provided generalist support to community health centers and clinics.

Level two health care was provided at regional hospital level. These hospitals received referrals from and provided specialist support to a number of district hospitals. These included general surgery, orthopaedics, general medicine, paediatrics, obstetrics and gynaecology, radiology and anaesthetics. Within most regional hospitals, however, there was some of the level one services provided.

Level three health care was provided in tertiary hospitals that received referrals from and provided specialist support to a number of regional hospitals. Level four health care was provided in only one central hospital, consisting of the very specialized referral units which together provided an environment for multi-specialty clinical services, innovation

and research. These services are generally of a high cost and low volume, and require high technology, and or multi-disciplinary teams of people with scarce skills to provide sustained care of high quality.

It was noted with concern however that the health facilities were not equitably distributed as a result of apartheid, for example, there were no regional hospitals within uMkhanyakude, Zululand and Sisonke Health Districts respectively, whilst other districts could count more than three. Hall & Erasmus (2003: 528) in line with the above statement argue that the most fundamental healthcare problem in South is the imbalance between the relatively small group of people, concentrated in urban areas, who have to first world healthcare services, and the majority of citizens who live mainly in rural areas, and depend on primary health care. It is a natural phenomenon that employees in any undertaking, and in any profession would prefer to work in environments that would boost their self esteem in terms of a number of variables. These would include the accommodation, the schools that would provide quality education for their children, the wards and other health units that are always vitalized infrastructurally, and the prevailing

spirit of good interpersonal relationships

The health care demands, in terms of the catchment populations reflected that the Durban Metro was the biggest and the densely populated health district. The deep rural districts were Zululand, uMkhanyakude to mention a few. The deep rural districts were overpopulated, with the highest percentages of malnutrition, infections, diarrhoeal diseases and HIV/AIDS.

As it has been mentioned earlier on that three rural districts did not have a regional hospital, they had to refer patients that needed level two care to regional hospitals outside their districts. In practice, it would mean that patients, drivers and nurse escorts would be on the road for plus minus ten hours.

In line with the effects of Apartheid the nurses tended to be concentrated in the urban than the rural areas, probably because of the normal phenomena of human nature mentioned above. Secondly, in practice it is not the same to manage a rural patient as against

managing an urban patient. This scenario would mean that the few nurses that had not left the country would in practice choose to work in less demanding environments, for example, urban hospitals. According to the views of the researcher, the Department of Health has a responsibility to ensure equitable distribution of resources within the province above there was no strategy in place that would ensure the retention of nurses in rural areas.

The South African Nursing Council, through the office of the registrar also provided data on the distribution of the population of South Africa versus nursing manpower. Although the researcher had actually requested the data to focus on KwaZulu-Natal as a province, the data provided gave a wider picture, including the summary that reflected the picture of KwaZulu-Natal.

The Levels of attrition of KwaZulu-Natal nurses

The data on the provincial attrition levels was requested from two areas. The first one was through the offices of the Deputy Directors of Nursing responsible for all the nursing issues within each of the eleven

Health Districts within the Province of KwaZulu- Natal. The second area was from the office of the Registrar of the South African Nursing Council, through the requests of the Professional Nurses requests for verification of qualifications along the emigration process. According to the South African Nursing Council, there are no correct statistics that would reflect the Provincial Attrition rates in isolation from the total population of nurses in South Africa. However the following figures according to the South African Nursing Council give the overview. Table 1 reflects the numbers of registered nurses applying for overseas registration between 1999 and 2001. Table 2 reflects the general growth in the registers of the South African Nursing Council, and table 3 reflects the geographical distribution of the population of South Africa versus nursing manpower.

It is however noted that the total loss for the province could be higher than 1159, since it did not include the figures for the two districts, that is uMgungundlovu and iLembe, since they only formed part of the pilot study. Coupled with the figures reflected above, is the need to revisit the recommended registered nurse population ratios. The World

Health Organization in 1985, recommended 1: 250 for the first world, and 1: 500, for the third world. In 1990, the South African Nursing Council recommended 1: 416. Presently, the total Registered Nurse / Population ratio in South Africa is 1: 460, only less by 40 to be equivalent to the third world countries, yet South Africa is presently rated as a developing, and not the underdeveloped country.

