

Factors Affecting Turnover of Nurses In Rural Clinics Of Lesotho

By

Sekhametsi Matamane

A Field Study

Submitted to the UFS Business School

In the Faculty of Economic and Management Sciences

In partial fulfillment of the Requirements for the Degree

MAGISTER IN BUSINESS ADMINISTRATION

AT THE UFS BUSINESS SCHOOL UNIVERSITY OF THE FREE STATE

BLOEMFONTEIN

SUPERVISOR: DR. LIEZEL MASSYN

20 November 2014

DECLARATION

"I, Sekhametsi Matamane, declare that this research is my own independent work and that it has not been submitted previously for any degree or examination at any other University".

I also hereby cede copyright of this work to the University of the Free State

Signed Date

ABSTRACT

The primary objective of the study was to establish the factors affecting turnover of nurses at the nine rural clinics in Lesotho that are managed by the Lesotho Flying Doctors Services. The turnover of nurses at the nine rural clinics of Lesotho has contributed to challenges faced by the health care system of the country. This is exacerbated by the high prevalence of HIV and AIDS that has led to a heavier burden on nurses to provide anti-retroviral treatment and primary health care. The widespread poverty dominant in the rural areas affected a large number of Basotho to use public health care as opposed to private health care. In addition, low remuneration and hardship allowances paid to nurses in the rural areas may drive them to look for better paying jobs. Challenges faced by the health college are aggravating the situation.

Using the qualitative research method, the study concluded that demographic factors have varying effects on the turnover of nurses. However, their influence is less significant in comparison with general factors and economic factors. Among other factors identified in the three themes, the participants were dissatisfied with accommodation, which was very poor despite the recent refurbishment and construction of the clinics. It appears from the findings that non-financial factors were more significant than the financial ones, and many participants were concerned about a number of them. The most significant non-financial factors, for example, include the issue of accommodation, communication, and infrastructure, which in turn affect access to the remote clinics negatively. Economic factors had a significant effect on the turnover of nurses, and the main challenges were caused by budgetary constraints.

The turnover of nurses, particularly with regard to those working in the rural areas, can affect the quality of services in the nursing profession negatively. A number of factors, consequences, and challenges may also hamper nurses' work at the remote clinics. Management at the Ministry of Health should implement a number of strategies that will assist in reducing the level of turnover of nurses and enhance health care services at the rural clinics.

Keywords: *turnover, shortage, nurses, job satisfaction, infrastructure, communication, financial and budgetary constraints, demographic and economic factors.*

ACKNOWLEDGEMENTS

I wish to thank and praise God, who has provided me with the strength and courage to complete my studies successfully.

My deepest gratitude goes to my husband, Leoma, for his undying love, encouragement and support throughout my journey.

My sincere gratitude to my children, Setsoto and Reitumetse, for understanding when I locked myself up to study or when I was away from home.

My deepest gratitude to my supervisor, Dr. Liezel Massyn, who, despite her busy schedule, provided me with tremendous and remarkable guidance throughout.

My acknowledgement and sincere credit to Irish Aid, my sponsor, for allowing me the opportunity to embark on this journey.

My special appreciation to Mr. Monaphathi from Lesotho Nursing Association for his valuable input and motivation to complete my studies.

My sincere gratitude goes to my parents for their persuasion and encouraging words.

Very special thanks to my brothers and sisters for understanding, believing in me and keeping an eye on my children when I was away.

My special thanks to my friends and colleagues who stood by me and endured my absence at special gatherings and important meetings.

TABLE OF CONTENTS

ABSTRACT	2
ACKNOWLEDGEMENTS	3
LIST OF FIGURES.....	8
LIST OF TABLES	9
CHAPTER 1: RESEARCH PROPOSAL.....	10
1.1 background	10
1.1.1 Background information on the nine selected rural clinics	12
1.1.2 Nursing initiative in Lesotho	14
1.2 Problem Statement	17
1.3 Objectives	18
1.3.1 Primary objective	18
1.3.2 Secondary objectives	18
1.4 PRELIMINARY LITERATURE REVIEW	19
1.4.1 Turnover of nurses	19
1.4.2 Shortage of nurses.....	20
1.4.3 Remuneration of nurses at rural clinics	20
1.4.4 Workload effects on nurses due to turnover	20
1.4.5 Effects of HIV and AIDS on turnover of nurses	21
1.4.6 Cost implications of turnover of nurses	21
1.5 Research METHODOLOGY	22
1.5.1 Research design	22
1.5.2 Sampling.....	22
1.5.3 Data collection	22
1.5.4 Data analysis	23
1.6 Ethical Considerations	23
1.7 Demarcation of the study	23
1.8 LAYOUT OF THE STUDY	24
1.9 CONCLUSION	24
CHAPTER 2: TURNOVER OF NURSES AT RURAL CLINICS	25
2.1 INTRODUCTION	25
2.2 DEFINITIONS	25

2.2.1	Definition of staff turnover in a nursing context	25
2.2.2	Definition of intention to leave/resign	27
2.2.3	Inconsistent definition of turnover	28
2.3	MODELS OF TURNOVER.....	28
2.3.1	The patient care system and nurse turnover model	29
2.3.2	Model of turnover determinants and intervening variables.....	30
2.3.3	Intermediate linkages model of turnover	31
2.4	CHALLENGES RELATED TOTURNOVER OFNURSING STAFF.....	32
2.4.1	Recruitment.....	33
2.4.2	Training.....	33
2.4.3	HIV and AIDS.....	34
2.5	FACTORS AFFECTING TURNOVER OF NURSES	35
2.5.1	Job satisfaction	36
2.5.2	Individual factors	38
2.5.3	Organisational factors	40
2.5.4	Monetary factors	42
2.5.5	Other non-financial factors.....	43
2.6	CONSEQUENCES OF TURNOVER OF NURSES.....	44
2.6.1	Shortage of nurses.....	45
2.6.2	Quality of patient care delivery.....	45
2.6.3	Cost-related effects.....	46
2.7	CONCLUSION.....	47
	CHAPTER 3: RESEARCH METHODOLOGY	49
3.1	INTRODUCTION	49
3.2	RESEARCH DESIGN	49
3.2.1	Qualitative research	49
3.2.2	Exploratory research.....	50
3.3	SAMPLING	51
3.3.1	Sampling method and type	51
3.3.2	Element and population	52
3.3.3	Sample and sample size.....	52
3.4	DATA COLLECTION	53
3.4.1	Semi-structured interviews.....	53

3.5	DATA ANALYSIS.....	54
3.5.1	Content analysis	54
3.6	ETHICAL CONSIDERATIONS.....	55
3.7	CONCLUSION.....	56
	CHAPTER 4: FINDINGS.....	57
4.1	Introduction	57
4.2	Interviews.....	57
4.3	Data Analysis.....	58
4.3.1	Theme 1: General aspects.....	59
4.3.2	Theme 2: Work-related factors.....	75
4.3.3	Theme 3: Economic determinants	86
4.4	Conclusion	90
	CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS	91
5.1	Introduction	91
5.2	Conclusionsof the study.....	91
5.4	Recommendations.....	92
5.4.1	Biographical factors	92
5.4.2	Infrastructure.....	92
5.4.3	Telecommunication.....	93
5.4.4	Safety.....	93
5.4.5	Quality of accommodation	93
5.4.6	Workloads and Staffing levels.....	93
5.4.7	Administration of clinics	94
5.4.8	Training and development	94
5.4.9	Equipment and medicine supplies	94
5.4.10	Remuneration	94
5.4.11	Retention package.....	94
5.4.12	Budgetary constraints and financial support	95
5.5	Limitations of the study	95
5.6	Conclusion	95
	REFERENCES.....	97
	APPENDICES	107

APPENDIX 1: MINISTRY OF HEALTH-ETHICS COMMITTEE APPROVAL	107
APPENDIX 2: INTERVIEW QUESTIONS	108
APPENDIX 3: CONSENT FORM	110

LIST OF FIGURES

Figure 2.1	Patient care system and nurse turnover model	28
Figure 2.2	Price's turnover determinants and intervening variables model	31
Figure 2.3	Mobley's intermediate linkages model of turnover	32
Figure 2.4	Factors affecting turnover	37
Figure 2.5	Job satisfaction	38
Figure 4.1	Age distribution of the participants	61
Figure 4.2	Gender of participants	62
Figure 4.3	Marital status of participants	63
Figure 4.4	Nationality	64
Figure 4.5	Education level	65
Figure 4.6	Years of work experience	66

LIST OF TABLES

Table 1.1	Staffing Levels per Health Centre at the End of July 2014	13
Table 4.1	Total Number of Nurses Interviewed per Clinic	57
Table 4.2	Key Informants or Individual Position Holders	58
Table 4.3	Themes	59
Table 4.4	Demographic Factors per Clinic	60

CHAPTER 1: RESEARCH PROPOSAL

1.1 BACKGROUND

Lesotho is one of the smallest countries in Africa and is entirely landlocked by South Africa with a total area of 30 355 square kilometres and the population a little over 2 million (Mwase, Kariisa, Doherty, Khotle, Mukiibi, & Williamson, 2010). The country is largely a rural economy with approximately 75% of the people living in the rural areas (African Peer Review Mechanism, 2010). It is the only country in the world that lies entirely 1400 metres above sea level. Three quarters of the country is mountainous, rural, and hard to reach; therefore, it is sometimes referred to as the “Mountain Kingdom” or the “Kingdom in the Sky.” The remaining quarter covers the lowlands, populated by approximately 25% of the citizens.

As it attempts to manage the HIV and AIDS pandemic, which has a prevalence of approximately 23%, and widespread poverty, Lesotho faces many challenges in terms of its health system (Joseph, Rigodon, Cancedda, Haidar, Lesia, Ramangoela & Furin, 2012). These include severe human resource shortages in a variety of health care services. Consequently, the burden of providing primary health care and improving access to anti-retroviral (ART) services has fallen on nurses, particularly in the rural areas (Mwase et al., 2010). The widespread poverty prevailing in the rural areas caused a large number of the country’s population to use public health care as opposed to private health care. Among other factors, the challenges are exacerbated by an increasing turnover of nurses from rural to urban areas, from the nursing profession to other professions, from public health care centres to private ones and from the country to other countries, particularly to the neighbouring country, South Africa, and to other international or overseas countries. Health care personnel are one of the most essential components of the health system of any country. No health system can operate efficiently and effectively without adequate and experienced human resources, including nurses (Matjila, 2006).

A nurse is a skilled health care expert who combines scientific knowledge with the art of caring and skills acquired through training (Australian College of Nursing, 2007). Vance (2011) describes a nurse as someone who cares and, to illustrate further what a nurse is, he refers to images of Florence Nightingale during the Crimean War when she provided care to injured soldiers. He further describes a nurse in many ways, as an educator, data provider, computer, researcher, psychologist, clergyman, philosopher

and an organisational specialist. He added that nurses' skills are developed through discipline, education and training. Chambliss (in Wall, 2010) mentions that nursing is a noble profession but also an unpleasant job. Lea and Cruickshank (2005) describe rural nursing as a distinct practice and state further that the largest group of health care workers in Australia is rural nurses. Montour, Baumann, Blythe, and Hunsberger (2009) reported that rural nursing is not a specialised practice; yet, it requires flexibility and a thorough general knowledge foundation. In addition, they reported that most nurses preferred this type of non-specialised nursing practice. However, they noted that new nurses were likely to opt for specialised nursing practices. On the other hand, Mills, Birks, Hegney, and Collegian (2010) concluded that rural nursing definitions are integrated with remote nursing, contextual differences and a range of distances. Oloresisimo (2013) describes nursing by referring to three aspects, namely the core, care, and cure. The *core* is the patient who requires professional nursing; *care* refers to the role of nurses in nurturing the body of a patient; and *cure* is the attention the quality health care service qualified nurses provide to patients. Similarly, the Community College in Southern Maine (2012) concluded that nursing is based on three concepts, namely the nursing process, which involves decisive thinking in provision of quality health care; caring, which entail good relations between the nurse and the patient; and professional behaviour that expresses ethical and safe health care services.

According to Vance (2011), shortage of nurses is recognised universally. The trend of nurse migration is anticipated to continue until developed countries address the shortage of nurses and developing countries manage its factors (Buchan & Aiken, 2008). Nurses in Lesotho migrate from rural to urban areas or to other developed countries like the United Kingdom (Africa Peer Review Mechanism, 2010). Ross, Polsky and Sochalski (in Ntlale & Duma, 2012) report that South Africa, as a neighbouring country to Lesotho, lost about 1% of its nurses to the United Kingdom in 2002, and in 2006, the loss increased to 5.1% (Clemens & Pettersonin Ntlale & Duma, 2012). Consequently, South Africa manages this challenge by recruiting nurses from its neighbouring countries like Lesotho. Some move from the nursing profession to other professions or from public health care centres to private ones.

The major crisis the Lesotho health system is facing is the failure to attract nurses to work in rural clinics situated in vast catchment areas. In 2010, one of the local newspapers announced that Lesotho nurses went on strike over low wages and poor working conditions (Lesotho Times, 2010). The Ministry of Health and Social Welfare

(2004) identified forty-six health centres and pronounced them as the most remote and hard-to-reach clinics of the country. This research involves nine of the clinics that are accessible by aircraft only. Most of the rural clinics are understaffed with nurses and are without doctors, physicians, pharmacists or other health professionals. The staffing level of nurses and midwives in the nine selected clinics is lower than the minimum requirement of the World Health Organisation (WHO), Afro Region averages of 2.4 for nurses and 10.9 for midwives (National Health and Social Welfare Policy, 2011). The nurses are even below the official staffing level set by the Ministry of Health in Lesotho, which is a total of five nurses per clinic; thus, one nursing officer, two nursing sisters with midwifery and two nursing assistants. This is termed the two-two-one structure. The structure of nursing profession in Lesotho is divided into three levels. Nursing officers (NOs) or registered nurses are at the highest level and generally hold bachelor degrees in nursing. Nursing sisters (NSs) are at the next level and have a diploma in nursing. Finally, nursing assistants (NAs) mostly do not have certificates but provide basic nursing care under close supervision of NOs. Although the Human Resources Needs Assessment (HRNA) (2002) recommended a structure of six nurses consisting of one nursing clinician/officer, two nursing sisters with midwifery, and three nursing assistants the Ministry approved the two-two-one structure in the same year due to budgetary constraints. No changes have been made to the structure since its inception; therefore, it is still operational.

1.1.1 Background information on the nine selected rural clinics

The Government of Lesotho decided that district hospitals would manage health centres and clinics around them. However, due to the remoteness of the nine selected rural clinics, namely Nohana, Ha Nkau, Methalaneng, Tlhanyaku, Manemaneng, Bobete, Lebakeng, Semenanyane, and Kuebunyane, the Lesotho Flying Doctors Services (LFDS) under the Ministry of Health was assigned to manage these remote clinics. The first seven of these clinics are under the administration of the Partners in Health (PIH) organisation, with nurses recruited by both PIH and Government of Lesotho (GOL). This means the staff compliment in those clinics consists of nurses that are under different administrations. Thus, some nurses report to PIH, while others report to GOL. The last two clinics, namely Semenanyane and Kuebunyane, are under the direct administration of the Government of Lesotho. The PIH has experts providing primary health care, and it has adequate resources. The above-mentioned nine clinics are located in different mountainous villages that are not easily accessible by road but by aircraft, and patients

from the nearby villages ride on horseback to reach those clinics. With a view to extend a helping hand effectively, Lesotho Flying Doctors Services (LFDS) undertakes planned and emergency round trips to the remote rural clinics, mainly by aircraft. LFDS brings fundamental supplies, including vaccines, to the clinics. There are four aircraft in Lesotho, and the pilots are provided by the Mission Aviation Fellowship (MAF), which operates with 130 aircraft in 30 countries (Ministry of Health, 2013). As one of the donors in Lesotho, Irish Aid is committed to support the LFDS. The Government of Lesotho entered into an agreement with Irish Aid to provide financial support to the Ministry of Health for the nursing initiative, targeting rural clinics. The funds were budgeted for, amongst others to build and refurbish the nine rural clinics to enhance the working conditions and environment. Seven of these clinics are fully operational, while the other two clinics at Kuebunyane and Semenanyane, are currently being refurbished.

At the end of March 2013, there were 33 nurses in the nine clinics. Table 1.1 below shows how and where they were placed. The Ministry is currently working towards filling all the positions to complete the approved two-two-one structure. Nurses in those nine clinics are required to handle many responsibilities, including curative care, offering ante- and post-natal care, delivery of babies, taking blood samples and many other duties. As mentioned already, the staffing level of nurses is below the averages or minimum requirements of the Ministry of Health and WHO Afro Region. During that period, only one clinic, Lebakeng had the minimum required number of nurses, which is five. As illustrated in Table 1.1, the placement of nurses in those nine clinics has not followed the approved structure, meaning that, where the structure requires one nursing officer/registered nurse, there are clinics with two. Similarly, where the structure requires two nursing sisters and two nursing assistants, there are clinics with one nurse at those levels. The effects of the prevalence rate of HIV and AIDS and widespread poverty worsen the situation and result in nurses being overburdened in providing primary health care services and anti-retroviral treatment (ART) and being exposed to diseases without much protective equipment.

Table 1.1

Staffing Levels per Health Centre at the End of July 2014

Health Centre	Total number of nurses	Registered Nurses/Nursing Officers (NOs)	Nursing sisters with midwifery(NSs)	Nursing Assistants (NAs)
Nohana	6	1	3	2
Nkau	5	1	3	1
Methalaneng	6	1	3	2
Tlhanyaku	4	0	3	1
Manemaneng	4	1	2	1
Bobete	5	1	2	2
Lebakeng	5	2	2	1
Semenanyane	5	0	3	2
Kuebunyane	5	2	1	2
Total	45	9	22	14

The nursing profession in Lesotho is quite homogeneous as far as gender and nationality are concerned. Generally, the career is dominated by females, and more than 90% of nurses are women. The statistics in Table 4.4 on page 60 categorise nurses by nationality. The table shows that 50% of the nurses are foreign, while the remaining 50% are local.

1.1.2 Nursing initiative in Lesotho

While Lesotho continues to deal with the crisis of a high prevalence rate of HIV and AIDS, together with a great turnover and shortage of nurses, in 2006, the country launched the Lesotho Nursing Initiatives (World Health Organisation, 2011). Subsequently in 2010, the Government of Lesotho through Ministry of Health commissioned an exercise to assess the impact on nursing initiatives in Lesotho. The results of that exercise indicate that there is still a shortage of nurses in Lesotho (Ministry of Health, 2010). Given the shortage of nurses, the assessment recommended that foreign nurses be employed permanently in Lesotho. The Human Resources Needs Assessment, (2002) of the Ministry of Health validates the issue of the shortage of nurses in Lesotho and it states that the nursing profession is the largest cadre in the formal health sector in the country.

There are 188 Government health centres in Lesotho. The Christian Health Association of Lesotho (CHAL) receives subvention from the Government for running 75 of these

health centres. CHAL operates mostly in rural areas. Initially, the Government of Lesotho received financial support from the Global Fund, then Irish Aid, for payment of nurses. In 2011 a memorandum of understanding (MOU) between the Government of Lesotho and the Government of Ireland, through the Embassy of Ireland/Irish Aid was signed for provision of funds. This was a temporary intervention by Ireland to assist the Government of Lesotho to improve the situation and attain the minimum staffing requirements for nurses in 46 selected rural clinics (Embassy of Ireland, 2011). The intention was to increase the number of health care workers, enhance access to anti-retroviral treatment and provide primary health care, targeting the rural population. These additional nurses would be absorbed in the public service. The Ministry of Health was then tasked to advertise one hundred positions for local nurses for a three-year contract. The salary scale was higher than the existing Government scale was, and there was a gratuity of 38.5% of the salary at the end of the contracts. There was a poor response from Basotho nurses; only 40 applicants responded. The Government then approached other countries in the region, and bilateral agreements were signed. Finally, 60 Kenyans and 50 Zimbabweans were recruited and deployed to health facilities in the hard-to-reach areas, including the nine selected clinics. Contracts of employment for most foreign nurses have expired, and only a few are still present in the country. The Government has not been able to close the gaps of those who have left. Currently, measures are taken to attract more local nurses and close the gaps in the nursing profession. On the positive side, this initiative succeeded in keeping skilled nurses in the Southern African Development Community (SADC) region and in scaling up nursing positions for a while. Moreover, the Ministry of Public Service succeeded in increasing the number of nursing posts on the Government's establishment list (Ministry of Health, 2013).

As part of its five-year Country Strategy Paper (CSP) 2008-12, Irish Aid continued to provide financial support to the initiative. In 2012, an addendum to the memorandum of understanding (MOU) of 2011 was signed between Irish Aid and the Government of Lesotho to fund an increased number of nursing posts further. The total Irish Aid grant, amounting to M32.3million (thirty-two million, three hundred thousand Maloti) was set aside for the Ministry of Health, and this was disbursed and channelled through the Ministry of Finance. This amount was intended to support the payment of 257 nurses' salaries and retention packages in the 46 rural clinics, including the nine selected clinics (Embassy of Ireland in Maseru, 2012). The retention package covered the hardship

allowance, cell phone airtime, transport costs, gas refills, and provision of basic furniture per nurse. The Irish Aid support was on condition that the Government would establish nursing positions and absorb those nurses into the public sector establishment list for purposes of retention and sustainability. This time, the salaries and other allowances were based and aligned with the Government grades, as opposed to what was agreed before. This salary alignment was meant to sustain the programme and make it affordable for the Government when the Irish Aid funding ends. Nonetheless, there was a delay in filling these posts, as prospective nurses were unwilling to relocate to rural clinics and the Government was unable to attract them. Nurses who have been recruited are demotivated, since there was a delay in implementing the retention package and they are spreading the news to the prospective nurses. At the end of March 2013, about 74 nursing posts in the 46 clinics had been filled. Most of these positions were filled at the beginning of 2013, just after Irish Aid had made efforts to ensure that the Ministry complied with the conditions of the signed MOU. This figure includes the 45 nurses in the nine clinics. The increasing turnover of skilled nurses in rural areas continues to raise concern about the effectiveness of health care service delivery. The delay in filling the 257 nursing posts shows that the Government still faces a shortage of nurses in the rural areas (Ministry of Health, 2013).

The approval of the two-two-one structure by the Ministry after the completion of the 2002 Human Resources Needs Assessment was intended to standardise the minimum staffing level, not taking into account the discrepancies in population size and services provided at each health centre. In partnership with Irish Aid and the Clinton Health Access Initiative (CHAI) the Ministry of Health undertook a study which would assist the Ministry to understand the available human resources in health centres across the country (Health Workforce Optimisation Analysis, 2014). In addition the study considered the catchment area and its population size including the types of services provided at each health centre. This will assist the Ministry of Health to know how to utilise available health care workers best and to prioritise placement of new nurses, particularly in hard-to-reach areas. Eventually, the Health Workforce Optimisation analysis will inform whether the current standardised two-two-one structure is suitable to all health centres and what adjustments would be required to provide good service delivery to patients.

The study investigated the underlying factors affecting turnover of nurses in the nine rural health clinics of Lesotho. This chapter will outline the problem statement and

objectives of the study. The research methodology, ethical considerations and demarcation of the study will be described.

1.2 PROBLEM STATEMENT

In spite of the reforms and strategies the Government of Lesotho is putting in place, the problem is to retain professional health care workers because turnover of nurses in the rural health clinics is still a challenge. The delay in implementing the retention package is likely to aggravate the situation. If the situation is not resolved, the Government of Lesotho, through the Ministry of Health, will not achieve the objective of providing good primary health care, and the underserved population in the rural areas will continue to suffer most.

Statistics on Lesotho show that there is high attrition of health workers in the public sector. Between 1994 and 2004, the number of hired nurses decreased by 15% and in 2007, 54% of nursing posts at health facilities were vacant, 6 out of 171 Government health facilities had the minimum staffing requirement and most health employees were aggressively looking for other jobs (Retention Strategy for Health Workforce, 2010). The current situation has not changed considerably, since only 18 in 188 Government health facilities have the minimum staffing requirement of five nurses. In addition, there are still vacant nursing posts. In liaison with the Ministry of Health, the Ministry of Public Service is working towards filling all vacant nursing posts and absorbing additional nurses from the nursing initiative, but at a slow pace. The delays in filling available posts may be aggravated by problems faced by many countries caused by wage bill caps, which limit the number of civil servants (Matjila, 2006). The nine LFDS clinics serve densely populated villages but are understaffed with only three to four nurses, and there are no doctors and other health professionals.

Considering the delay in recruiting nurses and in providing retention packages, the Ministry of Health will be unable to overcome the challenges of the shortage of health professionals and to retain skilled nurses. According to the World Health Organisation (2011), it is generally acknowledged that the shortage of health workers is the major constraint to attain millennium development goals related to reducing health and poverty. Turnover of nurses is a global concern, and Lesotho, like many other developing countries, is not an exception to this challenge (Retention Strategy for Health Workforce, 2010).

The analysis above raises the following primary and secondary research questions:

The overarching research question is the following: Which underlying factors affect turnover of nurses at the nine rural clinics in Lesotho?

The following research questions relate to the secondary objectives:

- How does job satisfaction affect turnover of nurses working in the rural clinics in Lesotho?
- What effect do demographic and organisational factors have on turnover of nurses at rural clinics?
- What effect do monetary factors have on turnover of rural nurses?
- How does infrastructure influence turnover of nurses in the nine rural clinics of Lesotho?

1.3 OBJECTIVES

1.3.1 Primary objective

The primary objective of the study is to establish the factors affecting turnover of nurses in the nine rural clinics in Lesotho that are managed by the Lesotho Flying Doctors Services.

1.3.2 Secondary objectives

Information collected in this research will be used to answer research questions related to secondary objectives, namely to:

- determine the factors that influence staff turnover of nurses;
- examine whether infrastructure affect turnover of nurses at rural clinics in Lesotho;
- determine whether job satisfaction influences nurses' turnover in rural clinics in Lesotho;
- determine the influence of biographical factors on turnover of nurses at rural clinics in Lesotho and

- analyse economic determinants that influence turnover of nurses at rural clinics in Lesotho.

1.4 PRELIMINARY LITERATURE REVIEW

The preliminary literature review critically checks and summarises past research studies on turnover of nurses at rural clinics and will form the basis of this study. Current theories and limitations in the theories will be discussed.

Vance (2011) describes a nurse as someone who cares, has various skills, and considers ethics. Images of the noble Florence Nightingale who provided care to wounded soldiers during the Crimean War illustrate a nurse. Other experts explain the importance of nurses in health systems of any country. Turnover involves the rational thinking of a nurse when deciding to quit and search for a new job. Behavioural intention to leave has been found to be the leading factor of staff turnover across industries, and in theory, it is assumed an essential originator of turnover (Gregory, in Hecimovich, 2011). Professional nurses in the rural health clinics place high value on the role of the public and government as major stakeholders in the community in which they work (Pillay, 2007).

1.4.1 Turnover of nurses

Various experts describe factors affecting turnover of nurses in rural health centres. Amongst others, they refer to factors such as low salary levels, inadequate planning of human resources, high workloads, poor infrastructure, and bad working conditions that lead to dissatisfaction among public health employees, particularly in the rural areas. Other studies show that a key factor of nurses' intention to leave is work dissatisfaction (Mrayyan, 2009; Larabee, 2003; Lambert, 2001; Tzeng, 2002; Ying & Yong, 2002, in Pillay, 2007).

Some experts indicate that high levels of nurse turnover and subsequent low levels of staffing have a negative effect on performance, quality of health care, patient satisfaction (Needleman et al., 2002; Foley, 2002; Aiken et al. in Pillay, 2007), workplace safety (O'Leary in Pillay, 2007), and working conditions (Aiken et al. in Pillay, 2007). High staff turnover of skilled nurses leads to loss of institutional memory and reduced expertise. Without continuity, all these factors negatively affect the efficiency and effectiveness of health care facilities (Holmstrom & Elf in Pillay, 2007). Turnover of nurses due to retirement also negatively affects productivity and effectiveness of the

health workforce due to loss of knowledge and skills (Waldman et al. in Leurer, 2007). Turnover also affects the remaining nurses, as it may result in increasing workloads, low morale, and reduced efficiency. Matjila (2006) states that some of the factors leading to staff turnover in the Bophirima Health District include shortage of staff and a high vacancy rate, causing increased workload on the remaining workforce.

1.4.2 Shortage of nurses

There is evidence of a worldwide shortage of nurses, and in most developed countries, this is exacerbated by a mixture of quickly ageing nursing staff and the population as a whole (Leurer, 2007). A shortage of well-trained nurses, including tutors, may affect mentoring of remaining nurses and future production of prospective nurses negatively (Pillay, 2007). Such shortages in the health workforce have been defined as an indication of insufficient recruitment and retention policies (Zurn, Stilwell & Dolea, 2005).

1.4.3 Remuneration of nurses at rural clinics

Insufficient salary was viewed as the major reason for turnover by Finnish researchers (Webb in Gow, Warren, Anthony & Hischen, 2008). Low salaries mostly lead to job dissatisfaction and relocation of health workers in most developing countries (Stilwell, De Waal, Solimano, & Sewankambo, 2004). Compensating health employees with sufficient salaries and allowances has been recognised as a vital aspect of motivating and retaining them (World Health Organisation, 2011). According to Manafa et al. (2009), health employees working in the rural areas of Malawi were of the opinion that they were stopped from meeting their needs due to poor salaries. In Kenya, nurses were unwilling to work in the rural areas due to insufficient hardship allowance and other monetary incentives (Mullei et al., 2010). Manongi et al. (in Adezi & Atinga, 2012) points out that other allowances directly related to salary increment such as promotion may make staff hesitant to work in rural areas when promotion is overdue. Matjila (2006) explains that some staff left the Bophirima Health District in the North-West Province in South Africa to the private sector and abroad.

1.4.4 Workload effects on nurses due to turnover

Van der Heijden (in Ntlale & Duma, 2012) points out that the nursing career is normally considered as an emotionally challenging job situation combined with very challenging working conditions, for example fluctuating shifts, working on weekends and heavy workloads. Other factors may include workload (Barret & Yates, in Pillay, 2007), work

environment (Backman in Pillay, 2007), remuneration and work security (Newman, 2002; Foundation for Health Communities in Pillay, 2007).

1.4.5 Effects of HIV and AIDS on turnover of nurses

Thupayagale (2007) states that, in most developing countries, the high prevalence of HIV and AIDS is one of the factors that lead to shortage of nurses, since they are frequently exposed to the infection. It is challenging to sustain service quality in this health care area because of increasing HIV issues, poverty and the ageing of the population (Da Costain Ntlale & Duma, 2012). Poor working conditions, inadequate facilities and resources, lack of treatment policies for diseases such as HIV and AIDS and TB in public sectors are among the factors affecting the health system (Padarath & Pagett, 2007). Barron et al. in Ntlale & Duma (2012) state that the low expectancy rate in the black African people is due to numerous reasons, including widespread poverty, inadequate access to health care, and HIV and AIDS infection.

1.4.6 Cost implications of turnover of nurses

Turnover of nurses has financial implications for the quality of care. These include the cost of recruiting, training, and efficiency losses. The calculated turnover cost for nurses cover over 5% of the annual operating budget at an American academic medical centre (Waldman, in Leurer, 2007). Jones (2005) says the calculations include both pre- and post-hire costs. According to Pillay (2007), loss of professional nurses affects the economic situation of countries. This relates to loss of nurses' contribution to the gross domestic product and loss of investment in training since it costs approximately R300,000 to train nurses in countries like South Africa. Costs linked with nurse turnover have been well recognised and include tangible and intangible costs (Leurer, 2007).

The theories and literature review above highlight what experts say about factors affecting turnover of nurses in rural health clinics. They also show challenges in the rural health facilities brought about by turnover of nurses. Therefore, it is important to conduct an in-depth analysis of factors affecting turnover of nurses at rural clinics in Lesotho.

1.5 RESEARCH METHODOLOGY

A research design provides a basis for the collection and analysis of data (Bryman & Bell, 2007). This exploratory study selected factors affecting turnover of nurses at rural clinics of Lesotho. Exploratory studies lean towards loose structures with the goal of providing insight and a better understanding of the study (Cooper &Schindler, 2011).

1.5.1 Research design

The research design used is qualitative by nature. This design was selected to comprehensively establish the factors affecting turnover of nurses in the nine selected rural clinics in Lesotho managed by the Lesotho Flying Doctors Services. According to Cooper and Schindler (2011), qualitative research seeks to define, convert, translate, and obtain better understanding of a problem.

1.5.2 Sampling

A non-probability purposive sampling strategy was used to ensure reasonable representation of the target population. Purposive sampling includes the selection of participants who are conversant about the area of research being studied (Brink,in Ntlale & Duma, 2012). The total population size of 50 for this study consisted of existing and newly recruited nurses as well as officials or key informants knowledgeable about the nursing profession, mainly from the Ministry of Health, the Lesotho Nursing Association, and Lesotho Flying Doctors. A total number of 29 people formed the sample size, and they were eligible to participate. This sample size was made up of 24 nurses from all nine rural clinics and 5 key informants. The interviews continued until theoretical saturation was reached.

1.5.3 Data collection

Data for this field study were collected by means of semi-structured interviews. Two types of interviews were conducted, namely personal interviews and telephone interviews particularly for participants in the geographically dispersed rural clinics. These interviews allowed questions to be omitted or added. In addition, more information was gathered by investigating the responses from the sample in greater depth. In doing so, better understanding of the causes of turnover of nurses in the nine remote clinics was obtained (Cooper & Schindler, 2011).

1.5.4 Data analysis

Data collected for this study were analysed by using content analysis. According to Cooper and Schindler (2011), content analysis is a research technique that may be used to analyse written, video, or audio data from observations, experiments, surveys, and previous studies. This analysis measures the semantic content or the '*what*' part of the message.

1.6 ETHICAL CONSIDERATIONS

In conducting the study, ethics were considered. Ethics are principles or norms that guide moral choices about manners and interactions with others, with the goal of ensuring that no one is hurt by research activities (Cooper & Schindler, 2011). The study was conducted with integrity. The proposal was submitted to the Ethics Committee of the Ministry of Health to seek approval, and written consent to conduct this study was obtained. For informed consent, the purpose of the study was explained clearly without any distortions. This enhanced cooperation and facilitated the whole process. Because of the sensitivity of the issues regarding human resource management such as remuneration, information gathered during the field study was treated confidentially. Participants' rights to privacy were respected. Resources available for this study included equipment such as laptops, and because reaching selected remote clinics posed difficulties, the plan to travel to those clinics was aligned to the routine schedule of the Lesotho Flying Doctors (Cooper & Schindler, 2011).

1.7 DEMARCATION OF THE STUDY

The research questions investigated in this research are categorised under the human resource management field. The study focused on the nine rural clinics that were managed by the Lesotho Flying Doctors Service. In order to enhance the working conditions and health services in the rural clinics, Irish Aid provided financial support to Lesotho Flying Doctors. The funds were used for building and refurbishment of some of the rural clinics. Seven of the nine targeted clinics were fully operational, and two were being refurbished at the time of the study. In determining the factors affecting turnover of nurses in the nine rural clinics, the research gathered information from the past five to ten years. The research sample size consisted of nurses from the nine rural clinics and other individuals who were knowledgeable about the nursing profession in Lesotho.

1.8 LAYOUT OF THE STUDY

Once the problem and the aim of the study with respect to turnover of nurses in the nine rural clinics of Lesotho had been demarcated, the study was structured as follows:

Chapter 2 deals with the literature review. The emphasis is on job satisfaction, individual, organisational, monetary, and other general factors affecting turnover of nurses in rural clinics. The distinction between actual turnover and intention to leave is explained. The models, challenges, and consequences of nursing turnover are also described. Information gathered from the literature review was used as a basis for designing interview questions.

Chapter 3 comprehensively describes the research methodology and design used to collect data, including sampling techniques, data collection, and analysing methods.

Chapter 4 focuses on the findings of the study. Data collected were analysed thoroughly and compared with the literature review.

Chapter 5 presents the conclusion and recommendations based on the results obtained from the analysis and literature review.

1.9 CONCLUSION

Turnover of nurses in the nine rural clinics of Lesotho has contributed to challenges faced by the health care system of the country. This is exacerbated by the high prevalence of HIV and AIDS that has led to a heavier burden on nurses to provide anti-retroviral treatment and primary health care. The widespread poverty dominant in the rural areas affected a large number of Basotho to use public health care as opposed to private health care. In addition, low remuneration and hardship allowances paid to nurses in the rural areas may drive them to look for better paying jobs. Challenges faced by the health college are aggravating the situation. Therefore, it is important to investigate the factors affecting turnover of nurses at rural clinics in Lesotho.

The next chapter is a literature review of the definition of turnover, models, challenges, consequences and factors affecting turnover (job satisfaction, individual, organisational, monetary and non-monetary factors). The Ministry of Health in Lesotho can apply these theories to overcome the challenges of turnover of nurses in the rural clinics in Lesotho.

CHAPTER 2: TURNOVER OF NURSES AT RURAL CLINICS

2.1 INTRODUCTION

Chapter 2 presents a comprehensive literature review of the turnover of nurses at rural clinics. The focus is on the theoretical views of various authors and recent and past studies related to turnover of staff. Literature on definitions of turnover in general and in a rural nursing context is reviewed. In addition, literature on challenges related to turnover of nurses, factors affecting turnover, and models and consequences of turnover of nurses are explored.

Most health centres, mainly in the rural areas, are faced with the challenge of losing health professionals, particularly nurses, due to staff turnover. Turnover of nursing staff is becoming a concern in many countries. While health care organisations nowadays face nursing shortages, consideration of factors, challenges, and consequences of turnover is crucial in building a work environment that retains nurses. With the growth of speciality in nursing and innovative nursing models in the health care system, the increased potential for work-related stress requires on-going investigation of the significant issues and proper management approaches to ensure that nurses are supported adequately when performing their work (O'Brien-Pallas, 2010). In this whole process, it is important to define turnover and highlight related issues.

2.2 DEFINITIONS

There are many definitions of turnover (Hayes, O'Brien-Pallas, Duffield, Shamian, Buchan, Hughes, Laschinger, North & Stone, 2006) that are often inconsistent. In addition, the accuracy of the reasons for turnover is normally not consistent and makes it difficult for comparisons across different studies and health care systems (Tai, Bame, & Robinson, in Hayes et al., 2006). Furthermore, different record-keeping methods adopted by organisations that are also inconsistent affect the definition of turnover and the reliability of determinations of turnover. When defining turnover of nurses, it is of essence to describe the meaning and the relationship between actual turnover and the intention to leave or to resign.

2.2.1 Definition of staff turnover in a nursing context

According to Jones (2005), nursing turnover is defined as the process in which nurses leave or move within the hospital environment. This definition includes voluntary and

involuntary turnover as well as external and internal turnover. Similarly, Irvine and Evans (in O'Brien-Pallas 2010) concur that many studies have not always distinguished between voluntary and involuntary turnover, and where they have, it is still unclear due to inaccuracy of organisational data. Hayes et al. (2006) states that many gaps linked to a definition of turnover limit the value of findings for developing organisation policies.

Various studies describe turnover as a job change, while others explain nurse turnover as exiting the nursing profession or leaving the organisation (Hayes et al., 2006). Krausz (in Duffield & O'Brien-Pallas, 2003) observed the continuous departure of nurses and analysed the premise that nurses first choose to leave the ward, after that the hospital and ultimately the profession. As described by O'Brien-Pallas (2010), turnover is perceived as a multistage process that links social and other predictors of turnover. On the other hand, Mano-Negrin and Kirschenbaum (in Hayes et al., 2006) state that turnover also shows the effect of balance between pull factors (organisational benefits) and the push factors (professional attitude towards work).

Grobler, Warnich, Carrell, Elbert, and Hatfield (2006) state that turnover may also be defined as the rate at which employees are replaced by an organisation. They further describe turnover as the movement of workers out of the organisation, which can be caused by resignations, retirements, discharges, transfers, or death. In another edition, Grobler et al. (2011) define turnover as permanent loss of staff that should be substituted. Employee turnover, which is sometimes referred to as labour turnover, attrition, or wastage, is defined as the rate at which employees leave an organisation (Armstrong, 2009). The researcher states that employee turnover causes disruptions and excess costs for the organisation. On the other hand, Price and Mueller (in Hayes et al., 2006) view turnover as the result of commitment and job satisfaction, which are influenced by a number of demographic, organisational, and environmental factors.

Throughout this study, the definition of turnover by Jones (in Buchan & Aiken 2008) will be used. The author describes nursing turnover as the process in which nurses leave or move within the hospital environment. This definition puts more emphasis on internal and external turnover as well as voluntary and involuntary, which many studies have not differentiated.

2.2.2 Definition of intention to leave/resign

It is important to define intention to leave/resign when discussing turnover, since the term *turnover* is often used interchangeably with intention to leave. Hayes et al. (2006) assert that the intention to leave and real turnover require more review, given that the intention to leave relates to only a small part of the actual turnover.

Intention to leave is observed as a greater predictor of employee turnover than any other variables are. Many studies on turnover are based on actual turnover, even though some are based on intentions to leave or quit. Therefore, there is a strong connection between actual turnover and intentions to leave. Mobley et al. (in Nangameta, 2010), state that the link between the intention to leave and turnover is constant and normally stronger than the turnover-satisfaction relationship is, although at a smaller scale. In their review of studies, Hanisch and Hulin (in Van der Heijden, Van Dam,&Hasselhorn, 2009) maintain that the intention to quit the profession can be regarded as a sign of individuals' tendency to pull out from specific career circumstances, which may be a signal to overcome the actual turnover.

According to Mano-Negrin and Kirschenbaum (in Nangameta, 2010), many studies were associated with intentions to quit, and few focused on actual turnover. This might be because the intention to leave does not occur spontaneously, just as intention to quit may not necessarily lead to actual turnover. Van der Heijden et al. (2009) point out that intention to quit may be more helpful than actual turnover, since it allows organisations to be proactive in developing retention strategies.

A number of researchers found that intention to leave might be counteracted by nurses' professional commitment and strong attachment to nursing, which may encourage loyalty to the profession despite the poor working environment, low pay or poor management and communication (Buchan& Aiken, 2008). Pillay (2007) affirms that work dissatisfaction is a major factor in nurses' intention to leave. The complexity of measuring and defining turnover and its determinants results in inconsistencies between different studies and therefore exacerbates the challenges. Turnover remains a challenge for many organisations in different sectors due to its inconsistent definition. Therefore, it is important for organisations to understand the reasons for turnover and nurses' intentions to leave to avoid untimely loss of health care resources.

2.2.3 Inconsistent definition of turnover

Section 2.2.1 above shows that there are many and different definitions of turnover that are inconsistent and confusing. The methodologies, quality of data and the availability of information from different sources used to define turnover also vary. There are different record-keeping methods and measurements for turnover; consequently, it is challenging and difficult to compare the results of studies on turnover (Cavanagh & Tai, in Hayes et al., 2006).

To illustrate inconsistencies in definitions of turnover, a study involving two variables to inspect why nurses leave their jobs resulted in contradictory results due to the information used that came from different sources. This illustrates the challenges in research regarding turnover of nurses (Cavanagh in Hayes et al., 2006). In the same way, Barak (in O'Brien-Pallas 2010) highlights that the results from studies are frequently inconsistent with each other due to complex definitions, multifaceted determinants of turnover and the different work contexts. The author states that much research on turnover is demonstrated on small sample sizes that would normally exclude other divisions of the employees in the organisation that could be of importance in addressing high turnover of nurses.

In sum, from the data and information reviewed, it was found that the definition of turnover is inconsistent. This is due to different record-keeping methods used by varying organisations, different sources of information and varying measurements of turnover. Consequently, this poses some challenges in formulating a proper definition. The literature review explains the definition and the difference between actual turnover and the intention to resign/leave.

In an attempt to define nursing, turnover, and intention to resign, many researchers have designed different models of nursing and nursing turnover that demonstrate the theory linking the nursing profession to the turnover of nurses. Various aspects of each model show the interaction and relationship between turnover and other components that rural clinics and hospitals need to consider reducing turnover and enhancing delivery of health care.

2.3 MODELS OF TURNOVER

A variety of models attempt to define turnover in a nursing context. These models also describe what processes take place to reduce turnover and achieve the best quality

nursing care. Many researchers explore the factors that determine or lead to turnover of nurses in health care organisations by developing different models. For the purposes of this field study, three models will be discussed.

2.3.1 The patient care system and nurse turnover model

Irvine and Evans (in Hayes et al., 2006) developed the patient care system and nurse turnover model. The model aims to study the relationship between the system inputs and outputs, including the influence of inputs on throughputs and repercussions for patients, nurses and the system as a whole. It illustrates the interaction between system inputs (characteristics of nurses, patients, nursing unit, and organisation) and the throughputs (turnover rate, staff deployment and utilisation, and environmental complexity) that generate system outputs (outcomes of the nurses, patients, and organisation as a whole) which respond to the whole patient care system. The model observes turnover rate as a throughput factor. Figure 2.1 below shows the patient care system and nurse turnover model in more detail.

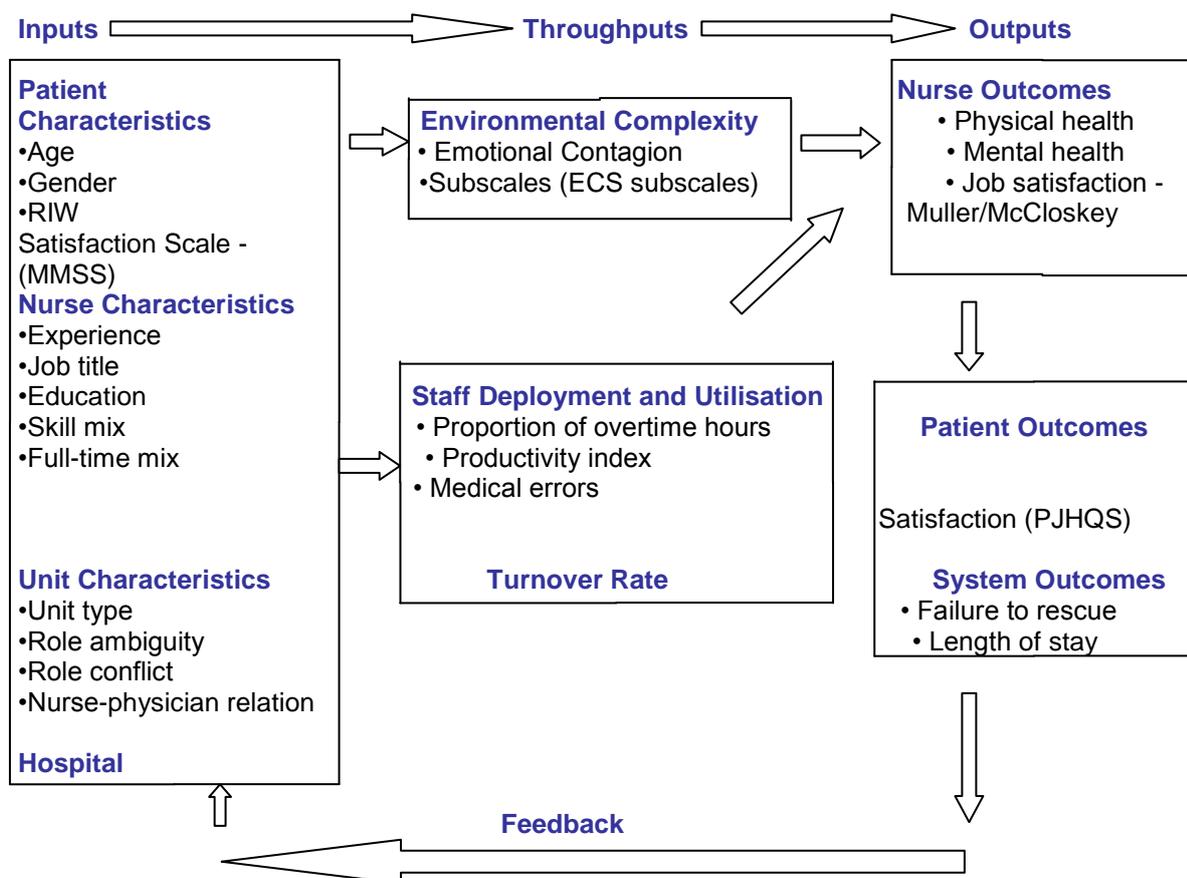


Figure 2.1. The patient care system and nurse turnover model

Source: Hayes et al., (2006).