Estimating the total loss for the KwaZulu-Natal Province in a three year period, in terms of the ratio of 1: 416 as recommended by the South African Nursing Council, one would conclude therefore that the population of 482 144 was left without a single professional nurse. This is obviously a very big loss of professional scarce category skills. Furthermore, this means that the demands for health care delivery would be higher than in the lesser-populated districts. It was noted again that, a number of regional hospitals and tertiary hospitals providing the specialist care on a referral basis were concentrated in the districts with the high attrition rate mentioned above, with a greater demand of specialized skills including those of the nurses, for example, the theatre and the critical care specialized nurses. Although the study

did not look at the figures around natural attrition, for example death, one would assume that such figures also compounded the problem, as the country is faced with the AIDS pandemic. There was also a remarkable attrition within Zululand, Amajuba, Umzinyathi, uMkhanyakude, Sisonke and Ugu health districts, but at a lesser degree than the districts mentioned above.

4.2.3 Factors influencing the KwaZul-Natal nurses to emigrate

Economic Factors: The results of the study indicated that the highest percentage of respondents (31%) rated the need for a better salary as the main reason to emigrate. Continuing disparities between in working conditions and pay between richer and poorer countries offer a great deal of “pull” towards the more developed countries. A survey of health care workers in six African countries who intended to leave their home country demonstrates that although the relative importance of factors affecting migrants varies from person to person, there are common patterns within countries. In Cameroon for example, a lack of promotion opportunities, poor living conditions, and a desire to gain experience ranked above wages as reasons why health care

professionals chose to migrate. By contrast, in Uganda and Zimbabwe, wages were the most important factor. Clearly when national policies are designed to try and retain health care workers, their strategies must be specific to the country or region in question, there are no universal strategies (Stilwell et al. 2004: 597).

An analysis by Vujicic et al. showed that the wage differentials between the source and the destination countries are currently so large that reducing them by small amounts is unlikely to affect migratory flow. This suggests that other factors, such as working conditions and professional development, will have to play a significant part in influencing the decision to migrate (Stilwell al. 2004: 597).

In line with the report by Stilwell et al, Barch (2003: 100) holds that differentials in salary levels between source and destination countries are still an important stimulus to migration. Furthermore, Xaba & Phillips (2001:5), maintain that the actual differentials in terms of purchasing power parities may be less important than the perceptions of higher earnings, especially when the private sector agencies are

actively marketing overseas employment. One of the respondents who stated the need for a better salary as the main reason to migrate had this to say:

"I have two teenage boys, both at their tertiary level of education, the house to pay for, I have even stopped to further my own studies because my husband is presently unemployed.

At the time of data collection, the authorities of the KwaZulu-Natal Provincial Department of Health had indicated that the retention strategy was still discussed at National level, and issues of a better salary, rural allowance and the scarce skills allowance would be part of the package.

Poor Working Conditions: The poor working conditions were rated as the second most important reason for nurses to emigrate. Specifically, the respondents mentioned among other things, work overload, lack of promotion opportunities, poor relations with supervisors, and sometimes with their own colleagues, poor or no accommodation facilities, and poor work scheduling, .The exacerbating factor relates to the consequences for those nurses who remained as their colleagues departed for employment abroad.

In expressing their frustration they envied those that had already migrated.

Social Factors: Two socially related issues were given as the contributory causes for the nurses of KwaZulu-Natal to emigrate. These included poor relations with the spouses, and poor relations with the in-laws. Poor relations with the spouses emanated from a number of issues including extra-marital relations, and the inability of some of the male spouses to fulfill their breadwinner roles, resulting in the female spouses having to cope with almost all the demands of running the family, and one of the respondents had this to say:"

"The only option I have now is to give this marriage a break, go to London, work for about two years, and perhaps after that come back to fetch my children, my husband has been unfaithful for long enough."

4.2.4 The Impact of Attrition on Health care Delivery

The respondents gave various responses on how they viewed the impact of the emigration of nurses from the province to other countries. From their responses, the impact on health service delivery was categorized into the following themes:

Declining standards of health care

All respondents mentioned among others, the declining standards of health care as one that would impact negatively on health care delivery. The shortage of professional nurses would necessitate that some of the activities normally scheduled to be done by professional nurses, would sometimes be allocated to junior nurses. Furthermore, professional nurses have to fulfil their teaching function in the wards where nurses on training are placed for their clinical experience. To emphasise the situation described above, some of the respondents had this to say:

“Our Nursing Assistants have never been properly trained to do some of the tasks, for example, the taking of blood specimens and the dressing of extensive wounds.” “They are doing all those tasks in spite of the risks because we are short staffed”

In the absence of enough professional nurses their ratio to nurses on training would be negatively affected. Since nursing is the science and art, the practical experience is as important as the theoretical

knowledge. Nurses on training therefore would miss the clinical guidance of professional nurses, and perceived as incompetent post graduation and to allude to this statement some of the respondents had this to say:

“There is actually no time to teach the nursing students anything”

Perceptions of nurse educators towards the four year Comprehensive Basic Nursing Diploma (CBNP) have been examined by Gwele and Uys (1995: 5-10) Respondents felt that the period of preparation in the speciality areas was too short to produce ‘competent’ practitioners, and most specifically with midwifery practice.

Poor human relationships amongst health workers themselves, and managers. Interprofessional and intraprofessional relationships play a major role in the strengthening of the working teams. The shortage of nurses, according to the views of the respondents had already worsened the poor relationships either between nurses themselves, nurses and their supervisors, or nurses and the other health care team members, for example, the doctors. The similar scenario was

verbalized by respondents in a study conducted by Ndlovu (1999: 82), on the exploration of clinical nursing practice of the Diplomates of the four year Comprehensive Basic Nursing Diploma. Explaining the state of poor relationships where they were allocated within the first three years of service, some of them had this to say”

“There is absolutely nothing interesting me in this theatre, as I am waiting to be called for another procedure. I am here for scrubbing only. People are given offers that we do not get, like the refunding of hours. Nobody has ever explained when and how these hours are refunded, and most of the time I do not get my lunch.”

Relationships between the service providers and the communities

Members of the community always expect to get the service of a high quality, on time. Respondents reiterated that due to the extreme shortage of nursing staff, the clients do not get attended to on time. As a result the waiting times increased.

According to the Sunday Times-South Africa, (26 May 2002) R.K Khan hospital in Durban had even launched the family caregiver programme, where families and community members would help with the basic care

of patients. Although there is a risk in allowing the untrained person like a relative to provide nursing care to the patients, it was seen as a way of promoting relations between the hospital and the community, provided the matter had been communicated effectively for the families and communities to understand. Appreciating the care that he received from his wife, and not underestimating the immense workload of nurses in R.K. Khan, Poobalan Govender, a patient in Sunday Times of May (26 :2002 1) had this to say:

“It’s almost like being at home. I have seen the immense workload of the nurses. I sometimes feel guilty to ask for small things that I need. With this programme, my wife comes in every day to tend to my needs.”

The demand to train more nurses.

It was a feeling from a number of respondents that the numbers of candidates to enter into the nurse training programmes would have to be increased in order to cope with the attrition levels within the period under study. In the opinion of the researcher, this would be a positive step, but would have to be coupled with the monitoring of the drop out rate during training.

4.2.5 The Role played by the Provincial Department of Health in controlling the attrition of nurses

Respondents mentioned that although the attempts by the department of Health to curb the attrition were underway, none of them were effective enough at the time of data collection. Those attempts included the following:

- Development of a comprehensive retention strategy for all the professionals categorized under the scarce categories including nurses. Briefly unpacked, the strategy would include:
 - Doubling the intake of learners into the different training programmes
 - Developing the contracts that would demand each learner at the end of training to serve the Province the years equal to the years of his or her training programme
 - Discussions around the payment of the rural allowance to other categories of clinical professionals including the nurses
 - Creating another category of the health workers that would relieve the nurses from doing the non-nursing duties so that the remaining nurses would concentrate on their

clinical core functions, for example clinical orderlies and ward clerks.

4.2.6 The role played by the South African Nursing Council in controlling the attrition of nurses

The office of the Registrar of the South African Nursing Council reiterated that the Council does not have any direct strategies to deal with the attrition issue. They leave that to the employers and organized labour. However, a mention was made that as the Council, they support all the initiatives by the government to deal with the problem.

One would assume therefore that, should the above proposals be implemented, it would have a positive effect in improving the working conditions of nurses, and therefore reduce the number of those who leave the province for employment opportunities in other countries

CHAPTER 5 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary

The purpose of the study was to examine attrition patterns of KwaZulu-Natal nurses with specific reference to those that seek employment opportunities in other countries.

The objectives of the study were

1. To examine the attrition levels of KwaZulu- Natal nurses in relation to seeking employment opportunities in other countries.
2. To identify the factors influencing the KwaZulu-Natal nurses to seek employment opportunities in other countries.
3. To examine the demand versus the supply of nurses through the training programmes supported by the KwaZulu-Natal Provincial Department of Health
4. To determine the effects of attrition on the health care service delivery within the Province of KwaZulu-Natal.
5. To examine the role-played by the Department of Health in controlling the attrition rate?

6. To examine the role-played by the South African Nursing Council as the watchdog of the public in controlling such attrition.

Research design and methodology

The descriptive study was both qualitative and quantitative. Both the questionnaires and interviews were used to collect three sets of data. Firstly from nine District Deputy Directors: Nursing for Kwa-Zulu Natal Department of Health, using a questionnaire identified as research instrument one. Secondly from the registered, practicing nurses who had submitted applications for resignation in their institutions using structured interviews, identified as research instrument two, and thirdly, from the office of the Registrar of the South African Nursing Council, using a questionnaire identified as research instrument three.