From [this](#) model, we discover that turnover of nurses is the main problem for health care organisations. That has been illustrated by the model to be influenced by different characteristics of nurses and patients at the nursing unit. The model also considers environmental issues. Consequently, it is important for organisations not to overlook the significance of inputs to ensure that they eliminate negative outcomes such as medical errors but achieve positive results and consequently reduce the turnover rate.

2.3.2 Model of turnover determinants and intervening variables

Price (in Grieffeth & Hom, 2007) developed a different preliminary casual model of turnover to demonstrate the theory of voluntary turnover and to reflect the determinants of turnover. This model comprises remuneration or pay, communication, integration, and centralisation. The study indicates that low centralisation together with high pay, integration, and communication result in job satisfaction, which in turn reduces turnover. It further shows the two intervening variables: opportunity and job satisfaction. Job satisfaction mediates the effect of the external factors, whereas the opportunity is a moderator. This is shown in Figure 2.2 below:

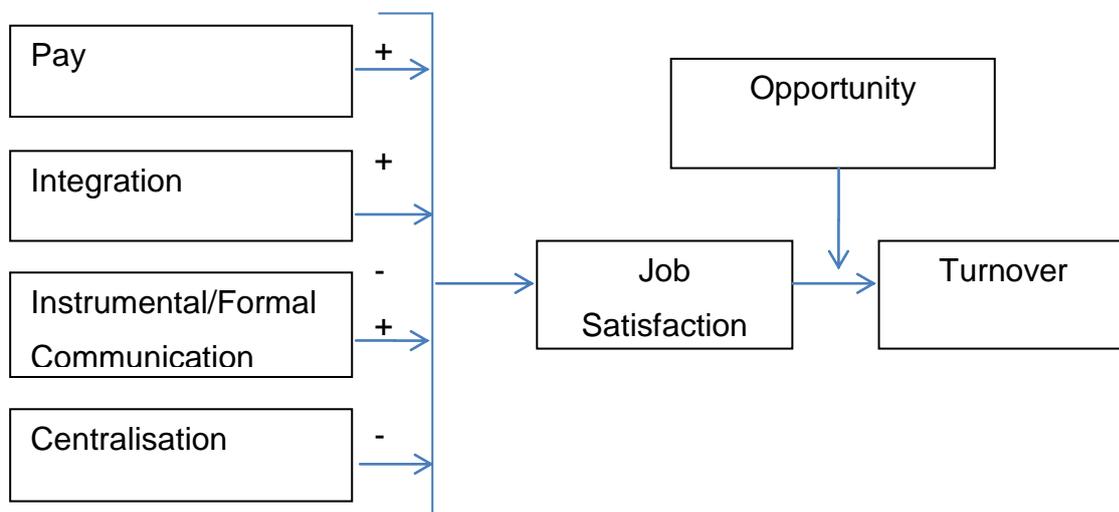


Figure 2.2. Price's model of turnover determinants and intervening variables.

Source:Grieffeth and Hom(2007).

This model is important and applicable, as it explains the relationship between turnover and satisfaction; meaning low job satisfaction results in employee turnover. It also reflects the relationship between opportunity and turnover; thus, available external job opportunities bring about turnover. This study shows factors that determine turnover.

Management should pay attention to these determinants and their effect so as to ensure that turnover is reduced.

2.3.3 Intermediate linkages model of turnover

Another turnover model by Mobley (in McBey & Karakowsky, 2011), the intermediate linkages model, illustrates the theory of intention to resign/leave and turnover. It indicates that an employee goes through a number of steps from job satisfaction to intention to resign and then to turnover. This model shows that, where there are great opportunities for getting a new job, an individual is likely to search for alternatives, then evaluate them and make comparisons with the current job. The intention to quit will be stimulated if the alternatives are found to be more favourable than the present job.

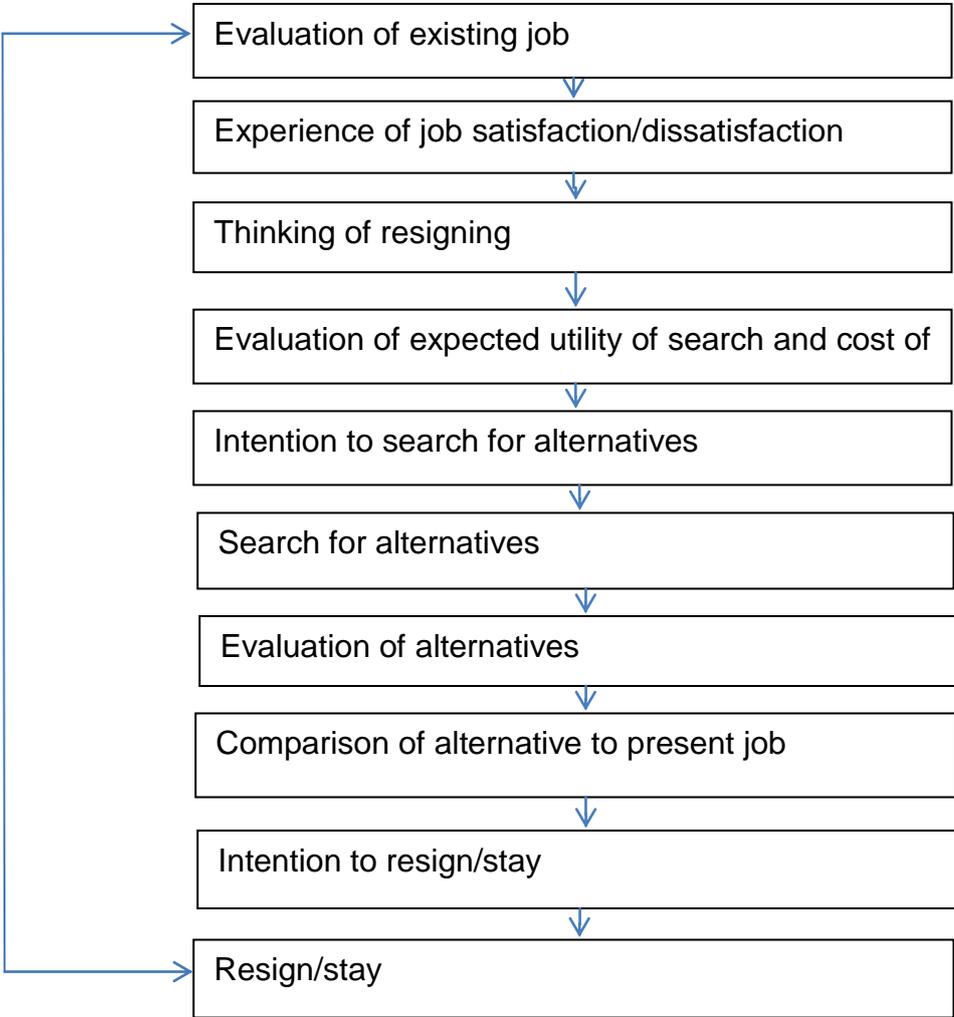


Figure 2.3. Mobley's intermediate linkages model of turnover.

Source: McBey and Karakowsky(2011).

The value of the intermediate linkages model in this field study is to show the relationship between the intention to quit and the actual turnover. The model thoroughly explains the psychological processes an individual follows up to a point of making a decision to resign from his or her job. Mobley concludes that the intention to resign best predicts the actual turnover.

To summarise the above models, the researchers indicate that the patient care system and nurse turnover model show the linkages between the inputs, throughputs and outputs. It further reflects how different characteristics can influence the outcomes and eventually affect the turnover rate of nursing staff. On the other hand, the turnover determinants and intervening variables model explains the factors that can affect turnover negatively or positively. It shows that job satisfaction will be enhanced, and at the same time, the level of turnover will decrease if there is pay rise, an increase in integration and communication and if there is a reduction in centralisation and external job opportunities. The last model, the intermediate linkages model, explains the relationship between actual turnover and the intention to resign. It also highlights the stages that individuals go through before finally deciding to resign from their jobs.

These nursing and turnover models are useful in ensuring that the theory of nursing turnover is well understood. This will assist health care organisations to reduce turnover of nursing staff and at the same time ensure that safety is not compromised and nurses at health care centres provide high-quality service consistently to patients despite any challenges that are likely to be encountered in the nursing profession. Understanding these models can assist organisations to know any challenges related to turnover and to determine which corrective measures management can take to overcome such challenges.

2.4 CHALLENGES RELATED TO TURNOVER OF NURSING STAFF

Many studies by Tia, Bame, Robinson, Jones (in Hayes et al., 2006) have identified the challenges associated with turnover of nurses. The Department of Health – DOH (2006) highlights that one of the main challenges faced by the health system in South Africa is migration of nurses from rural to urban areas, together with global migration of qualified nurses, which is aggravated by movement from the public to the private sector. Section 2.2 above has already dealt with the challenges of inconsistencies in defining turnover because of different record keeping, data collection, and measurement methods. This

section will discuss the main challenges posed by recruitment, training, and the HIV and AIDS pandemic.

2.4.1 Recruitment

There is a relationship between recruitment and turnover since high turnover leads to shortages of nurses, which then compels the need to recruit. Recruitment of new nurses, especially for underserved rural health clinics, may present distinct challenges. Most of the northern First Nation communities of Canada are faced with challenges of recruitment and retention of suitable nursing staff and they temporarily depend on relief nurses (Minore, Boone, Katt, Kinch, Birch & Mushquash, 2005). An aggressive recruitment of nurses in the private sector and globally, increases migration of nurses from the public sector. This causes many challenges, mostly in the rural health centres. Aiken (in Hayes et al., 2006) also confirms that this type of recruitment has a negative effect on turnover. According to Waldman (in Hayes et al., 2006), one of the major components of turnover is the cost associated with recruitment of new nurses.

Conversely, Lea and Cruickshank (2005) report that very little is known about recruitment and retention of newly graduated nurses, including the possible future investment they could offer to rural health centres. This brings us to challenges caused by training of health care workers, especially nurses.

2.4.2 Training

According to Shields and Ward (in Hayes et al, 2006), dissatisfaction with training and promotion opportunities has proved to have a more significant effect on turnover of nurses than pay and workload have. In addition, in their study on five African countries, the International Organisation for Migration (IOM) concludes that the main factor leading to increased turnover of health care experts is the lack of opportunities for further training (Hayes et al., 2006).

Diminishing enrolment and completion rates at training institutions pose a threat to production and recruitment of nurses. Lesotho also faces challenges with regard to producing health professionals, and there is no medical school. Existing orientation programmes do not necessarily address the needs of newly recruited nurses and may lower retention rates (Keahey, 2008).

In 1989, with support from Irish Aid, the National Health Training College (NHTC) in Lesotho was established and offered diploma courses for nurses, pharmacists, and medical laboratory scientists. The college faces challenges of an inadequate number of tutors and infrastructure for practical training. According to the Lesotho Times (2014), one of the local newspaper, announced on April 3, that NHTC was shut down indefinitely due to conflict between students and management about property maintenance. The National University of Lesotho (NUL) launched the Faculty of Health Sciences in 2001 and offers degree courses. As stated in the Annual Joint Review (2012), of the Ministry of Health, enrolment rates of nurses are declining. In addition, the faculty faces many dropouts of nurses and other professions, so the completion rate is approximately 60% (Mwase et al., 2010).The HIV/AIDS pandemic exacerbates this challenge and may affect training negatively.

2.4.3 HIV and AIDS

Some of the challenges causing turnover of nurses are related to HIV and AIDS effects. Most developing countries are faced with an increasing prevalence of HIV/AIDS, which in turn poses negative effects for nursing professionals (Thupayagale, 2007). The South African Presidency (in Pillay, 2007) reported that there had been increased levels of this pandemic and many reported cases of the related disease, TB, since 1990, which increased the mortality rates of health care workers, including nurses, in the country.

Vance (2011) states that, despite initiatives taken to reduce the levels of the HIV/AIDS epidemic, many challenges remain, particularly for poor countries, which are affecting the health sector and cause nurse turnover. He further states that, owing to the global financial crisis, many countries have cut their budgets for the health sector. This may imply limited resources, and provision of anti-retroviral (ARVs) treatment is affected negatively, leading to increased levels of HIV/AIDS transmissions.

Nurses are normally exposed to HIV/AIDS infections, and lack of treatment for this disease in many countries like Lesotho and South Africa also exacerbates the challenges. In review of his study, Dovlo (2007) found that more than half of the nurses are concerned about being infected by HIV through patients' wounds. He also adds that, although the relationship between nurse turnover and HIV/AIDS is not obvious, the workload in clinics and hospitals has increased due to this pandemic. This is causing stress for nurses, absenteeism and reduced quality of health care services. It is challenging to sustain service quality in health care centres due to increasing HIV/AIDS

factors. This reduces the number of health care workers and the quality of nursing staff and may further encourage turnover of nurses (Dovlo, 2007).

In summary, the review outlines that many challenges may affect turnover of nurses especially in the rural areas. Recruitment by the private sector or global migration is one of the challenges in the region and in Lesotho. Inadequate in-service training and poor enrolment rates at training institutions also cause great challenges in the nursing profession. Most developing countries such as Lesotho continuously face challenges such as HIV and AIDS diseases, which affect health systems negatively. The loss of nurses at clinics and hospitals brings about failure to achieve their goals and objectives. According to De Gieter (2011), many studies have reviewed the underlying causes of turnover of nursing staff to understand it better and assist health centres to reduce turnover rates of nursing staff.

Regardless of the challenges mentioned above, various studies reveal that turnover may sometimes be beneficial to organisations, since productivity is likely to increase. This means employees are likely to move to positions where their performance will increase; thereby, they contribute efficiently and effectively to the labour market (O'Brien-Pallas, 2010). Moreover, factors such as fear of unemployment or career advancement supported by the organisation may respond positively to turnover patterns and reduce it. Grobler et al. (2006) state that a certain amount of turnover is possible, inevitable and may be valuable to the organisation. They add that incoming employees may bring new, effective, and innovative ways to improve performance. However, excessive turnover may be dysfunctional. Therefore, it is essential for organisations to take note of the challenges and find means to overcome such challenges. Therefore, it is critical for health care centres to understand a number of factors affecting turnover of nurses, as discussed in the next section.

2.5 FACTORS AFFECTING TURNOVER OF NURSES

Many studies have scrutinised various factors affecting turnover of nurses and the findings from those studies are more or less similar. Grobler, Warnich, Carrel, Elbert, and Hatfield (2006) outline the factors affecting employee turnover in Figure 2.4 below, and these include general economic conditions (Oosthuizen, 2009), local labour market, personal mobility, job security, and demographic factors.

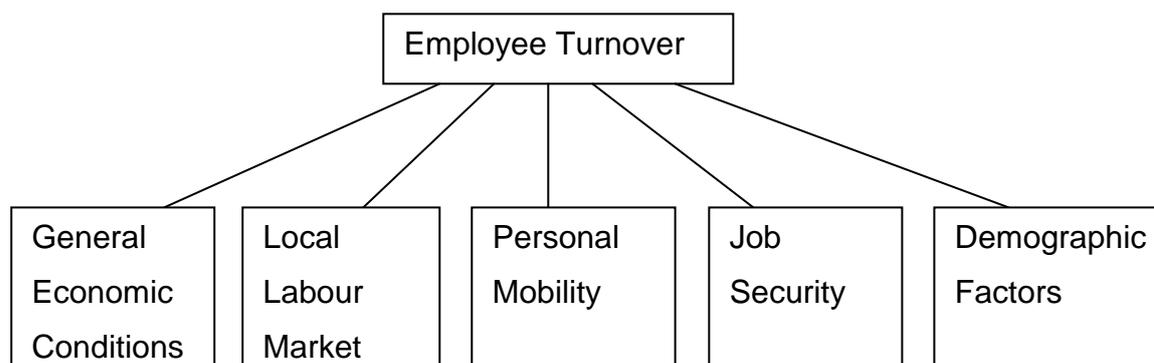


Figure 2.4. Factors affecting turnover.

Source: Grobler et al. (2006).

The literature review will examine these and other factors affecting turnover of nurses and categorise them into the following headings: job satisfaction; individual, monetary, and organisational factors; as well as other general factors.

2.5.1 Job satisfaction

Many theorists note that, among several factors that are linked to nurses' turnover, job satisfaction is referred to most and hence requires attention (Lu, While & Barriball, 2005). According to Kreitner and Kinicki (2010), job satisfaction is the emotional or affective response to one's job. They explain that job satisfaction fundamentally reveals the level at which a person likes or dislikes his job. In addition, they show five models that reflect the following determinants of job satisfaction: need fulfilment, value attainment, equity, discrepancies and genetic factors. Job satisfaction is also defined as the attitudes and feelings employees have about their jobs (Armstrong, 2009). Optimistic and positive attitudes towards work bring about engagement and, consequently, job satisfaction, and vice versa. Swanepoel, Erasmus, Van Wyk & Schenk (2005) point out that some researchers describe job satisfaction as the level of discrepancy between what employees anticipate to achieve from work and what they perceive is achieved in effect. They explain that other researchers define job satisfaction as simply emotional reaction to job circumstances. Grobler et al. (2006) state that employees' satisfaction can be described as the discrepancy between the amount of outcome that an employee obtains and the amount of outcome that an employee thinks he should obtain (Tourangeau, Hall, Doran & Petch, 2006). On the other hand, Aamodt (in Pillay, 2007) argues that there is a discrete relationship between job satisfaction and turnover. Brayfield and Crockett (in Armstrong 2009) maintain that there is minimal proof of a connection between employee satisfaction and performance. Molinari and Monserud

(2008) conclude that there is high job satisfaction for rural nurses with a rural background, as they prefer rural standards of living.

Equally, job satisfaction can be affected by other factors that may lead to turnover of nurses. Purcell et al. (in Armstrong, 2009) conclude that main factors that affect job satisfaction are career opportunities, teamwork, job challenge, and job influence. Rosse and Rosse (in Lu, While & Barriball, 2005) state that job satisfaction and intention to resign from nursing can be affected by role ambiguity and role conflict. According to the Herzberg theory, job satisfaction is affected by intrinsic and extrinsic motivating factors, social relationships among employees, the quality of supervision, and the extent to which employees accomplish or fail in their work. In his study, Mayo (in Armstrong, 2009) concludes that there is a direct relationship between job satisfaction and productivity. He adds that productivity will be high if employees have good relationships with their colleagues and are given excellent supervision.

Moreover, the equation or structure designed by Van der Heijden et al. (2009) shown in Figure 2.5 below, analyses the factors that may affect job satisfaction. The equation indicates that poor work environment; low quality of leadership, interference of work-to-home and home-to-work issues may result in low job satisfaction for nurses and thus stimulate the intention to leave the nursing profession. In this equation, job satisfaction mediates between nurses' intention to leave the profession and the work environment.



Figure 2.5. Job satisfaction

Source: Van der Heijden, Van Dam, and Hasselhorn (2009).

Figure 2.5 shows that job satisfaction and occupational commitment are likely to affect nurses' intention to resign from their career. Figure 2.5 also shows the factors that may possibly affect job satisfaction negatively or positively. It further shows that job satisfaction can contribute towards nurses' intention to resign, which consequently affects actual turnover.

In sum, job satisfaction is one of the key factors that affect turnover of nurses locally and globally. Moreover, many different studies have shown the link or the relationship between job satisfaction and turnover. All studies reveal relatively similar effects of job satisfaction, even though they vary. Nonetheless, certain demographic or individual factors can affect job satisfaction and consequently increase turnover of nurses in the rural areas, as explained in detail in the next section.

2.5.2 Individual factors

Some individual or demographic features that affect turnover of employees include the following: age, work experience, level of education, marital status, and gender. The literature review will describe these factors comprehensively.

2.5.2.1 Age

Age is one of the factors that may affect turnover of nurses and that may lead to chronic diseases, in which case there is a combination of many older patients with ageing nurses. The rapidly ageing population and shorter life expectancy pose a threat to nursing staff (Vance, 2011). Many studies found that there is greater intention to leave and find other employment among younger nurses than there is among older nurses. A study conducted in Canada by Montour et al. (2009) disclosed that many nurses were approaching the retirement age and younger nurses were attracted to work in the urban areas due to specialisation and absence of opportunities for full-time positions. Age also had a negative effect on the education system because many nurses approached the retirement age at an alarming rate, leaving few young, skilled nurses and thereby creating a gap in nurses' training.

2.5.2.2 Work experience

Work experience is one of the factors that may affect turnover. Lum et al. (in Hayes, 2006) state that highly experienced nurses have job satisfaction and are likely to stay in an organisation, while less experienced nurses are generally younger with fewer home

commitments and are therefore likely to leave the organisation. Turnover can be high when jobs are in abundance and vice versa (Price and Mueller, in Hayes et al., 2006). Krausz (in Hayes et al., 2006) claims that the relationship between turnover and employment exists only in densely populated areas.

2.5.2.3 Education level

Education level can also affect turnover of nurses. Malatsi, Decock, Depooter, Delobelle, Rawlinson & Ntuli (2011) report that younger and educated nurses are likely to express the intention to leave. Hayes (2006) indicates that highly educated employees are likely to leave for greener pastures. Kash, Naufal, Dagher & Johnson (2010) found that the intention to leave and the educational level were significantly high for directors of nursing working in the urban areas as opposed to those working in the rural areas. In another study by Wilson, Couper, De Vries, Reid, Fish, & Marias (2009), a management education programme was designed for new and existing nurse managers with a view to retain them. That incorporated scholarships for long-term and rural nurses (Ramani, Rao, Vujicic & Berman 2013). The study concluded that the programme and the scholarships reduced turnover of nurses. Many countries have opted for mentoring as a way of retaining and reducing turnover of nurses in the rural areas (Mills, Francis, & Bonner, 2007). Similarly, Bratt, Broome, Kelber & Lostocco (2009) states that although it was costly, the nurses' residential programme that was meant to train nurses yielded positive results. Harmon (2013) highlights that the rural model dedicated to education unit enhanced the student nurses' expertise and self-confidence as well as the recruitment of nurses. Lea & Cruickshank (2005) point out that, when nurses have had an optimistic experience of being attached to the rural health care centre during their training, they may decide to work in the rural area. Adoption of training and development policies that will ensure that nurses are trained adequately will reduce turnover (Leurer, Donnelly & Domm, 2007). On the contrary, Aiken et al. (in Hayes, 2006) point out that many countries, particularly developing countries, are reluctant to invest in training due to aggressive global migration of nurses.

2.5.2.6 Marital status

Marital status can affect turnover of nurses. The tasks associated with the status because of spouses, children or old-age parents may require nurses to leave their work (Hayes et al., 2006). Molinari and Monserud (2008) state that most single or unmarried nurses with no children expressed the intention to leave and preferred to work in the

urban areas. Part-time and unmarried professional nurses are more likely to leave their jobs as compared with full-time, unmarried nurses. The length of an employment term was not an important determinant of turnover of married nurses (Hayes et al., 2006). For married women, turnover may increase significantly in the early years of marriage during which they plan to have children.

2.5.2.7 Gender

The majority of nursing staff consists of females (Vance, 2011). In a study conducted by Pillay (2007), 94.1% of the respondents were females with more years of experience and above 40 years of age. From the literature reviewed above, it is evident that demographic aspects may affect turnover of nurses negatively, especially in rural areas.

According to Tai (in Hayes et al., 2006), although individual factors can affect turnover of nurses, these variables usually are not highly significant in turnover patterns as compared to the organisational factors that will be explained below.

2.5.3 Organisational factors

In comparison with the demographic factors discussed in the previous section, organisational factors seem to be more considerable, and the studies regarding these factors are more consistent (Hayes et al., 2006). Organisational factors discussed in the next paragraphs include organisational structure, promotion opportunities, policies adopted by organisations, leadership styles, and job security.