Descriptive statistics were used to analyze quantitative data. Qualitative data was analyzed according to categories and themes derived from each statement. The unit of analysis was the whole statement, and the meanings were derived from the whole statements rather than the single words or sentences.

5.2 Research findings

The results of the study reflected the following (a) the levels of attrition of KwaZulu-Natal nurses (b) the distribution of health facilities versus the nursing manpower within the Province of KwaZulu-Natal, (c) factors influencing the KwaZulu-Natal nurses to emigrate, (d) The demand versus the supply of nurses through the training programmes supported by the KwaZulu-Natal Department of Health, (e) the effects / impact of attrition on health care services delivery, (e) the role played by the KwaZulu-Natal Department of Health in controlling the attrition, and (f) the role played by the South African Nursing Council as a “watchdog” of the public in controlling the attrition.

The Attrition Levels

The attrition levels totaled to 1159 registered nurses in KwaZulu-Natal Public health institutions between 1999 and 2001. The highest figures were within the Durban Metro, uThungulu, and uThukela respectively. In terms of the distribution of health facilities, the named districts that experienced the increased levels of attrition are the densely populated districts. Although the attrition was remarkable also in other health

districts, it was not as high as in the districts mentioned above.

The Distribution of health facilities

The distribution of health facilities within the Province of KwaZulu-Natal at the time of the study was in line with the Primary Health Care approach within the ambit of the District Health System. It reflected four levels of care. It was noted with concern however that the health facilities were not equitably distributed as a result of apartheid, for example, there were no regional hospitals in three health districts namely, uMkhanyakude, Zululand, and Sisonke Health Districts, whilst other district could count more that three.

As stated earlier on , the government supported nursing programmes could only produce 886 graduates, within a three year period, at an average of 295 per year. Viewed against the total of 1159 nurses that left the province for other countries, it is evident that the output of these academic institutions could not make up for the loss.

Factors influencing nurses to emigrate

Factors Influencing the KwaZulu-Natal Professional Nurses to emigrate were firstly economically related in that the highest percentage of respondents (31%) rated the need for a better salary as the main reason to emigrate. The second factor was related to poor working conditions, followed by social factors specifically related to poor marital relationships, either between the spouses or the other in-laws.

The Impact of attrition on health services delivery.

Obviously the impact that the attrition had on service delivery was firstly the decline in the standard of health care. Ratios of registered nurses to patients had dramatically decreased. Patient care was compromised in that sometimes other duties that would normally be scheduled to be done by registered nurses would be performed even by a junior enrolled nurse or a nursing auxiliary.

The World Health Organization (2003: 11) reiterates that for the developing countries losing health care professionals may produce serious deficiencies in the services. To compensate for such losses the

remaining professionals may adapt to deliver services outside their scope of practice. Furthermore, the health professionals who remain behind also bear the burden of greater workloads, added stress, poor pay, inadequate supervision and lack of career opportunities (WHO 2003: 11)

Strategies to deal with the problem

The departmental strategies to deal with the problem were not at the implementation stage at the time of data collection. These included amongst others, the employment of a sub-professional categories of workers, named ward clerks and clinical orderlies whose main responsibilities would be to do all the non-nursing duties. The intake of nursing students into training programmes would be doubled in order to compensate for the loss. Lastly, the Department of Health at national level was still exploring the possibility of paying the rural allowance to those clinical health professionals working in rural areas, including the nurses.

As mentioned previously, the office of the Registrar of the South African Nursing Council reiterated that the Council does not have any direct

strategies to deal with the attrition issue. They leave that to the employers and organized labour. However, a mention was made that as the Council, they support all the initiatives by the government to deal with the problem.

Based on the objectives of the study, and the data collected, as it appears in chapter four as well as the summary above, the researcher therefore concludes that the objectives of the study were achieved.

5.3 Conclusions

Based on the findings of the study it can be concluded that:

- The attrition levels of KwaZulu-Natal nurses within the period under study was high, in that 1159 nurses resigned with the intention of seeking employment opportunities in other countries.
- The nurse training academic institutions could not cope with the replacement from the number of graduates that they produced within the same study period. That is, only 889 diplomates graduated, versus 1159 that left the country, excluding those

that left the service due to natural attrition, for example, death resulting from HIV/AIDS.

- The main factors that contributed to the nurses to leave the province were poor salaries, poor working conditions, poor relationships either at work and within marriages.
- There was a remarkable decline in the standard of patient care due to the shortage of skilled nurses in clinical settings.
- Strategies to deal with the problem were still at the planning stage at the time of data collection, but one would say that those were the good plans that would contribute to resolving either the actual problem or it's effects on health care delivery.

Limitations of the study

The study focused on the attrition of nurses in only one out of nine provinces, and as a result the findings can not be generalized to South Africa as a country.

5.4 Recommendations

Based on the findings of the study, as well as literature reviewed on the topic, the following recommendations appear to be feasible.

5.4.1 Improving the salaries of nurses.

The Department of Health has to examine the problem of the perceived poor salaries of nurses in general. The strategy to pay nurses with special skills, as well as payment of rural allowances would be a great move as part of the greater strategy.

Nevidjon & Erickson (2001:22) argue that retention of nurses begins with how the organization does or does not value the staff. Rhetoric notwithstanding, most health care executives view staff as an expense and in times of financial constraints, as is currently the state, watch personnel budget line very closely. Rather than viewing staff as an expense, seeing them as an asset on the balance sheet will drive different decisions about the work environment.

5.4.2 Improvement of the conditions of service of nurses.

Studies have shown three factors of overwhelming importance to nurses. They are compensation, scheduling options, and work intensity. Retention efforts must address these three areas to prevent dissatisfaction. That would include the numbers of hours worked, the scheduling of their shifts, monitoring of the nurse-patient ratios, and particular attention paid towards the improvement of their accommodation.

5.4.3. Establishing a database for all nurses in the “diaspora”.

The Department of Health to create a database of all nurses in the “diaspora” including those that are still going to leave, so as to be aware of their destination countries. Specifically the database should reflect the quantity or figures, the location, as well as quality or qualifications of nurses who have emigrated (Nurses in the diaspora).

This view has been supported by Stillwell, Diallo, Zurn, Vujcic, Adams & Dal Poz (2004: 598), as they maintain that appropriate information

system on human resources including a database on migration is the first step. They further argue that data from the destination countries are much more accurate than data from the source countries. One easily recommended strategy would be to set up a regular exchange of data between countries. This would include information on the number of nurses entering the destination country.

5.4.4 Creative contracts:

Creative contracts can be signed bilaterally between hospitals in the country of origin and the recruiting country to recruit nurses for a limited period of time. These have been suggested in literature by WHO (2003: 12). They would give for example, five year contracts, but three of these years would be spent in the country of origin, not the recruiting country. This allows the recruiting country to financially subsidize the health sector, particularly human resources in the country of origin, as well as enables the health professionals to work overseas.

5.4.5. Investing in education

Investing in another country's education system is unusual, but where there are labour imbalances, this may make good sense and provide an opportunity to compensate the "sending" country financially and strengthen the infrastructure.(WHO 2003: 12)

Example. If London wishes to recruit from South Africa, instead of simple recruitment, London has to set up a nurse training institute in South Africa financed by London employers. This institute trains nurses according to South Africa's requirements, and some of these nurses migrate to London, while others stay in South Africa. The researcher therefore further recommends that South Africa examines and adopts this option.

5.4.6 Reviewing the extent of nursing documentation

Nevidjon & Erickson (2001:43) hold that a number of regulatory and policy issues may also be exacerbating the shortage of nurses. These include state and federal law, regulation by accreditation / certification organizations, licensure and nursing practice acts, requirements from

reimbursement organizations, private organizations and the government. Some issues are factors in causing nurses to leave and others may be barriers for recruiting nurses if not attended to. In all sectors of patient care delivery, nurses complain about the amount and complexity of paperwork. This dissatisfies nurses who want to have interaction with patients and families. The department of Health must engage in aggressive process improvement initiatives which can help standardize and streamline paperwork without increasing the risk of litigation.

5.4.7. Dealing with work related stress.

Measures should be taken to recognize and provide programs for dealing with stress. Hospitals may conduct focus groups to identify the root cause of stress within the individual nursing units, and then develop a wide range of programs that may provide relief from job stress. (Bennewick: 2001:33).

5.4.8. Preparation for retirement

It was noted with concern that nurses who were over the age of 46 years were also leaving the province. It would be assumed that they had financially poorly prepared for retirement. Nurses at this age would be employed as casuals after retirement, rather than leaving the country at this critical age.

5.4.9. Non-financial incentives.

Over and above the monetary incentives payed to the nurses, particular attention would have to be paid to the non-monetary incentives as a form of positive reinforcement. Studies have shown that non-financial incentives are important in motivating health care workers both to do a good job and to continue working in public health services. These incentives include training, study leave. Specifically for health workers allocated in rural areas, providing good accommodation, transport, and agreeing on the number of years that will be in a rural health facility, rather than expecting the worker to remain there indefinitely (Stilwell et al. 2004: 598). A monitoring mechanism may be employed at district

level, and be reported upon as part of the annual report of institutional managers.