2.5.3.1 Structure

The ageing workforce undoubtedly will change the structure of organisations, which may lead to high vacancy rates and in that way increase workloads for the remaining nurses. Generally, nursing is an affecting and challenging work. This is exacerbated by structural changes, demographic factors and other resources that may affect working patterns, which in turn will lead to fluctuating shifts, working overtime, working over weekends, and increasing workloads (Van der Heijden et al., 2009). Zurn (in Leurer et al., 2007) advises that well-planned shifts that allow for greater choice, flexibility, and free time will enhance job satisfaction and reduce turnover of nurses. Hayes et al. (2006) point out that constantly increasing workloads increase stress and pressure at work, which in turn increases turnover. Vetter (in Hayes et al., 2006) refers to the self-

scheduling process that increases job satisfaction, sustains employment values of a unit, and reduces turnover of nurses.

2.5.3.2 Promotion opportunities

The structure that allows for upward mobility or promotion of nurses enhances job satisfaction and reduces turnover. In Lesotho, most nurses opt to work at the rural hospitals rather than at rural clinics because of the structural patterns that allow for growth and promotions in the hospitals (Mwase et al., 2010). After Shields and Ward (in Hayes et al., 2006) had compared remuneration and promotion, they concluded that employees frustrated by lack of promotion opportunities were more likely to quit than were those who earned low salaries.

2.5.3.3 Policies

The policies that government may put in place or adopt are likely to affect turnover of nurses. Hayes (2006) refers to the decentralised organisational structure, which promotes independence and innovation. Research by Montour et al. (2009) highlights the changes in the organisational structures of the participating seven rural hospitals that influence turnover of nurses. They observe that changed structures that adopted part-timers increased nurses' opportunities to seek employment from different employers, thereby increasing their income.

2.5.3.4 Leadership style

Another factor that may affect nurses' turnover is management or leadership style. The style that is participative rather than directive reduces bureaucracy and improves communication, coordination, and working relationships between nurses and their supervisors. Skilled managers can drive innovation, support, motivate, and encourage their subordinates (Leurer et al., 2007).

2.5.3.5 Job security

Job or work security is likely to affect turnover of nurses. Availability of more permanent or full-time employment has less influence on turnover than temporary and short-term employment has (Van der Heijden et al., 2009). Short-term appointments are unattractive due to common issues like delays in salary payments (Muelli et al., 2010). Conversely, donor-funded projects, which normally support short-term employment for

nurses, have played a role in increasing the numbers of nurses in the rural areas. However, because of their short-term nature, they are not very popular because they do not provide pension and they lack job security. The situation in Lesotho shows that Irish Aid as one of the donors in Lesotho entered into an agreement to support payment of salaries and hardship allowances for 257 nurses working in the 46 hard-to-reach clinics. Irish Aid's intervention was for the short term, and there was a condition that, for purposes of sustainability and retention of nursing professionals, starting from April 2014, the Government of Lesotho would establish nursing posts and absorb those nurses into the public sector (Embassy of Ireland, 2012).

It is important to carry out further work to define the significance and relevance of the above-mentioned organisational factors, since organisations differ. Some theorists indicate that economic or monetary factors are more important with regard to turnover of nurses.

2.5.4 Monetary factors

Many studies consider monetary, quantitative, financial, or economic factors in relation to turnover of nurses as important. As argued below, factors such as remuneration or salaries, inflation, and budgetary constraints may affect turnover of nurses.

2.5.4.1 Salaries

Remuneration is one of the factors that may influence nurses' intention to leave or stay in an organisation. Finnish researchers viewed inadequate income as the key reason for high turnover (Webb, in Gow, 2008). Stilwell (in Pillay, 2007) states that low salaries lead to job dissatisfaction among employees. Health care workers in rural health care centres of Malawi believed that poor salaries stopped them from meeting their needs. Kenyan nurses were reluctant to work in the rural areas due to unsatisfactory monetary incentives and hardship allowances. Nurses in the Bophirima Health District in the North-West Province of South Africa left the clinic to go abroad and to the private sector (Matjila, 2006). In Lesotho, local nurses were also reluctant to work at rural clinics due to low remuneration and allowances. The government intervened by recruiting foreign nurses (Retention Strategy for Health Workforce, 2010). Other researchers indicate that remuneration can affect turnover of nurses directly or indirectly. Lum et al. (in Hayes et al., 2006) assert that employees' reward satisfaction can reduce the intention to leave.

Anderson (in Hayes, 2006) reports that low turnover in nursing homes were due to the reward-based structure, accuracy and honesty.

2.5.4.2 Inflation and budgetary constraints

A study by Manafa, McAuliffe, Maseko, Bowie, MacLachlan & Normand (2009) indicate that, in Malawi, salary was considered an extremely important determinant of turnover across all cadres. The researchers further indicated that, in 2005, the Ministry of Health increased the salaries of health employees by 52%. However, that did not suffice because a large portion of this increment was consumed by tax. The effects of inflation also affected remuneration, and the government of Malawi was not flexible enough to increase allowances due to budgetary constraints.

Then again, some researchers show inconsistent findings in relation to remuneration and turnover. Frisina (in Hayes et al., 2006), found that remuneration was not the key predictor of turnover. Michaels and Spector (in Hayes et al, 2006) indicate that salary is not linked with turnover. On the other hand, non-monetary factors may affect turnover of nurses.

2.5.5 Other non-financial factors

Some researchers conclude that various non-financial factors, including the following, may affect turnover of nurses: infrastructure, utilities, environment, accommodation, medical equipment, equity, and spouse employment prospects.

Good hospital infrastructure that facilitates access roads and transport as well as availability of utilities such as water and electricity may attract nurses to work at rural health care centres (Dovlo, 2007). In rural areas in Ghana, it was observed that poor quality roads, absence of transportation and long distances to health centres led to reluctance of nurses to work in the rural areas (Baffour, Rominski, Nakua, Gyakobo & Lori, 2013). A secure, good environment and community to raise children may reduce turnover. A study in Tanzania reveals that availability of quality accommodation for nurses in the rural areas, whether it was rented or staff housing, had a positive effect on their turnover (Songstad, Moland, Massay & Blystad 2012). They also viewed that employees' quarters in the public sector were generally of poor quality as compared to the ones in the private sector and those run by churches.

Availability of *medical equipment* and other instruments like stethoscopes, microscopes, syringe pumps etc. may attract nurses to work in rural areas (Songstad et al., 2012). Adzei and Atinga (2012) add that retention of nurses may be difficult if medical equipment is perceived inadequate. Moreover, accessibility of modern technology that facilitates good communication channels to allow for information flow either through the internet, telephones or cellphones may affect nurses' intention to leave.

Another study from New South Wales concludes that employment opportunities for spouses of married nurses form part of factors that may influence their intention to leave (Keane, Lincoln, & Smith, 2012). Nurses in remote rural areas will be attracted to work there if they feel there is equity in their treatment in terms of issues such as promotions, training opportunities, and transfers to different locations (Manafa et al., 2009).

In sum, of the factors that affect the level and turnover rate of nursing staff, job satisfaction is mostly referred to as the main factor. Job satisfaction is also influenced by other factors such as quality of leadership, occupational commitment, and work-to-home or home-to-work interferences, etc. It can affect the nurse's intention to leave her job. Individual factors such as gender, age, marital status, education, and work experience are less significant in comparison with organisational factors that are considered to contribute more to the rate of turnover and therefore require more attention. In terms of monetary factors, salaries or remuneration is taken as the most significant factor that can affect turnover directly or indirectly. Non-monetary factors should not be disregarded, as they can affect turnover of nursing staff.

The findings of different studies on factors affecting turnover vary. Nonetheless, if organisations do not address the effects of turnover discussed above, there will be more challenges to attract and retain nurses and to reduce the turnover level of nurses, particularly in the rural areas. This will eventually lead to adverse consequences that may hamper the quality of health care services in the rural health centres.

2.6 CONSEQUENCES OF TURNOVER OF NURSES

The consequences of turnover of nurses may be difficult to measure, given the inconsistent definition and reasons for the turnover derived from different studies. According to the American Association of Colleges of Nursing (2014), the annual turnover rate for registered nurses was 14 per cent on average in June 2011. Similarly, in 2008, the survey of turnover, retention, and recruitment conducted by the Chartered

Institute of Personnel Development (CIPD) established that an average rate of turnover in the United Kingdom was 17.3 per cent. This was calculated as the number of employees leaving as a percentage of the total number employed (Armstrong, 2009). However, this section will examine three categories of consequences of turnover, namely shortage of nurses, quality of health care delivery and cost-related effects.

2.6.1 Shortage of nurses

Turnover of nurses results in shortage of qualified and professional nurses. According to De Gieter (2011), turnover of nurses is one of the greatest factors contributing to the shortage of nurses universally. Rural health care centres are mostly affected negatively by increasing turnover. Consequently, they are faced with a great shortage of nurses and lose health professionals and this creates many challenges with regard to the nursing profession.

The World Health Organisation (2011) states that at least half of the people live in underserved remote areas, but served by merely 38% of the nursing staff. According to Ramani et al., (2013), the shortage of professional nurses in the rural areas has been accepted in many countries as the key barrier in implementing health care strategies and policies.

Holmstrom and Elf (in Pillay, 2007) state that loss of skilled nurses leads to institutional memory loss, reduction in competencies and a decline in efficiencies and effectiveness of health care centres. A shortage of nurses results in increased workload and inadequate staffing levels (Hayes et al., 2006). Because of the shortage of nurses, existing nurses are likely to work overtime, and the occurrence of missing shifts due to sickness is high. Similarly, Zboril-Benson (in Hayes et al., 2006) concluded that increasing rates of absenteeism are linked to low job satisfaction, working full time and long shifts. Other studies indicate that a shortage of nurses leads to emotional fatigue. A shortage of nurses can result in workloads that are connected to near-collision and needle-stick injuries. The shortage of nurses will have an adverse effect on the quality of patient care delivery at health care centres.

2.6.2 Quality of patient care delivery

The ability of a clinic to provide good quality care and to meet patients' needs can be affected negatively by a high nurse turnover (Duffield & O'Brien-Pallas, 2003). Turnover of nurses is costly and may have a negative effect on the quality of patient care (Vincent

& Dunton, 2012). Cavanagh, Coffin and Sofer (in Hayes et al., 2006) state that a high turnover of nurses at health centres affects productivity of existing or remaining nurses, especially in the process of recruitment and orientation of new nurses. A shortage of qualified nurses and tutors has a negative effect on production of new nurses and on mentoring those that remain (Pillay, 2007). Buchan & Aiken (2008) agree that presently there is a shortage of nursing tutors to take part in education and training of nurses, despite recruitment initiatives to attract nurses. If there are no tutors, training and development of nurses, together with quality of health care delivery will be compromised. Once there is a compromise, infections, hospitalisation and mortality rates will increase (Blegen et al., in Hayes et al., 2006).

Pillay (2007) points out that high levels of turnover of nurses and low levels of employment negatively affect the performance of the health centre in terms of quality health care and patient satisfaction. Adequate numbers of nurses are critical for safety of patients and for preventing any adverse events (Needleman et al. in O'Brien-Pallas, 2010).

On the other hand, turnover of nurses will adversely affect the quality of health care by reducing the well-being of staff, the skills mix, and the patient-nurse ratio below the minimum requirement. According to Leurer et al. (2007), nurses were not able to provide good quality health care to patients due to insufficient staffing levels. Adequate staffing levels will have positive effects on patients and service delivery outcomes. However, a study by Quinn (in Pillay, 2007) concluded that staff turnover is not a major determinant of patient devotion. Once the quality of patient care is affected negatively, organisations are likely to incur additional and unnecessary costs, which can hamper the business as a whole.

2.6.3 Cost-related effects

Besides the consequences of health care delivery, turnover may cause economic, monetary, or cost-related effects. Many researchers have estimated the cost of turnover. According to Kreitner and Kinicki (2010), the cost of turnover is categorised into two categories: replacement cost, which comprises hiring, relocation, training, and orientation expenses; and separation cost, which may contain severance pay, potential lawsuit expenses or exit interview-related expenses. They further explain that turnover cost can go up to 30% of annual salary or the total salaries costs can exceed the budget and go up to 150% in total, particularly for highly qualified staff.

Hayes et al. (2006) pointed out that replacement cost differ in accordance with the components included in the measure and the location. They refer to two categories of turnover cost, namely direct and indirect costs. Direct cost includes recruitment and advertising expenses, whereas indirect cost consists of termination or training expenses. Jones (2005) emphasises the significance of indirect cost, as it can have a major effect on productivity and staff morale. The estimated turnover cost amounts to \$10,000 to \$60,000 per registered nurse, then \$42,000 and \$64,000 for surgical and speciality nurses respectively. The cost of reduced production varies between \$5,245 and \$16,102 (Hayes et al., 2006).

Pillay (2007) adds that organisations are likely to incur additional training cost for incoming nurses. It costs approximately R300,000 to train new nurses in South Africa. He indicates further that turnover of qualified nurses may hamper the economy of the country, since nurses also contribute to the gross domestic product (GDP). Other financial implications may result from cost such as recruitment expenses, which include pre- and post-employment expenses.

The overall view of these consequences is that they can have adverse effects on the quality of nursing and patient health care. The review reflects that high turnover may cause a shortage of nurses and then negatively affect staffing levels at rural clinics. From the studies, it is evident that financial cost related to turnover is high and includes the cost of recruitment and induction training for new nurses and also the cost of separation or exit packages for nurses who leave.

2.7 CONCLUSION

A number of concerns concerning the issue of nursing turnover locally and globally exacerbate the shortage of professional nurses. The comprehensive literature review above examined the definition of turnover, models that relate to turnover, challenges, factors, and consequences of turnover. It was found that the different methodologies and the definition of turnover itself pose some challenges.

There are many different definitions of turnover from varying studies. The different methods of gathering information and keeping record of turnover have led to many inconsistencies in defining, comparing, and understanding the determinants and the factors affecting turnover of nurses. The definition by Jones (2005) includes and underlines voluntary and involuntary turnover together with external and internal

turnover. He defines turnover as the process in which nurses leave or move within the hospital environment. This definition will be used throughout the study.

The literature has also shown the relationship between turnover and intention to leave. It concluded that the intention to leave does not necessarily constitute turnover, but it is a significant predictor of actual turnover. Various nursing models are used to define nursing and turnover further.

Many researchers have revealed that a number of challenges relate to turnover of nurses. However, some argue that turnover may sometimes bring about efficiencies, effectiveness and increase productivity. With regard to factors affecting turnover of nurses, the literature review shows that job satisfaction is the major one. Remuneration is one of the main monetary factors, while individual factors such as age, gender, and marital status may not be that significant in comparison with organisational factors. Furthermore, some non-monetary factors are also related to turnover of nurses.

Little theory on consequences of turnover was evident, with shortage of nurses, quality of patient care and cost-related effects on nursing turnover discussed in detail above. Different studies have shown that nurse turnover may result in negative consequences that may lead to a shortage of nurses, high workloads, stress, and low productivity. The quality of patient care services is likely to decrease due to inefficiencies that are caused by turnover. Turnover of nurses also have negative financial implications.

The continuing instability and turnover of nurses in the nursing profession raises a number of questions worldwide. To enhance productivity, efficiency, and effectiveness in the health sector, especially in the rural areas, it is crucial that organisations should understand the definition, challenges, factors, and consequences of turnover of nurses. This will also assist in dealing with these issues on time and then reduce the turnover rates of nursing staff.

The following chapter will focus on research methodology. It will highlight the research design, data collection, and methods of data analysis. The population of the study and the sample size will be shown.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter outlines the research methodology of the study. Research methodology is described as research decisions in the context of defined elements unique to the study (Bryman & Bell, 2007).

In the preceding chapter, a literature review was done to investigate the theoretical views of various authors. It includes an analysis of recent and past studies related to turnover of nurses in the rural clinics and provides theoretical interpretations or definitions of related terminology. The chapter provides guidance on how the whole study was conducted and explores the insights and then explains the reasons for turnover of nurses at rural clinics in Lesotho. In this chapter, the research methodology and design and sampling techniques are explained. In addition, the research population, sample, and the sample size are discussed. Furthermore, the chapter considers ethical considerations together with the appropriate methods of data collection and data analysis.

3.2 RESEARCH DESIGN

Research design is referred to as the blueprint for investigating, collecting, measuring, and analysing data to achieve the research objectives and answer research questions (Cooper & Schindler, 2011). Similarly, Parahoo (in Langen, 2009) defines research design as a plan that describes how, where and when data are to be collected and then analysed. In addition, research design is defined as the researcher's all-inclusive plan for responding to the research question or challenging the research hypothesis (Polit, in Langen, 2009). That means the research design for this study provided guidance on preparations for data collection and analysis so that conclusions might be drawn.

3.2.1 Qualitative research

A qualitative research design was used in the study. According to Cooper and Schindler (2011), qualitative research is the interpretive method that aims to describe, explain, and translate a certain phenomenon in the social context. Rossman and Rallis (in Leurer et al., 2007) state that qualitative research aims to provide information that assists government, organisations or institutions to improve programmes or create policy decisions. Burns and Grove (2011) define qualitative research as a logical

subjective method that is used to describe life circumstances and experiences to provide meaning.

Qualitative research is considered as the main method of exploration that focuses on the meaning, not the frequency, of events or facts. Furthermore, it aims to accomplish a thorough understanding of problems or circumstances. Therefore, qualitative research was preferred to explore and obtain a thorough understanding of the models of turnover, challenges, consequences, and factors affecting turnover of nurses at the nine rural clinics of Lesotho. In qualitative research, the researcher is normally highly involved; therefore, reliability of the researcher's presentation or ability to produce the findings of the study may be questioned. Consistency is not to be expected in qualitative research, because the research design may alter throughout the course of the study. By choosing qualitative research, fundamental attitudes, perspectives and approaches that provided background information on the topic were inspected exhaustively (Broda, 2006).

3.2.2 Exploratory research

The study was exploratory and aimed to establish the factors affecting turnover of nurses at the nine rural clinics of Lesotho. Exploratory research is centred on loosely structured studies to gather further background information, expand understanding of the issue, and improve the research questions (Cooper & Schindler, 2011). In this study, the main research question was "Which underlying factors affect turnover of nurses at rural clinics in Lesotho?"

Exploratory studies provide in-depth investigation of a particular process, and in this case, turnover of nurses at the rural clinics. Qualitative exploratory studies are also conducted when new and specific areas or topics are investigated (Broda, 2006). There was no evidence that there had been any investigations on turnover of nurses at rural clinics in Lesotho, and not much was known about the phenomenon of Lesotho nurses at rural clinics who left their jobs; hence, this study attempted to investigate that topic or area. Instead of simply observing or describing the process, the exploratory study investigated it fully, included the way in which it was established and reviewed other related factors.

The research worked from a *post-positivism epistemological paradigm*. Epistemology is referred to as the concept of knowledge. It interprets how researchers come to know

about certain facts (Bryman & Bell, 2007). There are different epistemological paradigms; however, this research worked from the post-positivistic theory. According to Noor (2008), the philosophy of post-positivism is based on understanding the social phenomenon prejudice. Lobato (2008) indicates that this type of theory is able to explain why an issue happened, predict what will happen in related circumstances, and then control upcoming events. This epistemological paradigm is relevant to the study because it guided the researcher to understand the factors affecting turnover of nurses in the rural areas. It also helped the researcher to foresee the other forthcoming events that might negatively affect rural nursing in Lesotho. The paradigm assisted the Ministry of Health to plan and to take adequate control measures that would overcome such negative events.

The research study reviewed the sampling techniques.

3.3 SAMPLING

According to Cooper and Schindler (2011), sampling is the process of choosing certain units or elements from a larger population that fairly represent that population and from which conclusions may be drawn.

3.3.1 Sampling method and type

Sampling can be categorised into two methods: *probability* and *non-probability* sampling. This study attempted to investigate which factors affected turnover of nurses at rural clinics in Lesotho. To ensure that there was a reasonable representation of the whole population, a non-probability sampling method was chosen to be most suitable. In non-probability sampling, there is an element of subjectivity or bias because not all elements of the population have an equal chance of being selected in the sample (Brink, in Ntlale & Duma, 2012).

The type of non-probability sampling used was *purposive sampling*, which included a selection of participants who were familiar with the area of the study being investigated (Brink, in Ntlale & Duma, 2012). In purposive sampling, the researcher used own decisions based on knowledge and speciality of nurses including experience of other relevant people, to select participants that were considered to be fairly representative of the whole population.

3.3.2 Element and population

Cooper and Schindler (2011) define an *element* as the unit of study that provides the foundation for analysis. In this study, the main element was the health professionals, particularly the nurses recruited and working at the nine rural clinics. Other individuals in the health sector, including other related fields, were considered.

The research *population* for this study included 50 participants. A population is described as the entire collection of elements that will be analysed and from which results will be generalised (Bryman & Bell, 2007). It consisted of existing and newly recruited nurses employed at the nine selected rural clinics. The nurses were categorised into registered nurses (RN), nursing sisters (NS) and nursing assistants (NA). Other officials from the Ministry of Health formed part of the population. Furthermore, officials from the following non-governmental organisations were included: Lesotho Flying Doctors Services (LFDS), Partners in Health (PIH), Lesotho Nurses Association (LNA).

3.3.3 Sample and sample size

A representative *sample* was selected carefully from the above-mentioned organisations. A sample is a group of participants, events, records, occasions, or circumstances that consist of a portion of the entire population (Cooper & Schindler, 2011). In other words, these are elements selected to participate in the study. To maintain an objective representative sample for this study, assistance was sought from the Ministry of Health, particularly from the nursing directorate, to identify and select participants. Potential participants were selected from the population of 53 referred to in 3.3.2 above. The whole research study was explained to all possible participants.

A *sample size* of 29 individuals was eligible to participate in the study. The sample size was made up of nurses from the nine selected rural clinics. Additionally, key informants or participants who were knowledgeable about the nursing profession in the country were from the Ministry of Health as well as officials from the Embassy of Ireland. Generally, it would have been better to have a larger sample size to avoid or minimise any sampling errors that might produce inconsistent results. However, qualitative, exploratory research such as the current study on factors affecting turnover of nurses uses a relatively small sample size. According to Thomson (2011), it is not simple to set an accurate sample size for qualitative, non-probability research that adopts interviews

as the method of data collection. In this case, the researcher adopted the concept of *theoretical saturation*, which means that provision was made to continue interviewing more individuals until no new information was available (Thomson, 2011). Similarly, for this study, the interviews or sampling continued until theoretical saturation was reached. The data collection methods are discussed in the next section.

3.4 DATA COLLECTION

There are different methods of data collection. Data collection is a process of obtaining detailed information about the phenomenon (UNESCO, 2014). Data for this study were collected by means of interviews. Delgado and Gutierrez (2007) explain an interview as a communicative process that allows the investigator to collect information from an individual. The researcher personally visited the clinics and the selected offices to interview participants, and telephonic interviews were used where participants could not be visited personally. In an interview, the participant was able to act, interpret and influence collected information based on past experiences. Notepads and audiotapes were used to record the discussions. Collected data were transcribed into a Microsoft Word document.

3.4.1 Semi-structured interviews

Semi-structured interviews were conducted. Cooper and Schindler (2011) explain that semi-structured interviews commence with a few specific questions that also permit addition or omission of some questions. Such interviews provided some flexibility, since there was no standard set of questions. Moreover, additional information could be gathered by means of further investigation and probing by the interviewer, following the responses from the sample (Cooper & Schindler, 2011). In that way, there was better understanding of factors that affected turnover of nurses at the rural clinics.

Personal and telephonic interviews with individuals were also used to collect data. These two types of interviews were selected because of the disconnected geographical locations of the nine selected clinics. Personal interviews allowed the researcher to gather as much information as possible, and then any ambiguity could be clarified by encouraging participants to elaborate on issues. On the other hand, owing to the remote geographical location of some clinics, telephonic interviews were also used. Telephonic interviews were quick and more cost effective in comparison with personal interviews.

However, the response rate was relatively low, and network challenges were experienced due to poor infrastructure, especially in the rural areas of Lesotho.

Before interviews were held, an interview guide which outlined the important areas and topics discussed during the interview, was developed. The interview questions were developed to guide the data collection process. The questions were open ended to encourage more probing or exploration. The method of data analysis will be discussed next.

3.5 DATA ANALYSIS

Following the interviews, data was analysed. Data analysis is referred to as the process by means of which the researcher edits and condenses collected data to a controllable size, develops summaries, looks for patterns and applies statistical methods (Cooper & Schindler, 2011). The goal of qualitative data analysis was to reveal emerging insights, topics, blueprints, theories and understanding (Patton, in Miles & Huberman, 2013).

To begin that process, data were transcribed into a Microsoft Word document, and the interview material was summarised. Then themes were generated based on issues highlighted in the literature review, four research questions, and the primary and secondary objectives.

3.5.1 Content analysis

To analyse the text-based responses to open-ended questions from the nurses and other selected officers, as well as to obtain a better understanding of the study results, content analysis was used. Cooper and Schindler (2011) define content analysis as a research technique following a systematic approach that may be used to analyse written audio data from surveys, observations, experiments and past studies. Delgado and Gutierrez (2007) state that content analysis may be envisaged as an instrument of reducing and categorising qualitative data, and it focuses on the context and the meaning of the text. *Coding* was used during the content analysis. It is referred to as the process of reducing text into manageable components of analysis (Patton, in Miles & Huberman, 2013). In the following section, the standards of behaviour that should be followed by the researcher will be discussed.

3.6 ETHICAL CONSIDERATIONS

This chapter is concluded by discussing the ethical considerations required, including integrity, privacy, confidentiality and informed consent. Ethics are standards or patterns of behaviour that direct the moral choices about the conduct and relations with others (Cooper & Schindler, 2011). When conducting the study, ethics had to be considered to protect participants against any harm, discomfort, conflict of interest or embarrassment during the research.

The study was conducted with integrity. The proposal was submitted to the Ethics Committee of the Ministry of Health to obtain approval for conducting the research. The researcher obtained written consent to conduct the study. Bryman and Bell (2007) consider the issue of informed consent as highly important.

The researcher commenced by introducing herself to the participants to let them know with whom they were dealing. In doing so, participants were comfortable to take part and provided truthful responses. Participants were informed that audio recording would be used during the interviews and the transcribed information would be send back to them to be reviewed and confirmed. They were also informed that for the purposes of confidentiality, once the research study had been completed, the transcribed data would be destroyed.

The principle of autonomy was adopted, meaning that the participants voluntarily decided if they wanted to take part in the study. Participants were also protected from any harm and informed that they had the right to withdraw from participation at anytime. Deception was eliminated by explaining the purpose and benefits of the study clearly without any distortions, and that enhanced cooperation and facilitated the research study. During the interviews, the researcher listened attentively to participants' words and avoided own interpretation. Due to sensitivity of the issues concerning turnover of nurses and management of human resources, for instance salaries, information collected for the study was treated with proper confidentiality. Participants' rights to privacy were also respected, and their names were not mentioned in the final report. The researcher avoided any conflict of interest during the interviews, and the right to non-prejudice or equal treatment to all participants was applied.

3.7 CONCLUSION

This chapter defined the research methodology that was adopted to examine the factors affecting turnover of nurses at the nine selected rural clinics in Lesotho. The study followed a qualitative exploratory method. Sampling techniques were adopted, and a sample size of 29 individuals out of a population of 53 was eligible to participate. Data were collected by means of semi-structured interviews, using telephonic and individual interviews. The same questions were asked to all participants, aided by an interview guide. Data analysis was discussed in this chapter and content analysis was used to analyse data gathered from interviews. Prior to commencement of the interviews, the researcher introduced herself and explained the purpose of the research. The researcher clarified that all nurses and key informants would participate in the study voluntarily. The interview questions were drafted in advance as outlined in Appendix 1. All participants readily and voluntarily consented to contribute to the study and provided informed consent to take part voluntarily (attached as Appendix 2). The Ethics Committee of the Ministry of Health granted written permission to undertake this study. Later on, tape-recorded data were transcribed into a Microsoft Word document. Content analysis was used to obtain good results, and coding was used at that stage to present excellent findings. In line with the literature review, during data collection and analysis, there was emphasis on the following five factors or categories: demographic issues (individual/personal factors), job satisfaction, organisational factors, monetary factors, and non-monetary factors. These aspects are analysed comprehensively in the next chapter using three different themes as outlined below.

The results and findings of the study will be presented and interpreted in the next chapter.

CHAPTER 4: FINDINGS

4.1 INTRODUCTION

This chapter presents the findings on the factors affecting turnover of nurses at the rural clinics in Lesotho. The responses of the individuals who participated in this study evidently indicate the factors affecting turnover of nurses in the rural areas. Most of the findings are linked directly to the literature review discussed in Chapter 2.

4.2 INTERVIEWS

The researcher travelled by helicopter to all nine clinics to conduct interviews. Prior to the interviews, the researcher obtained approval from the Ethics Committee of the Ministry of Health to conduct the study. During the field visit, it was found that at most clinics, nurses work on shifts; thus they were off duty eight days every month. Therefore, not fewer than two of the five nurses were on leave, resulting in an average of three nurses present at each clinic as illustrated in table 4.1 below

Table 4.1

Total Number of Nurses Interviewed per Clinic

Health Centre	Total number of nurses	Registered Nurses/Nursing Officers (NO)	Nursing sisters with midwifery(NS)	Nursing Assistants (NA)	Number of nurses interviewed
Nohana	6	1	3	2	3
Nkau	5	1	3	1	2
Methalaneng	6	1	3	2	3
Tlhanyaku	4	0	3	1	2
Manemaneng	4	1	2	1	4
Bobete	5	1	2	2	3
Lebakeng	5	2	2	1	1 & 1 PIH nurse
Semenanyane	5	0	3	2	3
Kuebunyane	5	2	1	2	2
Total	45	9	22	14	24

The total population was 50, made up of 45 nurses from the nine LFDS rural clinics and 5 key informants from various organisations. There were 29 participants, made up of 24 nurses and 5 key informants. This is illustrated correspondingly in Tables 4.1 above and 4.2 below. All participants voluntarily provided written consent. A semi-structured interview schedule was developed, which made it easier to repeat the interviews and subsequently to analyse data. Each interview took between 10 and 20 minutes. The interviews continued until theoretical saturation was reached; thus, towards the last few interviews, the participants did not provide any new information.

Informal interviews were also conducted with a group of village health workers (VHWs) at Nkau Clinic. The VHWs are the link between the patients and the clinic. They normally assist the nurses with patients on a daily basis, sometimes with home-based health care activities. Another interview with the Partners in Health (PIH) nurse was conducted at Lebakeng Clinic, forming part of the 24 interviewed nurses. These individual interviews were done telephonically using a semi-structured interview schedule to probe more questions and to gain a better understanding of views raised by the participants. Key informants who were knowledgeable about the nursing profession were also interviewed. Table 4.2 shows a list of five key informants or individual position holders that were interviewed during this field study.

Table 4.2
Key Informants or Individual Position Holders

Position	Organisation
Director Nursing Services	Ministry of Health
Head Clinical Nursing Services	Ministry of Health
President	Lesotho Nurses Association
Finance Manager /Accountant	Irish Aid
Public Health Nurse	Lesotho Flying Doctors

4.3 DATA ANALYSIS

The transcribed data were analysed using content analysis. During the data analysis, the following three themes were identified: 1) general aspects; 2) work-related factors; and 3) economic determinants. Each theme had a subcategory, as shown in Table 4.3 below. Several participants referred to work-related factors that could influence the nurses’ decisions to resign from their jobs. Consequently, the theme of “work-related

factors” was recognised as being more significant than the other two themes. However, the three themes are closely interlinked because the response in one theme may flow into other themes. The following sections will analyse each theme in detail.

Table 4.3.
Themes

Themes	Subthemes
Theme 1: General aspects	<ul style="list-style-type: none"> • Demographic issues • Non-monetary
Theme 2: Work related factors	<ul style="list-style-type: none"> • Job satisfaction • Organisational aspects
Theme 3: Economic determinants	<ul style="list-style-type: none"> • Remuneration • Incentives • Financial Support • Budget

4.3.1 Theme 1: General aspects

This theme analyses the demographic or personal factors as well as the non-monetary factors affecting turnover of nurses at rural clinics in Lesotho.

4.3.1.1 Demographic issues

The following features emerged under individual factors: age, gender, nationality, marital status, education level, and work experience.

Table 4.4

Demographic Factors per Clinic

Clinic	Age	Gender	Marital Status	Nationality	Level of Education	Years of Experience	Salary (Maloti)
Nohana	32	Female	Married	Lesotho	Certificate	5	5,100
	53	Male	Married	Lesotho	Diploma	25	9,000
	38	Female	Single	Zimbabwe	Diploma	14	9,900
Nkau	30	Male	Married	Lesotho	Degree	4	12,000
	43	Female	Single	Zimbabwe	Diploma	17	9,000
Methalaneng	33	Female	Married	Lesotho	Certificate	6	4,000
	33	Male	Married	Zimbabwe	Degree	10	12,000
	45	Female	Widowed	Zimbabwe	Diploma	22	12,000
Tlhanyaku	38	Female	Married	Lesotho	Diploma	10	18,000
	56	Female	Married	Zimbabwe	Diploma	28	12,000
Manemaneng	42	Male	Married	Kenya	Diploma	14	9,400
	34	Male	Single	Lesotho	Certificate	6	4,100
	37	Female	Single	Zimbabwe	Diploma	13	7,500
	27	Female	Married	Lesotho	Diploma	2	7,500
Bobete	42	Male	Married	Zimbabwe	Degree	18	12,000
	38	Female	Married	Zimbabwe	Diploma	12	9,200
	26	Female	Married	Lesotho	Diploma	3	9,100
Lebakeng	36	Female	Single	Zimbabwe	Diploma	14	9,400
	26	Male	Married	Lesotho	Degree	3	PIH
Semenanyane	31	Female	Married	Kenya	Diploma	9	7,770
	32	Female	Married	Lesotho	Diploma	1	6,600
	65	Female	Single	Lesotho	Certificate	34	6,500
Kuebunyane	34	Male	Married	Lesotho	Certificate	5	5,100
	50	Female	Married	Zimbabwe	Diploma	24	9,400

Table 4.4 above summarises these individual or personal features per clinic for the 24 nurses who were interviewed. Each personal factor is analysed further and discussed thoroughly using the pie charts below.

4.3.1.1.1 Age

In this study, age of the nurses was considered as one of the aspects that may affect turnover of nurses at the rural clinics. The age group at the nine LFDS clinics ranged between 26 to 65 years. As illustrated in Table 4.4 above, the participants' age distribution was as follows: Between 20-30 years, there were 4 nurses, representing 17% of the sample size. Between 31-40 years, there were 12 nurses, representing 50% of the sample size. Between 41-50 years, there were 5 nurses, representing 21% of the sample size, and from the group older than 50 years of age there were 3 nurses, representing 12% of the sample size. It was discovered that there were fewer elderly nurses aged between 41 and 50 years and above 50 years. Consequently, there were more young to middle-aged nurses between the ages 20-30 and 31-40 than nurses from any other age group. In an interview with one of the senior officials at the Ministry of Health, it was indicated that most people at this age still aspire to advance their studies or start families, and some already have children. This confirms what was identified in the literature review, namely that more younger nurses than old nurses intend to leave the profession. One participant said:

Actually having established the positions at the health centres is quite new and we haven't experienced much of the... of the turnover, rather they would apply for transfer to move from hard-to-reach to the urban areas. The reasons being, most of our nurses are still in childbearing age and it would be because they have children who need to attend schools and up there ...there are no good schools and sometimes there are not even schools nearby the health centre. That could be most of the time that's the reasons that they would be saying. And most of the time they are still very young they want to progress professional. They would be saying they would like to pursue their studies so if they are there they would be unable to do it online. It's a challenge because of the communication (cough) and most of the time you find that they are actually not going away they are asking for transfers to move from that area to this area.

It was also important to review the gender of nurses placed at the nine selected rural clinics and the next section discusses the gender of participants.

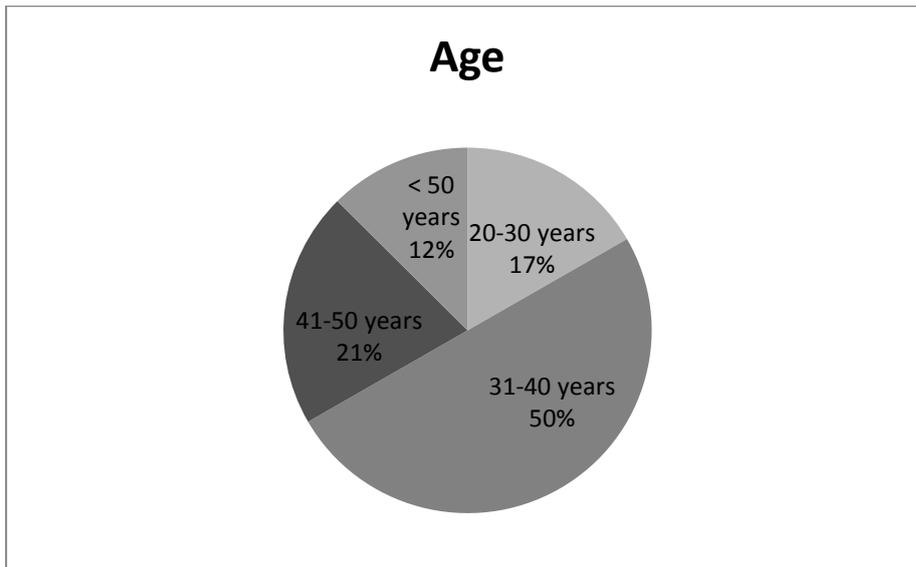


Figure 4.1. Age distribution of the participants.

4.3.1.1.2 Gender

The entire staff structure of the nine clinics shows that there are more female nurses than male nurses. As illustrated in Table 4.3 above, there are more female nurses than male ones. Of the 24 nurses who participated in this study, 16 (75%) were female, and 8 (25%) were male. This is demonstrated again in Figure 4.2 below. This analysis shows some bias in the nursing profession, which is inclining towards women. This endorses what Pillay and Vance say, namely that the majority of the nursing workforce is composed of females. However, this is not a major factor affecting the turnover of nurses at the rural clinics. The marital status of participants is also considered a vital aspect and will be discussed next.

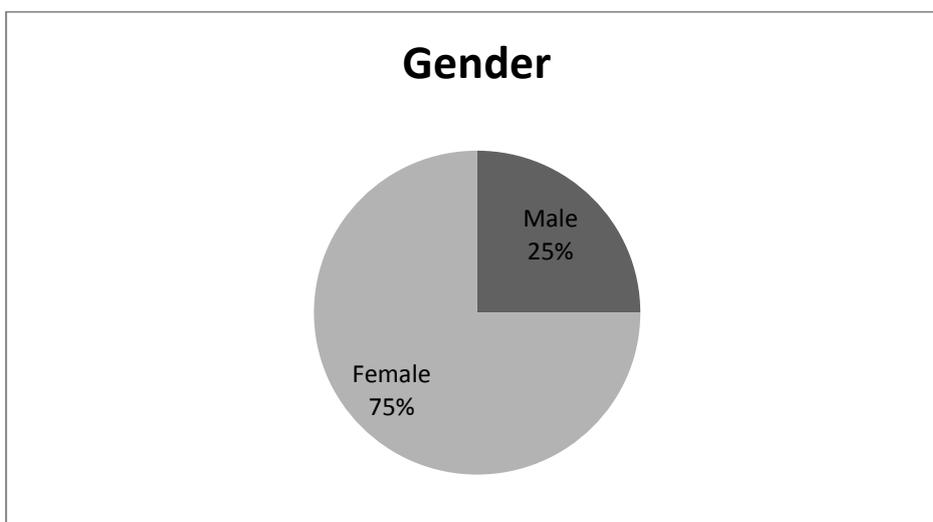


Figure 4.2. Gender of participants.

4.3.1.1.3 Marital status and number of children

Marital status was considered one of the crucial aspects in this research, as it may assist a nurse to decide whether to work at a rural clinic or not. Seventy-one percent or majority of the nurses who participated were married, 25% were single and 4% widowed. There was a relationship between marital status and turnover of nurses, though to a lesser extent. Figure 4.3 below illustrates that there were more married nurses; followed by single ones, and a few were widowed. As stated already, most nurses were middle aged, ready to start families. Another variable related to marital status was whether the participants had children or not. In the interviews, many nurses confirmed that they had children. Almost all the married nurses expressed their desire to stay with their families and raise their children together. This confirms what Hayes et al. (2006) said, namely that turnover is high in early years of marriage.

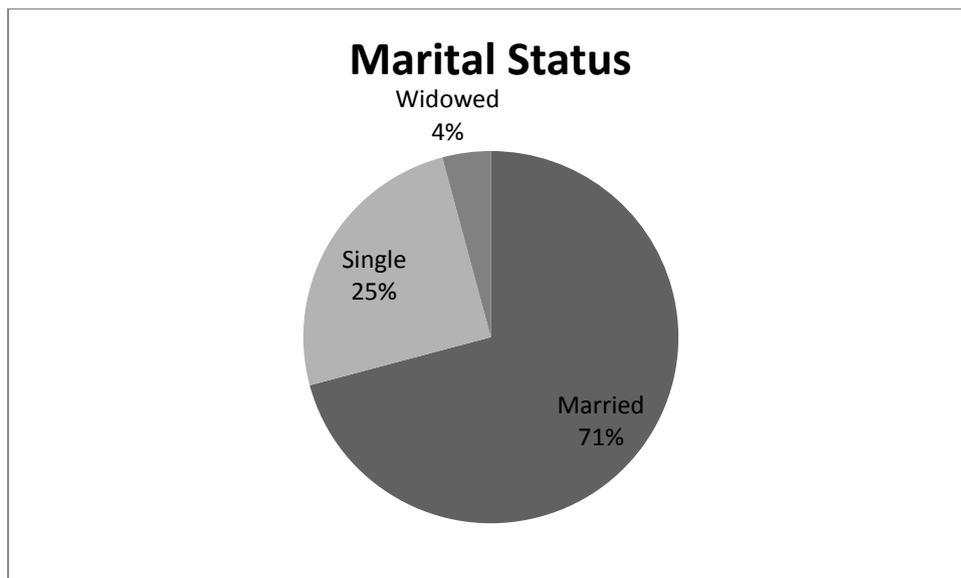


Figure 4.3. Marital status of participants.

4.3.1.1.4 Nationality

Nationality was another aspect considered. The findings of the study reflect that nationality did not have a significant effect on factors affecting turnover of nurses. As mentioned in Chapter 1 of this study, Lesotho considered recruiting nurses from foreign countries when it was faced with an acute shortage of professional nurses, particularly in the rural areas. While the country was trying to come up with strategies to enhance the nursing workforce, agreements were signed between the governments of Lesotho

and Zimbabwe as well as between the governments of Lesotho and Kenya to recruit foreign nurses with an initial employment contract of three years. Therefore, almost all nine of the clinics were staffed with some nurses from Zimbabwe or Kenya. As illustrated in Figure 4.4 below, out of a total of 24 participating nurses, 50% were Basotho, 42% were Zimbabweans and 8% were Kenyans.

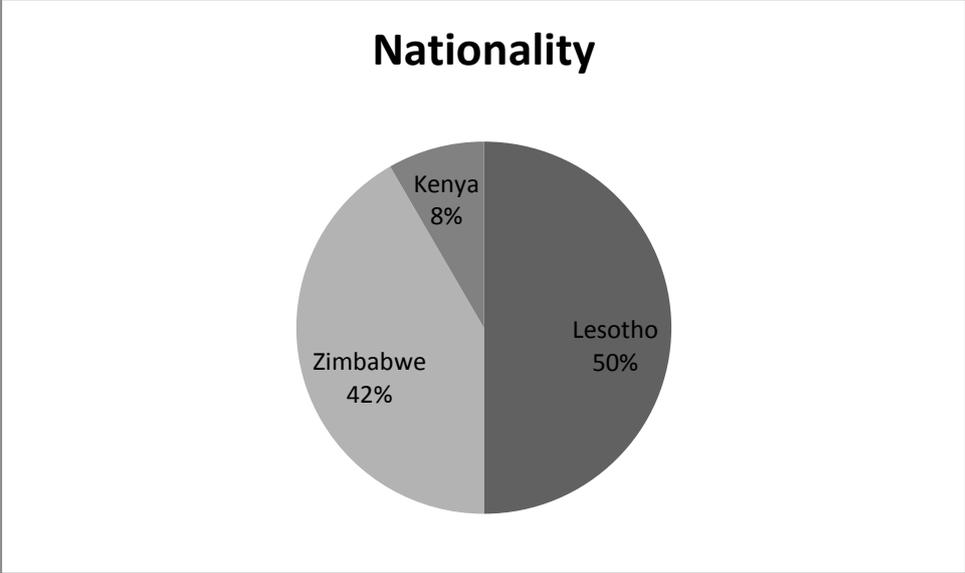


Figure 4.4. Nationality.

From the investigation, it was found that a shortage of Basotho or local nurses in the country was continuing. As shown in Figure 4.4 half of the 24 nurses interviewed were local, and the other half was foreign nurses. This means Lesotho still has a long way to go with regard to attracting and retaining nurses and reducing turnover of nurses. In the past, nurses used to migrate to other countries in the region. However, it was established that it is currently being controlled, as one of the key informants mentioned that Lesotho was no longer concerned about local nurses migrating to other African countries, including the neighbouring country, South Africa:

With Southern African Development Community (SADC) protocols approaching, you will find that it makes it difficult for nurses to move to other African countries. Yes they would like to go. You will find that they can go to South Africa or other African countries because that's where their spouses are (there), or they have relatives in that particular country. So, because of that, they would like to go to that country. But otherwise, they would wish to go there, but they don't do so as easy as they would like.

4.3.1.1.5 Education level

The study reveals that 62% of the participating nurses have obtained diploma qualifications, as shown in Figure 5.5. This is followed by 21% who have certificates and about 17% who have obtained degrees. At the certificate level, nurses qualified as NAs. The diploma holders normally work as NSs, and they are required to support the nursing officers. Degree holders are NOs who play supervisory roles and are in charge of the clinics. They also work as midwives. It was found that there were few nurses with higher levels of education at the rural clinics, hence the few midwives. This validates what Hayes et al. (2006) said in the literature review, namely that highly educated nurses did not opt to work at rural clinics.

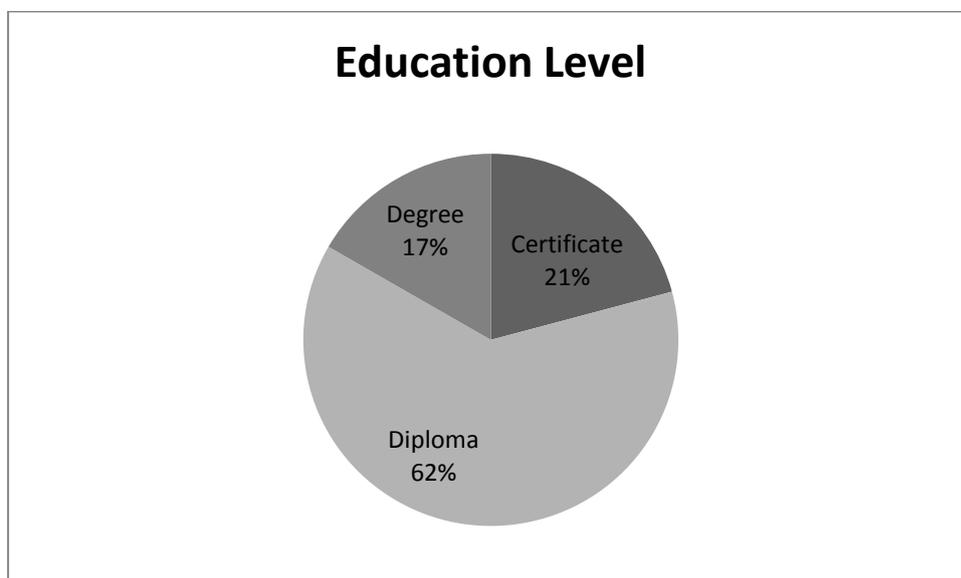


Figure 4.5. Education level

This poses some challenges at the clinics, as few nurses are able to handle most of the work at the clinics, including midwifery. Consequently, education qualifications had a major effect on turnover of nurses at rural clinics. The effects of years of work experience on nurses' turnover are discussed in the next paragraph.

4.3.1.1.6 Work experience

Figure 5.6 shows years of work experience indifferent age groups. Most nurses with many years of work experience are older, and vice versa. This confirms the findings of the literature review that highly experienced nurses are likely to stay at their work. The findings from the study indicate further that most nurses did not have rural training while

they were at college. Although it affected turnover, work experience was not a major factor affecting turnover of nurses at the rural clinics in Lesotho.