5.4.10 Improving the inter / extraprofessional relationships.

Strategies to improve and maintain interpersonal relationships between nurses and their supervisors, and between nurses and other members of the health teams would have to be explored and implemented. These might take form of the structured team building sessions organized, funded, and evaluated at district levels.

5.4.11 Intensifying the Employee Assistance Programme.

Research findings indicated that a number of nurses in KwaZulu-Natal opted to leave the country because they had socially related problems, specifically related to poor marital relationships. In order to assist the employees to deal with social problems impacting on their work, for example, the social problems, The Employee Assistance Programmes (EAP) presently available in Health institutions would have to be intensified.

5.4.12 Employment of casual nursing staff.

The budget for employment of casual nursing staff to be made available at all times in order to relieve the already overburdened nurses

5.4.13 Relieving the nurses of the non-nursing

duties. Recruitment into the clinical support posts, for example, ward clerks and clinical orderlies to be done as a matter of urgency, so as to relieve nurses of the non-nursing duties. Furthermore, the number of these clinical support posts to be increased such that there is coverage even for night duty as well as weekends and public holidays.

5.4.14 Increasing the number of bursary holders.

The Department of Health to support other academic institutions that train nurses by increasing the number of bursary holders. This option would complement effectively the strategy by the Department of Health of doubling the intake of nurse learners into the training programmes.

5.4.15 Retention as a management style.

The Department of Health would have to ensure that managers make retention a part of their overall management style and responsibilities. Their task in this area would include identifying roles and activities that lead to retention, customizing staff responsibilities, identifying the sources of dissatisfaction, and providing regular performance feedback. A tracking system should be in place for evaluating managers' performance on their retention plans and strategies. Poor managers could increase the risk of nurses' dissatisfaction whereas good managers would contribute positively towards the retention of their nursing staff.

5.4.16. Preceptor ship/Mentorship programmes

In view of the stress associated with challenges at the workplace, it is recommended that offering of professional support to both the newly qualified, as well as the experienced nurses, in the form of preceptor ship and mentorship programmes be initiated and monitored. It is verbally reported that there are preceptors in the clinical areas, but their effectiveness needs to be proven.

5.4.17 Further research

As it was stated as a limitation that this research was done in one province, it is recommended that research on the same topic be repeated in other provinces or in the whole of South Africa in order to expose the problem in its entirety.

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Ref./Verw.

2002-03-04

To Whom It May Concern:

This serves to certify that the Faculty Research Committee (Arts) considered and approved the PhD proposal submitted by **WINNETH LUNGILE NDLOVU (930373)** on 28 November 2001. The proposal met all the requirements. The title of her proposal was:

The Attrition Levels of KwaZulu-Natal Nurses with Special Reference to Seeking Employment Opportunities in other Countries and its Implications on Health Services Delivery within the Province

Thanking

Yours sincerely

A handwritten signature in black ink, appearing to read 'P M Lubisi'.

P M Lubisi

Secretary: Faculty Research Committee

ANNEXURE B

P.O. Box 12466
EMPANGENI 3880
10 March 2002
Tel 0826730962

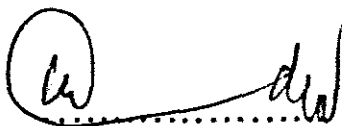
The Director
Human Resources Development
KwaZulu-Natal Department of Health
Private Bag x 9051
PIETERMARITZBURG
3200

REQUEST FOR PERMISSION TO UNDERTAKE RESEARCH

I am registered for a Doctoral degree with the University of Zululand. The title of my thesis is : *The Attrition levels of KwaZulu-Natal nurses with specific reference to seeking employment opportunities in other countries and it's implications for Health services delivery within the Province.*"

The problem of the perceived high attrition of nursing personnel in South Africa, and specifically in KwaZulu-Natal continues to plague the health care industry. Registered nurses, and specifically the specialized categories are perceived to be leaving the province in very high numbers, especially in the post democratic era (1994 to date).

The success of this research project will depend amongst other things on the quality of data collected. I intend collecting data from the District offices, Hospitals and the South African Nursing Council. Information will be handled with absolute confidentiality. Your office, is therefore kindly requested to grant permission to undertake research on the above topic from the District offices and the hospitals within the Province.



W.L. NDLOVU (MRS).