Figure 4.6. Years of work experience.

In sum, all these demographic factors affected turnover. Although these varied from one clinic to another, they are strongly connected. For example, in the rural setting, there were more younger to middle-aged nurses than any other age group. Most of them were mature enough to get married and so were still in the child-bearing stage. Another connection is that of age. They were in the early stages of their work experience and ready to enhance their educational qualifications. The study found that most of the qualified nurses had obtained diploma qualifications, and many of them had more than five years of work experience. It was also found that more foreign nurses than local ones were working at the rural clinics in Lesotho.

It was discovered that aspects related to gender, nationality, education, and work experience did not have a significant effect on turnover of nurses in rural areas in Lesotho. However, comparably, age and marital status might have a significant influence on turnover of rural nurses, although to a lesser extent. The next section will discuss the effect of non-monetary factors with regard to turnover of nurses at the rural clinics.

4.3.1.2 Non-monetary factors

Still under the first theme, this section assesses the effect of non-monetary factors on the turnover or performance of nurses at the selected health centres in Lesotho. The

factors discussed here are not exhaustive. The following are some key factors that affect the subject matter in this study:

4.3.1.2.1 Infrastructure

In the context of this study, infrastructure relates to physical aspects of social and personal support that enable efficient working and ability of nurses to attain organisational goals. The participants remarked on the following subgroups of infrastructure: road, telephone communication, water and electricity.

Roads

With regard to road infrastructure, most nurses indicated that roads were very poor. Access to roads can affect nurses' intention to resign from their jobs. Many nurses feel reluctant to work in the rural areas due to bad roads. One of them from Semenanyane complained about long travelling hours by road to and from the clinics and explained that the road trips normally took about seven or eight hours by road from the clinic to the capital town, Maseru, if they used Government vehicles. It becomes worse if they use public transport, as they may have to sleep over somewhere along the way. Another participant said he would like to invite his family to visit him, but he did not want to subject them to the stress of travelling a long distance by road. Therefore, bad roads can affect the turnover of nurses. This confirms Dovlo's (2007) finding stated in the literature review, namely that nurses may be attracted to work at rural health care centres if the infrastructure that facilitates access to roads and transport is good and utilities such as water and electricity are available.

Poor roads affect not only the nurses, but also negatively affect the transfer of patients from one clinic to another. A participant from Methalaneng Clinic confirmed and asserted that infrastructure related to roads was in a poor condition:

Problem ke (is)... the road. Ha re na (we don't have a) road e hantle (that is good) so when transporting patients to St James Hospital, we transport them by road and the road is not good at all, especially when it comes to pregnant women.

Air transport

The participant from Semenanyane further affirmed that owing to poor road conditions, they predominantly rely on air transport by Mission Aviation Fellowship (MAF) under LFDS, which is a faster mode than road transport. According to the interviewed participants, air transport was not the solution since there were still some challenges in air transport. For example, since the Government is paying for nurses' air transport, in some instances, payments were not made. In such cases, nurses were not transported or not allowed to travel to their respective clinics, leaving them frustrated. One participant explained it as follows: "We largely depend on air transport. And then some time back, around February, the Government failed to pay in time and they could not transport us."

Telephone Communication

This research study established that telephone communication was important and necessary for headquarters, district health centres, patients, nurses, and their families. Some nurses expressed frustration about lack of communication, and this affected the turnover of nurses, but not significantly. The nine clinics did not have fixed telephone lines in their respective areas. The nurses relied on their cellular phones, which posed some challenges. One participant from Kuebunyane clinic verified that the network was insufficient: "Network is not adequate as such... I think it's on and off at times. It's only VCL (Vodacom Lesotho), there is no Econet and when you are phoning you have to go to the air strip if you want to communicate hantle (well) with people because here at the clinic it's just not clear."

Although most participants raised similar concerns about the poor infrastructure at the selected clinics, there was some optimism regarding the telephone communication infrastructure in some areas. One participant at Tlhanyaku said the following:

It's improving! You know when I came in April they are actually... I think you saw when you came in... they are constructing the road and there is an improvement and also communication is starting to improve. Sometime, end of April they launched Vodacom, and if you go to some points, you get communication, unlike some years where I hear from stories that it was (inaudible)... initially when I came in early April, one had to go up the mountain to communicate, but now

there are some points where your Vodacom can communicate. So, I think there is an improvement.

A typical example of the development and shift from old-fashioned to more modern communication systems used at health centres in Lesotho was captured by one participant at Tlhanyaku as follows: “OK, I was talking about the communication. We used to have a radio, but the radio was taken down by heavy rains. So, we rely on our cellphones now.”

The usefulness of communication is that it provides a platform for effective relay and action on messages concerning care of patients. Therefore, communication is indispensable in all health settings. A key informant from the Ministry of Health in Maseru also expressed their frustration with regard to communication. It was explained that they had used walkie-talkies or two-way radios in the past, but the Ministry failed to maintain and service the devices. She further explained that, unless the nurses at a remote clinic initiate a call, it is not easy for headquarters to do so. Most of the time, the signal is poor, and the messages are not clear. The majority of the nurses explained that they had to go away from the clinic and climb the mountain or go to places like the airstrip, which is also a little far to be able to make calls. Therefore, communication between Maseru and the clinics is very poor, as the following participant from headquarters explained:

Yes, ‘roger-roger’ (walkie-talkie) I don’t know if that is the right name. But it was an open sort of network and we would communicate. But with time we failed to maintain them and we couldn’t get the parts to service them, and now we have resorted to cell phones, which is still a challenge for other health centres because for us, if you want to communicate from here, it would not be possible unless that nurse is the one who would communicate first, because she will go to a higher place where she can be able to communicate.

Overall, communication is an important tool that can help accelerate service delivery. With regular communication, nurses will be able to relate well with colleagues and supervisors. However, from what was gathered, the telecommunication and its significance on turnover of nurses is slowly improving due to improvements the Government is currently putting in place through relevant organisations.

Water

Water is one of the basic needs of human beings, and the study showed that there is limited access to water. According to one of the participants from Nohana Clinic, there is a shortage of water at the rural clinics. He emphasised this point as follows:

The main problem that we have got here is we rarely have some water, especially in winter because we are using solar system. The water that we are using here depends on the sun. And when it's cold like this, we are running out of water for so many days and we only had it yesterday. It was not enough so I think people have to make sure that we have got gravitational supply so that the water comes through gravity. Some time ago, there was water that was supplied through gravitational supply and it did not depend on the sun.

Shortage of water can cause health risks. Therefore, discussions indicate that water can affect the turnover of nurses at the clinics significantly.

Electricity

There is also limited access to electricity at the rural clinics. Most of them use a solar system that relies on the availability of the sun. However due to the mountainous terrain in Lesotho, almost all rural areas are cloudy throughout the year. The participants from Lebakeng Clinic reported a shortage of power or electricity, and one of them emphasised this point as follows:

Well we have a good road, it's just been um, constructed. But we don't have electricity. We use solar panels, but they are providing enough electricity only for lighting and some few appliances like TVs.

However, some participants reported positively about power or electricity due to ongoing developments of construction and refurbishment of the clinics. The participant from Kuebunyane said the following:

Hmm, before the construction, everything was not comfortable. There was no road, no electricity, no water, and when it snows there is no water... but hona tjee (right now) there is this renovation which is going to be done on the water system and there is going to be additional for electricity but it is still transport that is a problem.

Therefore, it was found that shortage of electricity can affect service delivery negatively and frustrate nurses, thus increasing the turnover of nurses at rural clinics. This proves references in the literature review that water and electricity are crucial and may attract nurses to work at rural clinics.

Accommodation

Poor accommodation was a general crisis at the clinics. Most participants shared small houses, which was not conducive for a family setting. Each participant in the study was provided with on-site accommodation. However, the quality and consistency of provision of accommodation varied from clinic to clinic. Despite the recent refurbishment of the clinics, many of the participants were unhappy about accommodation. Another observation at Lebakeng was that the house occupied by the PIH nurse was spacious and well furnished. All of these confirm references in the literature review that, in comparison with houses in the private sector, those in the public sector are usually of a poor quality. Therefore, it is apparent that accommodation has a significant effect on the turnover of nurses. In response to the question whether the new clinic that was being constructed at Kuebunyane would solve the issue of accommodation, one participant said accommodation still stood as a problem because two nurses had to share.

Some expressed their frustration about accommodation, and one from Bobete Clinic stated the following:

Accommodation is the worst, I think the worst ever for staff. We are now sharing with patients, toilets and everything, so, this is the worst, and there is no privacy. Even if you want to rest after a hard day's work, you cannot rest. It (inaudible) right that they need to cook for patients. You cannot stop it and this is about my welfare and my welfare is also compromised. I need to be awake during the day and work during the day, but I cannot with that state. So, in terms of accommodation and safety, I think it's very poor.

Safety issues

In rural work settings, safety is an important aspect, and with regard to the quality of safety, participants' views varied. Most of the nurses believed that they were safe. One participant at Manemaneng clinic stated, "In this area, the community is very friendly. They don't have any conflicts; we haven't seen much of that."

Some agreed that security and safety around them was improving. Participants from Kuebunyane and Tlhanyaku, in that order, explained:

I have been here for the past five years. That time when I came here, we were just two and we used to stay alone without anyone because the villages not near, so far we are just safe now, we have no problems.

Yes, that was one of my fears when I came here. I was told that the community used to attack the nurses. And when I came I thought the security was improved to what I heard because there is a security from the Government and there is a security from PIH. They are exchanging duties. As you enter the gate, there is a watchman there, so whoever is coming is reporting to the security, so I think the security is improving.

However, in other instances, there were concerns regarding the fencing and watchmen as means of safety and security. Some of the participants at Bobete and Kuebunyane correspondingly expressed the following:

Safety and security are very poor. The fence is falling, gates are not locked, and we don't have a watchman. We are only acting like a person who has got somebody like a watchman. So with that kind of a fence, there is no security, it's almost like none exists. There's a local person who has been hired long back, but it seems he is not obliged by being respectful and not obliged by the job description kapa (or)... I don't know, it's really a problem. He is a night watchman... previously he was said to be working day and night, but he wasn't doing much. So, at the moment, he is doing night but most of the time he is not reporting on duty.

From the interviews, it is evident that safety and security are of great concern and can significantly affect the turnover of nurses working in remote rural areas.

Family and next-of-kin matters

These matters have a significant effect on the turnover of nurses. Drawing from the participants' statements regarding opportunities for staying with spouses and family at these clinics, it appears that family is an important aspect of one's well-being, security and personal aspirations. Noteworthy in this study is that none of the participants

reported staying or living with their spouses, i.e. none of them lived with a husband or a wife at the clinic.

This issue becomes more sensitive to those who are married, as most of them would like to live in a family setting. As illustrated in Figure 4.3 above, most participants were married. A number of obstacles made it difficult for the participants to stay with their family members in the rural areas. These include lack of good schools for children, entertainment, and employment opportunities for spouses. This confirms views reflected in the literature review that a lack of job opportunities for spouses was seen as a factor that influenced nurses to leave their jobs in the rural areas. Furthermore, factors related to this pointed to difficulties with regard to visits by friends and foreign family members, as there were still many nurses from foreign countries at the selected clinics. A participant at Kuebunyane explained that she was a Zimbabwean and her family had visited her only once since she came to Lesotho.

Another participant from Lebakeng said the following:

I stay alone. Yes, I would like to stay with my family. It's just that the schools are not OK for the kids. One other factor is distance from family members and maybe lack of entertainment – being bored in the mountains. Lack of electricity in most cases, so, because they are used to watching TV and so on and so forth. And, well, the shops here don't have variety. They don't have the food that we want, and when available it's not in good condition, thus sometimes you find that when you get the meat it's rotten. We don't have many things and the distance that we cover from here to our homes if you use public transport, you find that it's a headache.

Access to schools and churches

This has a major influence on the turnover of nurses. As mentioned already, most participants were married and had children. It is common for most parents to aspire to provide their children with the best education. It was found that there were churches nearby; however, none of the participants confirmed that there were good schools in the rural areas. A participant from Nkau Clinic explained that the area in which the clinic was situated lacked good schools.

Others from Methalaneng and Bobete clinics, in that order, confirmed the following:

Yes, there are churches, and the schools are also there. But (eish) the schools here are not good at all.

The church is there, but mostly because of the commitment, you would be on stand-by during the weekend, unless when I am not on call.

Recreational or entertainment facilities

The majority of the participants stated that there were no recreational or entertainment facilities in their relevant areas. Two participants, one from Bobete and another from Nkau, correspondingly commented on entertainment as follows:

Ahhh, that one, I think it's almost non-existing. Besides the TV that we received recently, there is (interrupt) nothing.

Ahhh, there is no entertainment, except for us who go for snooker.

Some expressed a different view on entertainment, particularly after the delivery of the decoder and television sets, which all formed part of the retention package. One participant from Kuebunyane asserted the following:

The entertainment, Ehh! It needs somebody who doesn't care. But hona tjee (right now) with the TVs, it's not boring. The nurses have something to occupy them, especially the young ones, because ha ba le teng (when they are here) they are comfortable. Hona tjee (right now), unlike before, when you'd see one is very displaced; he goes to the naheng (fields) and back. I ended up wishing they could be away, but with the coming up of TV, I really see a change, and as I talk to them, they will say 'aha 'm'e Julia you can book me to go away on such a day. They are not in any hurry to go to their schedules. As such, they can stay a little longer in the mountains.

In sum, the non-monetary factors in this theme have a much greater effect on the turnover of nurses at rural clinics in Lesotho in comparison with demographic factors. The nurses are generally not pleased with the quality of accommodation, which is very poor. They are also frustrated with poor infrastructure at their respective clinics and surroundings. The nurses are concerned about staying away from their families, and they mention aspects like the lack of entertainment facilities and the lack of good schools for their children that hinder their families. Safety is another aspect of concern.

However, few participants reported negatively about it. They mostly feel safe in the community and in the villages where the clinics are situated.

4.3.2 Theme 2: Work-related factors

This theme contains job satisfaction and organisational factors that affect the turnover of nurses in the rural areas of Lesotho. The following subcategories will be discussed under theme 2: relations with colleagues and supervisors, relationship with the patients, job challenges and influences, risks associated with the job, workload and work schedule/shifts, staffing levels and competencies at the clinic, promotion, training and development opportunities, medical equipment, medicinal supplies or stock at the clinic, recognition from management, policies and procedures.

4.3.2.1 Job satisfaction

Job satisfaction can affect nurses' decisions to resign from their jobs or not. A number of factors may determine it. During the data collection, most nurses generally showed positive attitude towards their jobs, despite all the challenges they encountered. That reflected commitment to deliver the best quality service to patients. Many nurses expressed different feelings about job satisfaction, which confirms references in the literature review that job satisfaction can affect the turnover of nurses at rural clinics, and it can be measured by different factors illustrated in the next three sub-categories below.

4.3.2.1.1 Relationship with colleagues and supervisors

Generally, participants were satisfied with the good relationships they had with their colleagues and supervisors. This is a good sign, as it requires teamwork for nurses to successfully provide excellent service delivery to patients and increase nurses' productivity. It also confirms references in the literature review that social relationships among employees, the quality of supervision, and the extent to which employees accomplish or fail in their work affect job satisfaction. A participant from Manemaneng asserted, "Ahh there we have a very good relationship with our supervisors and community. With patients we have no problem."

Another participant from Tlhanyaku agreed that they had good working relationships with their colleagues. Even the newly recruited nurses had no complaints regarding

relationships at work and supervision. Some participants correspondingly verified it with the following:

Ahh, I am just new, but so far, I am not complaining about the relationship.

I was received well and we don't have problems in that regard.

Although they had good relationships with colleagues and supervisors, some participants expressed challenges with their interaction with members of the support staff who are not in the nursing profession. A participant from Kuebunyane stated, "With the nursing staff and Housing Warden there is no problem, but with the security, it's really challenging."

In an interview with participants at the Ministry of Health headquarters, they expressed their concerns about relationships between the clinics and headquarters, including the level and quality of supervision provided to rural nurses. They explained that supervision was affected by a number of challenges such as transport, telephone communication and inadequate budget for the Nursing Directorate. One explained:

Especially, when you focus on the relationship at the district, you find that the supervisors are basically at the district and the clinics are somehow far. So, the supervision that is being done most of the time is the indirect one. Yes, indirect supervision. But there is a chain of command between the district and the headquarters. The nurses from the clinic cannot just relate with headquarters before they can relate with the, err, immediate supervisors. So if there is anything – they will have to go to their immediate supervisors at the district level and then come to the headquarters, but all I can say, the relations are just, err, are not so good. It's fair relationship.

4.3.2.1.2 Relationship with patients and the community

It is important for nurses to have good relationships with patients and the community as a whole because, normally, the rural villages have some community members who are acquaintances in one way or another. Therefore, information can be disseminated rapidly, especially when the community is not satisfied with service provision.

Most participants were gratified with their contact with the patients and community as a whole. They said the community as a whole was happy and welcoming. Participants

from Nohana highlighted a warm relationship between the clinic, community, community council, health centre committees, and the modalities of work towards improved quality care, as follows:

Yeah, when it comes to that question of the community, actually we are in good relationship with the Nohana Council. We have got a Nohana Health Centre Committee which actually liaises with the community. We were at a point where we were talking about our relationship with the community and the public generally. We established a Nohana Health Centre Committee. The committee is the one which actually makes us meet and solve our problems within our committee. And we have got a committee which actually sits on the second week of every month. So we always get the idea about problems from them and we always have some meetings with them monthly or even with village health workers so they always give us the problems of what is happening with the community. At that particular meeting, we thrash out the problems which we encountered.

Participants from Lebakeng and Bobete respectively said the following:

It's OK, it's helping us to do our work with clients coming to the clinic, without any complaints, and we go to work.

In terms of patients, ahh, we are fine. I'm fine with the patients and the community themselves. They are welcoming, they are happy with the services that we are giving them.

The foregoing statements show that the nurses did not experience major challenges in their relationships with the communities they served. However, in counterbalancing and refining the factors around the views concerning relationships with the communities, nurses sometimes found it difficult to communicate with the community because of their literacy level. A participant at Tlhanyaku said the following:

Hmm, I think it's a community that is basically illiterate. You need to be patient with them. If one need to communicate ... the way I notice is that, for the health education they might want to incorporate some things but if the message is not transmitted to them, the cooperation might not be so good. So, we need more time with these patients and explain to them until they are ready to cooperate.

To sum it up, the statements reflect a wide variety of considerations for what can make a relationship with the community work or not. In the statements above, the participants highlight a need for

- considerations of levels of literacy;
- patience by service providers;
- communication;
- health education;
- inclusiveness; and
- explanation.

All these factors are in line with the Batho Pele principles, meaning principles that put people first (Mohale, Mulaudzi & Phil 2008). They can help improve relationships between clients and the service provider. This confirms references in the literature review that link job satisfaction with relationship with patients and the community as a whole. They emphasise that clients or patients must have easy and undisturbed access to services and that all patients must be treated courteously. Therefore it is important for nurses to have good relationships with the community as a whole.

4.3.2.1.3 Job challenges and influences

Nurses raised a number of challenges and influences affecting employee turnover, which confirms factors raised by many researchers in the literature review, including general economic conditions, local labour market, personal mobility, job security, and demographic factors. A participant from Tlhanyaku mentioned a number of challenges affecting health care service delivery as follows:

Of course, it's the staffing – we need more staff. Secondly, it's the transport. When we have a patient to transfer to Mokhotlong during the night, it's a bit complicated because we have to go in the village to look for a car.

The participants raised more concerns that may be hindrances to their family members in circumstances when they want to pay them a visit. Nurses experienced additional challenges, as indicated by the following detail given by a participant from the Nkau Clinic:

The financial support, like I told you, this is a cold area. First, because it affects our health, our members of staff say they need protective shoes. This place is

mountainous and we go for outreaches. We go with our normal shoes, and in one week, you don't have shoes anymore. We need special strong mountain boots. We need freezer suits in this place. Actually, this place is cold, the way you are seeing it throughout the year. Here there is no summer; even in summer, I still come to work in a jacket. So, we need freezer suits; they have never been brought here. Right now as I am telling you, there is no single gas cylinder that can serve my house by heating. For some offices, you will go there right now you will find people shivering.

In sum, the factors related to job satisfaction have a significant effect on the turnover of nurses. The participants did not complain about their relationships with colleagues. They also generally related well with the community and the patients.

4.3.2.2 Organisational factors

These factors proved to have great significance regarding the turnover of nurses in the remote rural health centres in comparison with the demographic factors. They will be explained and dealt with in detail in the nine subcategories below.

4.3.2.2.1 Workload and work schedule/shifts

Workloads and shift structures have an effect on the turnover of nurses. It was found that the nurses work in shifts, with seven days off duty per month, which validates references in the literature review that well-planned shifts allow for flexibility and enhance productivity. In general, the findings show that most participants expressed that the workload was high in relation to a high number of patients and use of the supermarket approach to providing services, which requires nurses to deliver all types of health services to different patients everyday. Against this background, a participant from Tlhanyaku said the following:

There are days where you are on duty and take up to seven to fourteen days, off duty. But we are always on call, we see emergency patients. Then we take ten days off per month and that's our shift then. For the workload, usually, we take expectant mothers. They are many and we take expectant mothers from other clinics. We also take primigravida (woman who is pregnant for the first time) in the clinic and we still have shortage of nurses especially midwives.

4.3.2.2.2 Staffing levels and staff competencies

The approved staffing level is five nurses per rural clinic. The majority of the rural clinics maintained the approved staffing level of five nurses. There were a few exceptions where clinics had six, and some had four nurses. The literature review confirms that workloads are aggravated by structural adjustments, demographic factors and other resources that may affect staffing levels and patterns, which in turn will increase workloads, fluctuate shifts, allow working overtime and working over weekends (Tevington, 2011). While the study sought to assess the numbers, adequacy and competencies of staff at the selected clinics, a participant at Bobete made a comment about the adequacy of staff and said, “We are four, we have two from Government. No, I don’t think so (enough), since there is insufficient numbers, no. Even including the PIH staff, we still need more.”

Inadequate numbers of nurses was also confirmed by the Lesotho Nurses Association. They indicated that there was still a shortage despite assistance by a number of donors in strengthening human resources in the health centres.

I think the rural clinics, most of them, have inadequate staffing levels; they are short of staff, most of them. Even though the Ministry of Health in partnership with the Pefpar family, the Jhpiegos, the MCAs, the EGPAF, the foundations like Clintons, they have been employing a lot of nurses. Also, the partners like Irish Aid, I know them to have contributed to strengthening human resources in health services and clinics.

According to the recent Health Workforce Optimisation Analysis (2014) that was commissioned by the Ministry of Health and conducted by the Clinton Health Access Initiative (CHAI), the size of the catchment area or the patient demand was not considered in approving the current staffing levels. It was endorsed arbitrarily as five nurses per clinic across all the rural clinics. A key informant of the Ministry of Health headquarters confirmed this as follows:

That is true. Actually, prior to the improvement of the health centre infrastructure, there were only three nurses who were on rotation from the hospitals, except the nurse clinician who was always at the clinic. And the other nursing sisters and nursing assistants rotated from the hospitals. So, we just looked at it at face value to say, these are the activities that are supposed to happen at the clinic, this is the

essential package that has to be provided. Therefore, if you have three, how many do we think could make, at least the services better at the health centres? Then we said “five.” But I think there is still inadequacy because the services requirements often exceed capacity and wherever you go nurses and doctors – all health workers – can never say we are fully adequate, we don’t need any more other people.

4.3.2.2.3 Administration of the clinics

As already mentioned in Chapter 1 of this study, seven of the nine selected clinics are under PIH administration; however, nurses deployed there are under different reporting lines. Some nurses report directly to PIH, while others report directly to the Government of Lesotho (Ministry of Health, 2011). The study identified this as a challenge for nurses that may affect their relationships. Some nurses acknowledged the assistance received from PIH in terms of provision of drugs, transport and, in some instances, money to cater for some minor expenses. Manemaneng participants emphasised, “PIH has been assisting. They are assisting but they are also demanding that the LFDS should be doing its job.”

Other nurses raised concerns about their interaction. One participant raised issues regarding the quality, frequency, and focus of supervision, job rotation and sharing tasks by MOH and PIH officers, saying that all nurses need to share and engage in serving all patients. One participant explained that they were sharing consulting rooms, and PIH nurses concentrated mainly on maternity-related issues and disengaged themselves from assisting patients in other areas of health care services. He explained as follows:

Actually, under LFDS, we do share duties, especially the general patients, ART, TB and as well as other issues. But for maternity, it seems like PIH are not willing to involve themselves in any area other than maternity, as if they were specifically trained for that. Hardly ever do they attend to other patients. No matter whether the patients are many or few, LFDS nurse has to see those patients alone. Whether there will be two patients, two hundred or two bana (children), it’s fine with them and they don’t help. That’s the problem. So we are hoping probably that everybody should rotate so that we are trained and engage in all areas.

4.3.2.2.4 Promotion, training and development opportunities

Lack of promotion, training and development opportunities can affect turnover of nurses negatively. Even though the Ministry of Health explained that they had training and development policies in place, many participants were dissatisfied.

It was found that only one nurse from Lebakeng was on two-year study leave for formal training. In an interview with a participant of the Lesotho Nurses Association, the participant pointed out that there are six nurses training institutions in the country that provide formal training for nursing professionals. These are Maloti, Paray, Scott, National Health Training College (NHTC), St Joseph and the National University of Lesotho (NUL). Even though these institutions produced low numbers of general nurses and midwives, the participant was satisfied with the standard and quality of training offered by these institutions. The training institutions were sometimes faced by challenges that affected their operations negatively, as was shown in the local newspaper, Lesotho Times dated 3-9 April 2014, highlighting that the NHTC had been shut down indefinitely because students had boycotted lessons because of the suspension of their fellow students.

The above-mentioned facts validate references in the literature review that highlight dissatisfaction with training and promotion opportunities, which have proved to have a more significant effect on turnover of nurses than pay and workload have. A participant from Lebakeng answered as follows when asked about training and promotion prospects in the rural nursing environment: "Except being a nursing officer, there is none, there is no promotion."

However, a few participants admitted that they had attended workshops or undergone some training, though not sufficient. A component of management responsibility is to provide ongoing training and capacity building. A participant from the Nkay Clinic said, "No training, except few workshops. There are these workshops. They come once in a long time and I don't know when."

The Ministry of Health explained that there had been more on-site training for nurses lately to improve health care services at the clinics and also to help nurses to accrue the twelve continuing professional development (CPD) points per year before renewing their practicing licences. Some nurses were happy about the training as they were able to accrue the (CPD) points. A nurse from Tlhanyaku said the following:

There is training. There is this CPD training where am I going to accrue my points for the CPD. The CPD (continuing professional development) is when you register with the Nursing Council, you should have been to a workshop and accumulate the points. And for me to register next year, I should have gone to that workshop.

A few nurses who had undergone training encountered some challenges at the time of implementation after completion of their training, as a participant from Bobete describes:

In particular, I went for circumcision training, I think in Thaba-Tseka, under Jhpiego. However, we haven't put it in place, we are doing logistics to prepare for when to start the circumcision and we have also mobilized the community about the circumcision. So, it's one of the trainings during this first quarter, and it's one of the developments that we have managed to do. There are some other small workshops that staff attended, (inaudible) and the other one on immunization. So, recently they were there.

4.3.2.2.5 Medical equipment

It is important for nurses to work in an environment with proper, adequate, and functioning equipment that enables them to deliver good quality service to their patients. Lack of such equipment can highly affect turnover decisions by nurses in rural areas. This confirms references by Adzei & Atinga (2012) in the literature review that it may be difficult to reduce the level of turnover of nurses if medical equipment seems inadequate. The majority of nurse participants reported that their clinics had medical equipment that was not being serviced and therefore not functional. They were dissatisfied with the quality and condition of the medical equipment at their relevant clinics. Participants from Tlhanyaku and Manemaneng respectively said the following in this regard:

I see that in the maternity unit there is a challenge. There is a cylinder but there is no oxygen. I guess if I have a flat baby, it's my concern to see that baby lives.

I would describe the equipment as fair, not 100 percent as such. We do have quite enough because we don't perform any technical procedures; we have a referrals system. But changing some of the old parts and adding one or two of those parts is lacking, thus they fail to do so. However, we have good equipment.

Other participants working at Kuebunyane and Lebakeng clinics confirmed that they had medical equipment but it was in a poor condition:

The medical equipment, we do have but, errr..., the machines I mean they are out of order like you can see the BP machines that we have here. At times, we don't have the buffers and like the PIMA machine. We don't have the cartridges, and for other diagnostics sets they are not here. It's in poor condition and inadequate, that's what I can say.

4.3.2.2.6 Medicinal supplies or stock at the clinic

Medicines and supplies are an essential component of a health service centre. However, the levels of supplies and availability of medicines can be a major factor affecting the ability of providers to serve clients and achieve job satisfaction. A participant at Methalaneng said the following about this:

Medicines supplies, we still need many of the drugs. Like I was saying, we are working with partners/PIH. We order drugs from PIH, and they have their own book where they have written the drugs. In that list, there are a lot of drugs that are not there. When we do the order, we have to order those ones that are in the book. And you may find that we need more than those that are in their book. So, there is a problem there.

Participants from Lebakeng and Bobete respectively reported as follows:

The stock, yes, I think with drugs we are OK and generally you know we don't run out of stocks.

Err, the stock at the clinic is fine, but sometimes because of challenges beyond the human... human control, sometimes because of the weather, you find they cannot even bring them, because of the weather. But we are not complaining about our supplies because as long as the weather is fine, we are OK. But sometimes there are a few problems

The overall picture and summary of the findings with regard to this component would be that there are no major shortages of medicines and supplies. However, when they occur, the effect on the quality of service is significant and may affect turnover considerably.

4.3.2.2.7 Policies and procedures

Non-existence of policies and procedures that guide the nurses in their daily operations may affect turnover negatively. In this study, participants acknowledged the existence of a number of national policies that guided service provision in their respective clinics. For example; participants from Manemaneng and Tlhanyaku respectively explained as follows:

Yes, we have standard medical guidelines, ART guidelines, we have PMTCT guidelines and IDSR (Integrated Disease Survey and Response Guidelines) and the National TB Guidelines, STI guidelines and many guidelines we are using.

Just two weeks ago, were just introduced. Where I came from (Mafeteng Clinic) we were just doing IPT (Isoniazid Preventive Therapy). It was launched two weeks ago here, and it appears there is a very good cooperation from the patients.

A participant from the headquarters of the Ministry of Health indicated that they had a number of policies in place, particularly those related to training. A participant from the headquarters said the following:

Yes, there is a policy, and there is also a strategic plan – the Ministry of Health Strategic Plan and even the Education plan is there of that Continuing Education Plan and other than even the implementation plan is there of that strategic plan. Other than that, even though it's still in a draft form, we have the nursing and midwifery strategic plan, which has identified the training needs of the nursing directorate. So, we are using those documents together with the Public Service Rules and Regulations, which determines what processes an officer has to follow for an office to be allowed to go for training. So, there are guidelines or legal frameworks pertaining to that, yes.

This confirms references in the literature review that state the importance of having policies and procedures in place.

To sum it up, work-related factors under theme 2 had a greater effect on the turnover of nurses than the general factors under theme 1 had. The nurses showed commitment towards their work and were fairly happy about it. Apart from job challenges that

existed, the nurses generally expressed satisfaction with relationships amongst themselves and with their supervisors, patients, and the community as a whole.

The findings indicate that staffing levels need to be revised because the nurses sometimes experience heavy workloads. The fact that the nurses were under administration of two organisations thus, GOL and PIH, posed some challenges during their daily operations. The nurses pointed out that equipment and medicine supplies were sometimes inadequate. The participants showed that training and development opportunities for them were limited. The next theme will analyse the economic factors that may affect the turnover of nurses at the rural clinics.

4.3.3 Theme 3: Economic determinants

This theme analyses financial or monetary factors related to the turnover of nurses, including remuneration, incentives paid to nurses, and budgets.

4.3.3.1 Remuneration

Salary is one of the main factors that may affect the nurses' intention to leave, hence the turnover. Generally, employees are likely to keep their jobs if they are paid competitive salaries. Many local nurses were also reluctant to work at the rural clinics due to low remuneration and allowances. Participants in this study appreciated their salary; however, they wished for an increase. Different participants expressed the positive and negative views on this aspect. A participant from Nohana Clinic explained that current salaries might seem adequate for newly recruited nurses:

Yes, I would say it's a fair salary because, for starters (new recruits) it's a fair salary. But for those people who have been here long, it's some sort of peanuts (laughs) but people who are new you know you can live with. Salary is not a big deal really.

Another one from Methalaneng explained that, in comparison with nurses working in Maseru, they were able to save money:

In the mountains, I think nna (me), on my side, I save a lot. In the mountains, you don't spend so much like when you are down there in Maseru.

Nurses from foreign countries expressed dissatisfaction with their salaries due to a number of economic factors that increased the cost of living, such as the exchange rate,

which affected the power of the Maloti currency negatively. A foreign nurse at Manemaneng explained as follows:

My salary is far from adequate. It is still less. Especially, there is something that I don't know if the people consider but when I come to Lesotho for the first time, Maloti (currency) which relies heavily on the rand was a very strong currency and when I converted it back home, it would be multiplied by nine (9) or ten (10) right now with the rand having lost value, it's like I have taken a salary cut.

So when I sent money back home, it used to be fifty thousand; now it's thirty-something. That has made me incapable of even paying school fees for my children. So my salary is seriously hampered by inflation. The weakening rand has hit it hard, but nothing has been done to compensate us on that.

This verifies references in the literature review that low salaries lead to job dissatisfaction among the employees, but if they are well paid, the turnover will decrease and they will be more satisfied in their jobs.

4.3.3.2 Incentives

Inadequate or lacking incentives for nurses can increase turnover. Organisations normally use incentives as a strategy to retain their employees. These can be in various forms, including monetary and non-monetary. In this case, the Embassy of Ireland provided financial support to the Government of Lesotho to cater for retention packages for components of five nurses, which were presented in monetary and non-monetary terms. The monetary form comprised the M350 mountain allowance, M250 transport allowance and M100 cellphone allowance. On the other hand non-monetary incentives comprised gas and basic furniture and appliances such as stoves, heaters, fridges, beds, television sets and satellite dishes. This was confirmed by the Ministry of Health headquarters as follows:

Incentives are in two forms. The other one is the monetary one. Monetary is to cater for communication and transport. And the other one is in terms of materials which is furniture. They are provided with furniture for the accommodation that they have. Even that accommodation that they are staying in, they don't pay rent unlike with other nurses in urban areas where they rent houses.

Another form of incentive that is not necessarily written down is that they are given first priority if they plan to pursue their studies since they are up in the mountains. So through the applications we will check whether this one is from the rural or this one is from (lowlands). And the one from rural is given priority.

A representative of senior management from Ministry of Health applauded the donor, Embassy of Ireland, for its contribution towards the retention package, since the Government of Lesotho was able to attract some nurses to the rural clinics, and said the following:

Well I can't say they are very happy, but I could say I feel at least there is something in it for them with the retention package that was introduced. Actually, it became much better because we were able to attract a handful of local nurses who wanted to go and work there.

Although this retention package was implemented late, nurses largely acknowledged it. However, they were faced with challenges, especially with regard to non-monetary incentives like furniture, because everything could not fit in their small houses. A participant from Nkau explained as follows:

Not good at all, we share one house. One room is very small; the other one is bigger. The furniture..., we have just had good furniture but it can't fit in the house and even the bed that is there it's too big for one room. And the wardrobe doors cannot be opened, uh, it's very small. Some houses don't have toilets. Some are leaking, the doors are broken and it's not in order.

4.3.3.3 *Financial support*

Insufficient funding can make it difficult for clinics to operate efficiently and effectively, which in turn may increase turnover of nurses. As mentioned already at the beginning of this study, seven of the nine clinics are under the administration of PIH, which also provides funds for running the clinics. PIH has hired administrative staff like bookkeepers. Most nurses appreciated the presence, involvement, and role of PIH as far as daily operations of the clinics that require money are concerned. Irish Aid (Embassy of Ireland) was also recognised in terms of providing financial support in the health sector. Participants at Nohana and Tlhanyaku clinics respectively stated the following:

As for financial support, PIH is the one which actually helps us with that in terms of the people, the outreaches, the cars that they use to go to the various places and do other things etc. So actually the PIH is the one which is helping us and even the Irish Aid has helped a lot with things like gas and other things.

The things are run by the private organisation (PIH). That is the one which even hires the transport from the village to take the patients to Mokhotlong. There is a bookkeeper from PIH, not Government.

4.3.3.4 Budgetary constraints

Turnover of nurses will increase where there are budgetary constraints that hinder the daily operations of the clinics. The study revealed that none of the clinics are involved in budget preparation exercises and have no control over budgets. Therefore, they do not know how much has been allocated to them in any given financial year. In addition, it was found that the Nursing Directorate does not have its own budget; however, the budget is shared with the health services, seeing that both fall under the Ministry of Health. This causes some challenges and makes it difficult for them to execute their planned activities, like conducting supervisory visits. One participant explained as follows:

Yes, because for some of the of our nine hard-to-reach clinics, you can only get there through the Mission Aviation which is the Flying Doctors Service and you will find that most of the time you don't have enough funding, especially with the Nursing Directorate. The Nursing Directorate does not have a budget of its own. It shares the budget with the health services.

Budgetary constraints affected other functions like transport negatively. In response to how they access the clinic, a participant from Bobete clinic stated the following:

Actually by flying; flying is our challenge, it's like the budget. We were told the budget that was given to LFDS is not adequate or half the time you know sometime you have the challenge that you are booked, but they say no booking. So you are forced to stay at the clinic; even if you want to go, you cannot go. If you want to go to Maseru, it means you will be prepared to travel for almost a day to arrive in Maseru.

Supervision at the district or even beyond the district is not very easy which makes our relationship fair.

To sum it up, nurses were dissatisfied with their salaries, particularly the nurses from foreign countries who referred to the challenges they encountered due to uncontrollable economic factors. There were challenges when it comes to budgets, as the clinics were not involved in drawing up the budgets, and the Nursing Directorate also did not have its own budget. The majority of nurses applauded PIH for its support and provision of financial support for daily operations of the clinics.

4.4 CONCLUSION

This chapter analysed the factors affecting turnover of nurses at the rural clinics in Lesotho. The findings in this chapter mostly confirm the literature review discussed in Chapter 2. The study concludes that demographic factors have varying effects on the turnover of nurses. However, their influence is less significant in comparison with general factors and economic factors. Among other factors identified in the three themes, the participants were dissatisfied with accommodation, which was very poor despite the recent refurbishment and construction of the clinics. It appears from the findings that non-financial factors were more significant than the financial ones, and many participants were concerned about a number of them. The most significant non-financial factors, for example, include the issue of accommodation, communication, and infrastructure, which in turn affects access to the remote clinics negatively. Economic factors had a significant effect on the turnover of nurses, and the main challenges were caused by budgetary constraints. The conclusions and recommendations of the study are discussed in the next chapter.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The primary objective of this study was to establish the factors affecting the turnover of nurses at the nine rural clinics in Lesotho. These clinics are under the management of the Lesotho Flying Doctors Services. The conclusions will be drawn based on the findings discussed in the previous chapter. Recommendations will be made based on the objectives of the study outlined in Section 1.3 of Chapter 1. These will be linked with the major challenges encountered by nurses in each of the three themes identified when analysing the data gathered for this study. The three themes referred to are general aspects, work-related factors, and economic determinants of the turnover of nurses at the rural clinics. The recommendations are meant to resolve the challenges recognised and problems identified in the nursing profession at rural clinics that are likely to affect the turnover of nurses at the rural clinics in Lesotho. Suggestions will be made to the Government of Lesotho through the Ministry of Health and other relevant stakeholders to inspire retention of nurses and reduce the turnover of nurses at the rural clinics. All these will be substantiated by the theoretical views of various researchers or the literature review in Chapter 2.

5.2 CONCLUSIONS OF THE STUDY

The secondary objectives of this study was to

- determine the factors that influence staff turnover of nurses;
- examine whether infrastructure affect turnover of nurses at rural clinics in Lesotho;
- determine whether job satisfaction influences nurses' turnover in rural clinics in Lesotho;
- determine the influence of biographical factors on turnover of nurses at rural clinics in Lesotho and
- analyse economic determinants that influence turnover of nurses at rural clinics in Lesotho.

These clinics are under the management of the Lesotho Flying Doctors Services. The findings were grouped under the three themes, namely general aspects, work-related factors, and economic determinants. It was concluded that work-related factors had a more significant effect on the turnover of nurses than general aspects and economic determinants had. The findings further revealed that the Ministry of Health faced budgetary constraints that negatively and significantly influenced factors affecting the turnover of nurses at the rural clinics in Lesotho.

Nurses reported experiences pertaining to infrastructure such as roads, telephone communication, water and electricity, and how the quality and inadequacy of these could affect the turnover of nurses at the rural clinics. In addition, poor accommodation was one of the factors that significantly affected nurses' intention to leave. The same was found with regard to work-related factors, about which nurses had varying views.

5.4 RECOMMENDATIONS

The recommendations will be based on the findings of Chapter 4.

Even though the Ministry of Health is currently working hard to put strategies in place that will assist in reducing the turnover of nurses and increasing the retention of nurses in the rural areas, challenges continue to exist. Consequently, the Government of Lesotho still has to go a long way to achieve its objectives in the health sector. The following recommendations are made with a view to overcome some of the challenges in the nursing cadre faced by the Government of Lesotho:

5.4.1 Biographical factors

The study concluded that there is some bias in the nursing profession, which is inclining towards women. This means the nursing profession is dominated by females. It is recommended that nurses should not be discriminated according to gender and more male nurses be recruited.

5.4.2 Infrastructure

Roads

Findings of this study indicate that there is generally poor infrastructure in terms of access roads. Therefore, it is recommended that access roads be constructed to make it easy for nurses and patients to travel to and from the clinics.

Water and electricity

A number of clinics have challenges in relation to supply and access to water. It is recommended that services such as water and electricity should be available at all times so as to enable the clinics to function effectively. For instance, they can buy a reservoir tank or drill boreholes. This will ensure that there is adequate water for the clinics and the nurses' houses at all times. To make provision for power cuts, they can install renewable energy sources (solar systems).

5.4.3 Telecommunication

It was found out that there is poor telecommunication infrastructure in the rural areas. The Ministry of Health should install telephones for all the clinics to enhance communication. The Ministry can also liaise with telecommunication and mobile companies in the country to improve the infrastructure and network access.

5.4.4 Safety

The study revealed that most nurses are concerned about the safety and security issues. It is highly recommended that the Ministry of Health put in place measures that will improve safety and security at clinics. For example they can put a fence around the compound or recruit security guards. This issue also relates to accommodation. It is therefore recommended that the Ministry also improves accommodation or housing by repairing broken windows and doors.

5.4.5 Quality of accommodation

It was found out that the quality of accommodation was one of the main concerns and was generally poor in all the nine clinics. It is recommended that the Ministry of Health address the concerns of the nurses with regard to the number and quality of accommodation. Additional houses may be built in order to provide privacy and accommodate nurses and their families.

5.4.6 Workloads and Staffing levels

It is further recommended that the issues concerning staffing levels should be addressed and dealt with. At national level the Government of Lesotho should ensure that there is adequate number of trained nurses. They should ensure that there are

strategies in place to sustain the retention plans and attract prospective nurses. Furthermore, the Ministry of Health should consider the findings of the Health Workforce Optimisation Analysis because it serves as a guide to overcome the workload and staffing level issues.

5.4.7 Administration of clinics

The research revealed some inefficiencies caused by dual administration of the clinics shared by the Ministry of Health and Partners in Health. The management from both organisations is recommended to devise plans and strategies to defeat the challenges brought about by the dual administration. This will avoid minor conflicts between the nurses, ensure proper allocation of duties at the clinics, and enhance service delivery.

5.4.8 Training and development

The Ministry of Health should address the shortcomings with regard to training and development. Relevant development programmes, training, or workshops should be organised regularly so as to equip nurses with adequate skills and competencies.

5.4.9 Equipment and medicine supplies

In order to enhance the health care service delivery, it is recommended that the clinics should keep adequate medicine supplies at all times. In addition, medical equipment should be in good condition and serviced regularly.

5.4.10 Remuneration

As discussed already, inadequate remuneration and other related incentives have a negative effect on the turnover of nurses. Therefore, it is recommended that nurses should be paid appropriate salaries. In addition, the Government should continue to pay or have a sustainability plan in place for payment of the retention allowance the embassy funded initially, even after the expiration of the funding.

5.4.11 Retention package

To attract more nurses and retain existing ones, it is recommended that the Ministry of Health should fully implement the retention allowance. All outstanding components of the retention allowance for instance the gas, should be bought and allocated to the nurses at the rural clinics.

5.4.12 Budgetary constraints and financial support

It was observed that there are budgetary constraints and insufficient funding to support the functioning of the clinics. The Ministry of Health should therefore allocate adequate funds and have realistic annual budgets for the clinics. This will avoid any monetary or financial constraints, and the clinics will be run efficiently and effectively.

5.5 LIMITATIONS OF THE STUDY

Perceived limitations and criticisms are associated with the qualitative exploratory method of this study. Bryman & Bell (2007) criticise qualitative research and explain that it involves high subjectivity and absence of transparency, and that it is hard to understand why and how conclusions were reached. Other limitations were experienced due to the dispersed geographical location of the rural clinics, and there were logistical problems to reach the clinics. Travelling to the clinics to gather information required an aircraft, which was affected negatively by the adverse weather conditions in the country during winter. Data collection was done in July, during the peak of the winter season, and it is usually very cold and snowy in Lesotho during that time, particularly in the mountainous areas where these nine clinics are situated. This impeded the flight schedule of the aircraft to the selected rural clinics, which made it difficult to stick to the travelling schedule. More than nine clinics in Lesotho are classified as rural clinics; consequently, the limited number of participants or the small sample size for this study, which excluded other rural clinics but concentrated only on the nine clinics under LFDS management, implies certain constraints. Additional limitations that hindered progress include the time frame for gathering relevant data, which was approximately two months. Some key informants had busy schedules; therefore, it was not easy to secure interview appointments with them, and possible difficulties in accessing confidential information from the Ministry of Health also had to be dealt with. In the section below, a brief layout of the chapters is provided, the main findings of each chapter are discussed, and the overall conclusion of the field study is given.

5.6 CONCLUSION

Chapter 1 lays the foundation of this field study and discusses the background of the nine selected clinics and the country in which they operate, Lesotho. It highlights the primary and secondary objectives and then describes the preliminary literature review of the research.

Chapter 2 presents the comprehensive theoretical review of factors affecting the turnover of nurses as described by different authors. In the chapter, various authors provide definitions and models of turnover and discuss challenges and consequences of turnover in the nursing profession. All of these are used to generate the interview questions given in Appendix 1.

Chapter 3 describes the qualitative exploratory design. In addition, it identifies semi-structured interviews as the data-collection method and the purposive non-probability sampling techniques for this field study. The population and the sample size are defined in this chapter, as well as the content analysis method that is used to analyse data collected.

Chapter 4 focuses on the findings of the study. Data collected are analysed thoroughly and compared with references in the literature review discussed in Chapter 2. Three themes are identified to present the findings, and it is established that nurses working at the rural clinics experience a number of challenges that have a negative effect on turnover. It is found that, although the demographic aspects could affect the turnover of nurses, it is to a lesser extent in comparison with other factors discussed in the previous chapter.

Finally, Chapter 5 presents the conclusions and recommendations, all of which are based on the findings in Chapter 4 and the literature review in Chapter 2. The chapter concludes by discussing the limitations of the study.

In sum, the turnover of nurses, particularly with regard to those working in the rural areas, can affect the quality of services in the nursing profession negatively. A number of factors, consequences, and challenges may hamper nurses' work at the remote clinics. However, management can overcome such challenges and achieve its objectives by implementing the above-mentioned recommendations.