ANNEXURE C

The University of Zululand
Nursing Science Department
Private Bag x1001
Kwa-Dlangezwa
3886
30 June 2002
Tel 0826730962

The Director
Human Resources Development
Private Bag x 9051
Pietermaritzburg
3201

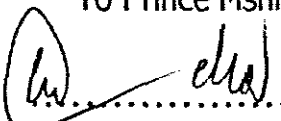
LIST OF KWAZULU-NATAL HEALTH FACILITIES WHERE RESEARCH IS TO BE CONDUCTED

(a) DISTRICT OFFICES

1. Durban Health District office
2. Uthungulu Health District Office
3. Umkhanyakude Health District Office
4. Umzinyathi Health District Office
5. Amajuba Health District Office
6. Sisonke Health District Office
7. Ugu Health District Office
8. Zululand Health District Office

(b) HOSPITALS

1. Addington Provincial Hospital
2. Benedictine Provincial Hospital
3. Bethesda Provincial Hospital
4. Edendale Provincial Hospital
5. King Edward V111 Provincial Hospital
6. Madadeni Provincial Hospital
7. Murchison Provincial Hospital
8. Ngwelezana Provincial Hospital
9. Stanger Provincial Hospital
- 10 Prince Mshiyeni Memorial Hospital


.....
W.L. NDLOVU (Mrs)

ANNEXURE D

The University of Zululand
Nursing Science Department
Private Bag X1001
KwaDlangezwa
3886
12 November 2001 -
Tel: 0826730962

The Director
Human Resources Development
Private Bag x 9051
Pietermaritzburg
3201

**AN UNDERTAKING TO ACKNOWLEDGE THE DEPARTMENT OF HEALTH IN THE
COMPLETED THESES AND A COPY TO BE SUPPLIED TO THE DEPARTMENT**

I hereby make a written undertaking that I will acknowledge the Department of Health in the completed theses, and I will supply a copy to the Department.

Yours Faithfully



.....

W.L. NDLOVU (Mrs)



TO :
D : Mrs S D Nelker
- :

DATE :
USUKU : 28 August 2002
DATUM :

REFERENCE :
INKOMBA :
VERYWYSING :

Mrs W L Ndlovu
University of Zululand
Private Bag x1001
KWADLANGEZWA
3886

Dear Mrs N Ndlovu

APPROVAL OF REQUEST TO CONDUCT RESEARCH

Your application for the above request refers.

- After careful consideration of your research proposal the Human Resource Development Directorate has resolved to approve your research project.
- Kindly ensure that your research project complies with accepted ethical standards and that the clients / patients are not harmed in any way.
- You may approach the Health Districts identified by you for permission to conduct the research.

Wishing you well with your project.

Kind regards.

DR L L NKONZO-MTEMBU
DIRECTOR
HUMAN RESOURCE DEVELOPMENT
ED:Vnam/Netter...

ANNEXURE F

P.O. Box 12466

EMPANGENI

3880

15 September 2002

TEL: 0826730962

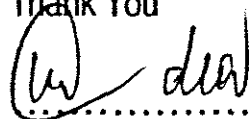
The Registrar
South African Nursing Council
P.O. Box 1123
PRETORIA

I am registered for a Doctoral Degree with the University of Zululand. The title of my theses is "The Attrition Levels of KwaZulu Natal Nurses, with Specific reference to seeking employment opportunities in other countries, and it's Implications for Health Service Delivery within the Province"

The Problem of the perceived high attrition of Nursing Personnel in South Africa, and specifically in KwaZulu Natal continues to plague the health care industry. Registered Nurses, and specifically the specialized categories are perceived to be leaving the province in very large numbers, especially in the post democratic era (1994 to date).

As the Statutory Body, that is also a "Watchdog" of the public, it is perceived that SANC has a role in ensuring that the Human Resources are maintained at a level that can minimally meet the total demands for patient care. The success of this research project will depend amongst other things, on the quality of data collected, and SANC is one of the three areas from which data will be collected for this study. Information will be handled with absolute confidentiality. Your office is therefore kindly requested to complete the short questionnaire attached, related to statistics, and the role of SANC in minimizing the exodus of South African Nurses.

Thank You



.....
W.L. NDLOVU (MRS.)