REFERENCES

- Adezi, F. A. & Atinga, R. A. (2012). Motivation and retention of health workers in Ghana's district hospital: Addressing critical issues. *Journal of Health Organisation and Management*, 26(4), 467-485.
- African Peer Review Mechanism (2010). *Kingdom of Lesotho Country Review Report No. 12, June 2010*. Retrieved from http://aprm-au.org/sites/default/files/cr12_lesotho_eng2010.pdf
- American Association of Colleges of Nursing (2014). Nursing shortage. Retrieved from <http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-shortage>
- Annual Joint Review Report (2012). Health Planning and Statistics Department, Ministry of Health. Government of Lesotho.
- Armstrong, M. (2009). *A handbook of human resource management practice* (11th ed.). London: Kogan Page.
- Arnold, H.J., & Feldman, D.C. (2006). A multivariate analysis of the determinants of job turnover. *Journal of Applied Psychology*, 67(3), 350-60.
- Australian College of Nursing (2007). *Becoming a nurse or midwife* Retrieved from www.nurseinfo.com.au/becoming/becominganurse.
- Baffour, A. P., Rominski, S., Nakua, E., Gyakobo, M. & Lori, J. (2013). Factors that influence midwifery students in Ghana when deciding where to practice: a discrete choice experiment. *BMC Medical Education*. Retrieved from www.biomedcentral.com/1472-6920/13/64
- Barron, P. & Roma-Reardon, J. (2008). *Health Review*. South African. Durban: Health Systems Trust; 2008
- Bratt, M.M., Broome, M., Kelber, S. & Lostocco, L. (2009). Influence of stress and nursing leadership on job satisfaction of pediatric intensive care unit nurses. *American Journal of Critical Care*, 9(5), 307-317.

- Broda, W. (2006). Event Marketing in IMC. *Research Methodology. Qualitative vs quantitative research*. Retrieved from http://catarina.udlap.mx/u_dl_a/tales/documentos/bce/erlenmaier_vs/capitulo3.pdf
- Bryman, A., & Bell, E. (2007). *Business research methods* (2nd ed.). New York: Oxford University Press Inc.
- Buchan, J. & Aiken, L. (2008). Solving nursing shortages: a common priority. *Journal of Clinical Nursing, 17*(24), 3262-3268.
- Burns, N., & Grove, S. K., (2011). *Understanding nursing research: Building an evidence-based practice* (5th ed.). United States: Elsevier Inc.
- Chartered Institute of Personnel and Development – CIPD (2008). Recruitment retention and turnover. *Annual Survey Report, 2008*.
- Cooper, R. D. & Schindler, P.S. (2011). *Business research methods* (11th ed.). New York: McGraw-Hill Companies Inc.
- Da Costa, M. (2007). "Private hospitals debate turns to utilisation". *Healthcare Review, 2*(1), 29-30.
- De Gieter, S. D. (2011). Revisiting the impact of job satisfaction and organisational commitment on nurses' turnover intention: An individual differences analysis. *International Journal of Nursing Studies, 48*(12), 1562-1569.
- Delgado, C. & Gutierrez, O. (2007). *Research Methodology*. Retrieved from http://catarina.udlap.mx/u_dl_a/tales/documentos/bce/erlenmaier_vs/capitulo3.pdf
- Department of Health (DOH) (2006). A national human resources plan for health. Retrieved from: www.doh.gov.za/docs/policy-f.html
- Dovlo, D. (2007). Migration of nurses from sub-Saharan Africa: A review of issues and challenges. *Health Services Research, 42*(3), 1373-1388.
- Duffield, C. & O'Brien-Pallas (2003). The causes and consequences of nursing shortage: a helicopter view of the research. *Australian Health Review, 26*(1), 192-199.

- Embassy of Ireland, Maseru (2008). *Irish Aid: Country Strategy Paper (CSP)*, 2008-2012.
- Embassy of Ireland, Maseru (2011). *Financing Agreement between Government of Ireland and Government of Lesotho on a strategy for establishment, recruitment, deployment, retention and financing of 257 nurses.*
- Embassy of Ireland, Maseru (2012). *Addendum on the Financing Agreement between Government of Ireland and Government of Lesotho on a strategy for establishment, recruitment, deployment, retention and financing of 257 nurses for the period 1st November 2012 to 31st March 2014.*
- Gow, K., Warren, C., Anthony, D., & Hischen, C. (2008). Retention and intentions to quit among Australian male apprentices. *Education and Training*, 50(3), 216-230.
- Greenwood, B. (2014). Challenges of a first-line nurse manager. *Everyday Life – Global Post*. Demand Media. Retrieved from www.everydaylife.globalpost.com/challenges-firstline-nurse-manager-13635.html
- Grieffeth, R., & Hom, P. (2007). The development of a casual model of voluntary turnover – James Price. *Innovative Theory and Empirical Research on Employee Turnover. Information Age Publishing (IAP)*, 1(1), 3-32. Retrieved from: www.infoagepub.com/products/downloads/html/1-59311-097-9.php
- Grobler, P., Warnich, S., Carrell, M. R., Elbert, N. F. & Hatfield, R. D. (2011). *Human resource management in South Africa* (4thed.). London: Cengage Learning.
- Grobler, P., Warnich, S., Carrell, M. R., Elbert, N. F., & Hatfield, R. D. (2006). *Human resource management in South Africa* (3rded.). London: Thompson Learning.
- Harmon, L. M. (2013). Rural model dedicated education unit: Partnership between college and hospital. *Journal of Continuing Education in Nursing*, 44(2): 89-96.
- Hayes, L.J., O'Brien-Pallas, L., Duffield, C., Shamian, J., Buchan, J., Hughes, F., Heather, K., Laschinger, S., North, N., & Stone, P.W. (2006). Nurse turnover: A literature review. *International Journal of Nursing Studies*, 43(1), 237-263.
- Health Workforce Optimisation Analysis (2014). Optimal health worker allocation for health facilities in Lesotho. Ministry of Health.

- Hecimovich, M. (2011). Development of professional confidence in health education. Research evidence of the impact of guided practice into the profession. *Health Education, 111*(3), 177-197.
- Human Resources Needs Assessment - HRNA (2002). Study Design. Medical Care Development International. Lesotho Human Resources Consultancy.
- IRIN (2011). *Lesotho's ailing public health system*. Retrieved from www.gurdian.co.uk/global-development/2011/oct/07/lesotho-ailing-public-health-system
- Jones, C.B. (2005). Costs of nurse turnover, Part 2: Application of nursing turnover cost calculation methodology. *The Journal of Nursing and Administration, 35*(1), 41-49.
- Joseph, K., Rigodon, J., Cancedda, C., Haidar, M., Lesia, N., Ramagoaela, L., & Furin, J. (2012). AIDS patient care and STDs: Lay health workers and HIV care in rural Lesotho. *A Report from the Field, 26*(3), 141-148.
- Kash, B. A., Naufal, G. S., Dagher, R. K. & Johnson, C. E. (2010). Individual factors associated with intentions to leave among directors of nursing homes. *Health Care Management Review, 35*(3), 246-255.
- Keahey, S. (2008). Against the odds: Orienting and retaining rural nurses. *Journal for Nurses in Staff Development, 24*(2), 15-20.
- Keane, S., Lincoln, M., & Smith, T. (2012). Retention of allied health professionals in rural New South Wales: A thematic analysis of focus group discussions. Retrieved from www.biomedcentral.com/1472-6963/175
- Kreitner, R., & Kinicki, A. (2010). *Organisational behaviour* (9th ed.). New York: McGraw-Hill Companies, Inc.
- Langen A.D. (2009). *Research Design and Methodology. Chapter 3*. Retrieved from <http://uir.unisa.ac.za/bitstream/handle/10500/1796/04Chapter3.pdf?sequence=5>
- Lea, J., & Cruickshank, M. (2005). Factors that influence the recruitment and retention of graduate nurses in rural health care facilities, *12*(2), 22-27.

- Lesotho HRH News (2013). Minister of Health launches retention packages for nurses and midwives working in hard-to-reach areas. *News bulletin issued by Human Resources Alliance for Africa Project April – June 2013*, 1(1), 1-12.
- Lesotho Nursing Initiative (2011). Global Health Workforce Alliance. Retrieved from <http://www.who.int/workforcealliance/forum/2011/hrhawardscs30/en/index.html>
- Lesotho Times (2010). Lesotho nurses strike over low wages, poor working conditions.
- Lesotho Times (2014). Health college shut down over M1,000.
- Leurer, M.D., Donnelly, G., & Domm, E. (2007). Nurse retention strategies: Advice from the experienced registered nurses. *Journal of Health Organisation and Management*, 21(3), 307-319.
- Lobato, D. (2008). *Chapter 3. Post-positivist perspectives on theory development*. Retrieved from: <http://davidlobato.wordpress.com/2008/09/14/chapter-3-post-positivist-perspectives-on-theory-development>
- Lu, H., While, K., & Barriball, L. (2005). Job satisfaction among nurses: A literature review. *International Journal of Nursing Studies*, 42(1), 211-227.
- Malatsi, I., Decock, R., Depooter, A. M., Delobelle, P., Rawlinson, J. L. & Ntuli, S. (2011). Job satisfaction and turnover intent of primary healthcare nurses in rural south Africa: a questionnaire survey. *Journal of Advanced Nursing*, 67(2), 371-83.
- Manafa, G., McAuliffe, E., Maseko, F., Bowie, C., MacLachlan, M. & Normand, C. (2009). Retention of health workers in Malawi: perspectives of health workers and district management. *Human Resources for Health*. Retrieved from <http://www.human-resources-health.com/content/7/1/65>
- Matjila, N.N. (2006). Staff turnover of health professionals in the Bophirima Health District. Record 23. Database: Africa-Wide Information. Retrieved from <http://web.ebscohost.com/ehost/delivery?sid=e339922b-b18d-4e45-9884-8c1bc22dbfbc@sessionmgr115&vid=10&hid=120>
- McBey, K., & Karakowsky, L. (2011). Examining sources of influence on employee turnover in the part-time work context. *Leadership & Organisation Development*

Journal, 21/3, 136-144. Retrieved from http://www.emeraldinsight.com/content_images/fig/1370110306001.png

Miles, M. B. & Huberman, A. M. (2013). *Qualitative data, analysis, and design*. Retrieved from http://www.sagepub.com/upm-data/43144_12.pdf

Mills, J., Birks, M., Hegney, D., & Collegian (2010). The status of rural nursing in Australia: 12 years on. *International Journal of Nursing Practice*, 17(1), 30-37.

Mills, J., Francis, K., & Bonner, A. (2007). Live my work: rural nurse and their multiple perspectives of self. *Journal of Advanced Nursing*, 59(6), 583-90.

Ministry of Health and Social Welfare (2004). *Lesotho Health Sector Human Resources Development and Strategic Plan 2005-2025*.

Ministry of Health (2010). *Report of the impact assessment on nursing initiative in Lesotho*.

Ministry of Health (2012). *Annual Joint Review 2011/12*, Ministry of Health.

Ministry of Health (2013). *Proposal for continuing activities in 2013*.

Minore, B., Boone, M., Katt, M., Kinch P., Birch S., & Mushquash C. (2005). The effects of nursing turnover on continuity of care in isolated first nation communities. *Canadian Journal of Nursing Research*, 37(1), 86-100.

Mohale, M.P., Mulaudzi, F.M. & Phil, D. L. (2008). *Experiences of nurses working in the rural primary health-care setting in Mopani District, Limpopo Province*, 312, 60-66. Retrieved from: <http://www.curationis.org.za/index.php/curationis/article/viewFile/984/921>

Molinari, D.L., & Monserud, M.A. (2008). Rural nurse job satisfaction. *Rural Remote Health*, 8(4), 1055. Retrieved from: www.ncbi.nlm.nih.gov/pubmed/19061306

Montour, A., Baumann, A., Blythe, J., & Hunsberger, M. (2009). The changing nature of nursing work in rural and small community hospitals. *Rural & Remote Health*, 9(1), 1089.

Mrayyan, M.T. (2009). Differences of hospitals' organisational climates and nurses' intent to stay: Nurses' perspectives. *Journal of Research in Nursing*, 14(5), 465-477.

- Mullei, K., Masamo, E., Blaauw, D., Goodman, C., Mudhune, S., Wafula, J., Lagarde, M, & English, M. (2010). Attracting and retaining health workers in rural areas: Investigating nurses' views on rural and policy interventions. *BMC Health Services Research*. Retrieved from www.biomedcentral.com/1472-6963/10/S1/S1
- Mwase, T., Kariisa, E., Doherty, J., Khotle, N.H., Mukiibi, P.K., & Williamson, T. (2010). *Lesotho Health Systems Assessment 2010*. Retrieved from www.healthsystems2020.org
- Nangameta, J. (2010). Literature review on labour turnover and retention strategies. Retrieved from www.academia.edu/5086398/Literature_review_on_labour_turnover_and_retention_strategies
- National Health and Social Welfare Policy (2011). Ministry of Health and Social Welfare, Government of Lesotho.
- Noor, M. K. B. (2008). "Case study: A strategic research methodology. *American Journal of Applied Sciences*, 5(11), 1602-1604.
- Ntlale, M.E., & Duma, S.E. (2012). Costs and benefits of nurse migration on families: A Lesotho experience Retrieved from www.ncbi.nlm.nih.gov/pubmed/23327715
- O'Brien-Pallas, L., Murphy, G. T., Shamian, J., & Hayes, L.J. (2010). Impact and determinants of nurse turnover: A pan-Canadian study. *Journal of Nursing Management*, 18(1), 1073-1086.
- Oloresisimo, D. C. (2013). *Lydia Hall's nursing theory: Core, care and cure model for geriatric care*. Retrieved from www.rnspeak.com/fundamentals-of-nursing/lydia-halls-nursing-theory-core-care-and-cure-model-for-geriatric-care/
- Oosthuizen, M.J. (2009). An analysis of the factors contributing to the emigration of South African nurses. Retrieved from <http://umkn-dsp01.unisa.ac.za/handle/10500/2273>
- Padarath, A. & Pagett, C. (2007). A review of codes and protocols for the migration of health workers. Health Systems Trust.

- Pillay, R. (2007). Retention strategies for professional nurses in South Africa. *Leadership in Health Services*, 22(1), 39-57.
- Ramani, S., Rao, K.D., Vujcic, M., & Berman, P. (2013). For more than love or money: attitude of student and in service health workers towards rural service. *Human Resources for Health*. Retrieved from www.human-resources-health.com/content/11/1/58
- Retention Strategy for Health Workforce (2010). Ministry of Health and Social Welfare, Government of Lesotho.
- Robin, J. B. (2009). Application of the nursing process in a clinical mentoring experience in Lesotho, Africa. *Health Care Management and Practice*, 22(5), 349. EBSCO Electronic Journal Services. Retrieved from www.hhc.sagepub.com
- Songstad, N.G., Moland, K.M., Massay, D.A., & Blystad, A. (2012). Why do health workers in Tanzania prefer public sector employment? Retrieved from www.biomedcentral.com/172-6963/92
- Southern Maine Community College (2012). *Program philosophy and conceptual model*. Retrieved from: https://my.smccme.edu/ics/Academic_Departments/Nursing/
- Stilwell, B., De Waal, A., Solimano, G. & Sewankambo, N. (2004). Human Resources for Health: overcoming the crisis. Public Health. *The Lancet Journals*, 364(9449), 1984-1990.
- Swanepoel, B., Erasmus, B., Van Wyk, M., & Schenk, H. (2005). *South African human resource management theory and practice* (3rd ed.). Juta & Co Ltd.
- Tevington, P. (2011). Mandatory nurse-patient ratios. *MedSurg Nursing*, 20(5), 265-267. Retrieved from: https://www.amsn.org/sites/default/files/documents/practice-resources/healthy-work-environment/resources/MSNJ_Tevington_20_05.pdf
- Thomson, S. B. (2011). Sample Size and Grounded Theory. *Journal of Administration & Governance (JOAAG)*, 5(1), 1-5.
- Thupayagale, T. G. (2007). 'Migration of nurses: Is there any option?' *International Nursing Review* 54(1), 107-109.

- Tourangeau, A.E., Hall, L. M., Doran, D. M., & Petch, T. (2006). Measurement of nurses' job satisfaction using the McCloskey/Mueller Satisfaction Scale. *Nursing Research*, 55(2), 128-136. Retrieved from www.researchgate.net/publication/7177454_Measurement_of_nurse_job_satisfaction_using_the_McCloskey/Mueller_Satisfaction_Scale
- UNESCO (2014). *Module A2: Data collection and quality control*. Retrieved from <http://www4.unescobkk.org/education/efatraining/module-a2/3-a-general-introduction-to-data-collection/#top>
- Van der Heijden, B.M., Van Dam, K. & Hasselhorn, H.M. (2009). Intention to leave nursing: The importance of interpersonal work context, work-home interference, and job satisfaction beyond the effect of occupational commitment. *Emerald, Career Development International*, 14(7), 616-635 Retrieved from www.emeraldinsight.com/journals.htm?articleid=1826854&show=html
- Vance, D.E. (2011). Nursing around the world: A perspective in growing concerns and the shortage of care. *Nursing Research and Reviews*, 1(1), 9-14.
- Vincent, S., & Dunton, N. (2012). Hospital and unit characteristics associated with nursing turnover including skill mix but not staffing level: An observational cross-sectional study. *International Journal of Nursing Studies*, 49(9), 1138-1145.
- Wall, S. (2010). Critical perspectives in the study of nursing work. *Emerald, Journal of Health Organisation and Management*, 24(2), 145-166.
- Wilson, N., Couper, I., De Vries, E., Reid, S., Fish, T. & Marias, B. (2009). A critical review of interventions to redress the inequitable distribution of healthcare professionals to the rural and remote areas. *Rural & Remote Health; Academic Journal*, 9(2), 1. Retrieved from <http://connection.ebscohost.com/c/articles/44369915/critical-review-interventions-redress-inequitable-distribution-healthcare-professionals-rural-remote-areas>
- World Health Organisation (2011). Ministry of Health and Social Welfare and Clinton Health Access Initiative (2011): *Lesotho Nursing Initiative*. Retrieved from www.who.int/workforcealliance/forum/2011/hrhawardscs30/en/index.html

Zurn, P., Stilwell, B., & Dolea, C. (2005). *Nurse retention and recruitment: Developing a motivated workforce*. Retrieved from <http://www.icn.ch/images/stories/documents/publications/GNRI/Issue4Retention.pdf>

APPENDICES

APPENDIX 1: MINISTRY OF HEALTH-ETHICS COMMITTEE APPROVAL



Ministry of Health
PO Box 514
Maseru 100

07 April 2014

Sekhametsi 'Masestoto Matamane

UFS/
Irish Embassy
Maseru 100

Dear **Sekhametsi 'Masestoto Matamane**

Re: Factors affecting turnover of nurses in rural clinics of Lesotho (ID74-2014)

Thank you for submitting the above mentioned proposal. The Ministry of Health, Research and Ethics Committee having reviewed your protocol hereby authorizes you to conduct this study among the specified population. The study is authorized with the understanding that the protocol will be followed as stated. Departure from the stipulated protocol will constitute a breach of the permission.

We are looking forward to have a progress report and final report at the end of your study.

Sincerely,

Handwritten signature of Dr. Piet McPherson in black ink.

Dr. Piet McPherson
Director General Health Services (acting)

Handwritten signature of Dr. Jill Sanders in blue ink.

Dr. Jill Sanders
Co-Chairperson
National Health Research and
Ethics Committee

APPENDIX 2: INTERVIEW QUESTIONS

Factors Affecting Turnover of Nurses in Rural Clinics of Lesotho

These interview questions are meant to address the problem statement and then respond to both the primary and secondary research questions which are linked to the objectives of the study.

The primary and secondary objectives of the field study are shown below:

The primary objective of the study is to establish the factors affecting turnover of nurses in the nine rural clinics in Lesotho that are under the management of the Lesotho Flying Doctors Services.

Information collected in this research will be used to answer research questions related to the following secondary objectives:

- To determine whether the level of job satisfaction can impact on nurses’ turnover in rural clinics in Lesotho;
- To investigate if the individual and organisational factors have an effect on turnover of nurses in the rural clinics in Lesotho;
- To determine if the monetary factors influence turnover of nurses in the nine rural clinics of Lesotho;
- To examine whether there are any challenges and consequences related to turnover of nurses in rural clinics of Lesotho.

In order to meet the objectives of this research, the interview questions will assess what factors are affecting turnover of nurses in the rural clinics of Lesotho. The questions are grouped into five areas as shown below and the participants will be requested to sign the attached consent form prior to interviews (attached below).

1. Individual factors

Age.....Gender.....

Marital status.....Number of children.....

Education level.....Work experience.....

Any rural experience during training.....

Current position held.....

Nationality.....Current salary.....

2. Job satisfaction

- How do you feel about your job?
- What are the job challenges/influences?
- Describe the relationship with your colleagues, supervisor, patients and the community?

3. Organisational factors

- Discuss your work schedule, shifts or workload?
- In your mind, is there adequate staffing level at the clinic and what are the competencies of staff?
- What are the promotional or training and development opportunities available for nurses?
- Describe the condition of the medical equipment? In your mind, do you feel there are adequate medicinal supplies/stocks at the clinic?
- What are the policies and procedures that guide you?

4. Monetary factors

- Discuss the attractiveness of the salaries or remuneration including the incentives or bonuses available for nurses in relation to the workload or your qualifications?
- Discuss the financial support required to enable execution of all duties related to the clinic? What are the budgetary constraints affecting the clinic?

5. Non-monetary factors

- Describe the availability of infrastructure in the area where the clinic is located, including the quality of safety and accommodation?

APPENDIX 3: CONSENT FORM

Study title: Factors affecting Turnover of Nurses in Rural Clinics of Lesotho

Principal Investigator: Sekhametsi Matamane

Institution: University of Free State (UFS)

Degree Level: Masters in Business Administration (MBA)

Invitation

You are being invited to take part in the study on factors affecting turnover of nurses in the rural clinics of Lesotho. Please read this form carefully and ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Before you decide, it is important for you to understand why the research is being done and what it will involve.

What is the purpose of the study?

The purpose of *the* study is to establish the factors affecting turnover of nurses in the nine rural clinics in Lesotho that are under the management of the Lesotho Flying Doctors Services.

How we will proceed?

If you agree to take part in this study, I will conduct an interview with you. The interview will include questions about your job, the challenges, and relationships with colleagues and management, policies that govern you, medical equipment used, your remuneration, your development at work, quality of accommodation and any infrastructure at clinics. The interview will take about 20 minutes to complete. With your permission, I will tape-record the interview and take some notes.

Why have you been selected?

You have been selected because of your experiences in working in the rural clinics as a nurse or because your experiences in working with the rural nurses are relevant and important for this field study. I intend to interview people who are directly involved in working with the clinics in the rural areas of Lesotho. Interviews will be individual, while others in groups.

Voluntary Participation

It is completely voluntary to take part in this study. If you decide to take part, you may leave out any questions that you feel you do not wish to answer. If you decide to take part you are free to withdraw at anytime even without providing reasons. Withdrawal from the study will not affect your current or future employment.

Confidentiality

Your responses to the interview questions will be confidential. All records of this study will be undisclosed and kept in a locked file; only the researcher will have access to those records. Tape- recorded interviews will be destroyed after transcription, at least after two months of taping. The final report will be made available to the Ministry of Health in Lesotho and no information will be included that will make it possible to recognise you even if the report is published.

What are the risks and benefits?

If you take part in this study I do not expect any risks to you other than those encountered daily in life and there are no benefits to you.

Who provided the ethical clearance of this study?

I have sought ethical clearance and an approval to conduct this study from the Research and Ethics committee in the Ministry of Health, Lesotho.

For further information contact:

Myself, Sekhametsi Matamane as the principal investigator at 58853079 or send me an email at sekha.mokone@gmail.com. If you have any concerns regarding the conduct of this study or your rights please contact: Research and Ethics committee, Ministry of Health, Headquarters, 2nd Floor, Maseru.

Statement of Consent:

I/We have read the above information, and I/We consent to take part in the study. I/We understand that my/our actual name(s) will not be used in any published report, without my/our authorisation and that I/we are free to withdraw from the study at any time, even without giving reasons. In addition, I/We also consent to having the interview tape-recorded.

Name(s): _____

Signature(s): _____ Date _____

Name of person obtaining consent: _____ Date _____

Signature of person obtaining consent: _____ Date _____