ANNEXURE G

RESEARCH INSTRUMENT ONE

A QUESTIONNAIRE

PROPOSED RESPONDENTS: DEPUTY DIRECTORS, NURSING IN HEALTH DISTRICTS

RESEARCH TOPIC:

"THE ATTRITION LEVELS OF KWAZULU-NATAL NURSES, WITH SPECIFIC REFERENCE TO SEEKING EMPLOYMENT OPPORTUNITIES IN OTHER COUNTRIES AND IT'S IMPLICATIONS FOR HEALTH CARE SERVICES DELIVERY WITHIN THE PROVINCE

1. DEMOGRAPHIC DATA

1.1 Description of the District

Urban	
Peri Urban	
Rural	
Deep Rural	

1.2 Catchment Population

Less than 250.000	
250.000 – 500.000	
500.000 – 750.000	
750.000 – 1000.000	
1000.000 and above	

1.3 Total Number of Health care Facilities within the District

Central Hospitals	
Tertiary Hospitals	
Regional Hospitals	
District Hospitals	
Established Clinics	
Mobile Services	
Community Health Centres	

1.4 Total Number of Nursing Academic Institutions (Campuses of the 4 Year Comprehensive Basic Nursing Diploma)

None	
One	
Two	
Three	

1.5 **Total Number of Learners Admitted to the Course in the past 3 years**

1999	
2000	
2001	

1.6 **Total Number of Diplomates Produced in the past 3 years**

1999	
2000	
2001	

2. **Total Number of newly recruited Professional Nurses in the past 3 years**

	1999	2000	2001
Central Hospitals			
Tertiary Hospitals			
Regional Hospitals			
District Hospitals			
Established Clinics			
Mobile Services			
Community Health Centers			

3. **Total Number of Resignations in the Past 3 years (Professional Nurses Only)**

	1999	2000	2001
Central Hospitals			
Tertiary Hospitals			
Regional Hospitals			
District Hospitals			
Established Clinics			
Mobile Services			
Community Health Centers			

ANNEXURE H

RESEARCH INSTRUMENT TWO

INTERVIEW SCHEDULE

PROPOSED RESPONDENTS: REGISTERED PRACTISING PROFESSIONAL NURSES
IN INSTITUTIONS

RESEARCH TOPIC

"THE ATTRITION LEVELS OF KWAZULU-NATAL NURSES WITH SPECIFIC
REFERENCE TO SEEKING EMPLOYMENT OPPORTUNITIES IN OTHER COUNTRIES
AND IT'S IMPLICATIONS FOR HEALTH CARE SERVICES WITHIN THE PROVINCE

AGE

20-25 Years	
26-30 Years	
31-35 Years	
36-40 Years	
41-45 Years	
46 and Above	

2. GENDER

Male	
Female	

3. LENGTH OF SERVICE POST GRADUATION

Less than 5 years	
5-10 Years	
11-15 Years	
16-20 Years	
21-25 Years	
26 Years and Above	

4. LENGTH OF SERVICE IN THIS PARTICULAR INSTITUTION

Less than 5Years	
5-10 Years	
11-15 Years	
16-20 Years	
21-25 Years	
26 Years and above	

5. AREA OF PLACEMENT

Casualty	
Paediatric Unit	
Medical Unit	
Surgical Unit	
Orthopaedic Unit	
Critical Care / High Care Unit	
Operating Theatre	
Other	

6. PERIOD OF PLACEMENT IN YOUR PRESENT WARD

Less than 3 Years	
3-6 Years	
7-9 Years	
10 –12 Years	
13-15 Years	
16 Years and above	

7. QUALIFICATIONS

General Nursing	
Midwifery	
Advanced Midwifery	
Child Care Nursing	
Operating Theatre Nursing	
Critical Care Nursing	
Trauma Nursing	
Community Health Nursing	
Primary Health Care Nursing	
Psychiatric Nursing	
Orthopaedic Nursing	
Other	

8. PERIOD WHEN LAST STUDY LEAVE WAS GRANTED

Never	
Less than 2 Years Back	
3 Years Back	
4 Years Back	
5 Years back and more	

9. REASONS FOR LEAVING

	25%	50%	75%	100%
Poor Working Conditions				
Poor Relations with Supervisors				
Poor Relations with a Colleague				
For Skills Development				
For a Better Salary				
Other				

10. KINDLY SAY MORE ABOUT YOUR MAIN REASON FOR LEAVING

11. HAVE YOU BEEN EMPLOYED AT A MANAGERIAL OR OPERATIONAL LEVEL?

Managerial	
Operational	

ANNEXURE I

RESEARCH INSTRUMENT THREE

A QUESTIONNAIRE

PROPOSED RESPONDENT:

THE REGISTRAR OF THE SOUTH AFRICAN NURSING COUNCIL

RESEARCH TOPIC

"THE ATTRITION LEVELS OF KWAZULU-NATAL NURSES WITH SPECIFIC REFERENCE TO SEEKING EMPLOYMENT OPPORTUNITIES IN OTHER COUNTRIES, AND ITS IMPLICATIONS FOR HEALTH CARE SERVICES DELIVERY WITHIN THE PROVINCE

