HEALTH POLICY IMPLEMETATION CHALLENGES IN THE CAPRICORN DISTRICT, LIMPOPO PROVINCE, SOUTH AFRICA

MASTER OF PUBLIC HEALTH (MPH)

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2011

HEALTH POLICY IMPLEMETATION CHALLENGES IN THE CAPRICORN DISTRICT, LIMPOPO PROVINCE, SOUTH AFRICA

by

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RESEARCH DISSERTATION

Submitted in fulfillment of the requirements for the degree of

MASTER OF PUBLIC HEALTH

In the

FACULTY OF HEALTH SCIENCES
(School of Public Health)

At the

UNIVERSITY OF LIMPOPO

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CO-SUPERVISOR: Dr F Tladi

2011

DECLARATION

I declare that the mini-dissertation hereby submitted to the University of Limpopo, for the degree of Master of Public Health and field of research has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

---------- Date: 2011 February 21

Mr/MS: Baloyi Jimmy Patric

[redacted]

DEDICATION

This dissertation is dedicated to my family, especially my wife P.M Baloyi and children Nhlamulo, Conny, Ntsako, Ntwanano, Matimba, my friends, my brothers and sisters, and my colleagues for their support and encouragement.

ACKNOWLEDGEMENTS

Special thanks to the following:

- Mrs Olwagen who provided expertise and knowledge on analyzing data.

- Dr F Tladi who also provided expertise and knowledge in this study.

- Dr P.K Chauke who also provided knowledge and expertise in this study.

- In particular I would like to acknowledge the important support from my supervisor, Dr MBL Mpolokeng, without whom this research project would never have succeeded.

- The Department of Health and Social Development for granting me the permission to collect data in the Capricorn District Hospitals.

- The management of Capricorn District Hospitals for unselfishly participating in my research study.

ABSTRACT

Since 1994, the post apartheid government and the Department of Health have developed and implemented a number of policies and pieces of legislation that impacted directly and indirectly on the delivery of health services such as the general public health, health personnel, financial matters, transportation of medicines and foodstuffs. These policies were timeously received by the hospitals from National Office, Provincial Departments and Local Government, but were not implemented due to numerous challenges.

This study explores the health policy implementation challenges facing implementers in the public health sector in the Capricorn district in Limpopo that constrain them from rendering their managerial functions effectively and thus, impact negatively on policy implementation and service delivery. The objective of the study is to explore the challenges with a view of describing the nature and causes of the challenges, explore and document them, develop suggestions for minimizing these challenges and subsequently suggesting possible solutions.

The study focused on the Capricorn district in Limpopo Province. The district is the biggest among the five districts and has eight functional hospitals which are under the leadership of Chief Executive Officers (CEO). The researcher used both qualitative and quantitative (mixed) research methods. The methodology entailed the distribution of self-administered questionnaires containing closed and open ended questions to the management of Capricorn district hospitals.

The results obtained in this study revealed that there are numerous challenges that constrain policy implementers from implementing health policies effectively and efficiently in their work environments. These challenges range between poor incentives, lack of equipment, lack of office space, lack of dedicated transport for outreach, budget constraints, shortage of resources – human and physical, lack of career mobility, poor working conditions, communication problems and poor supervision style. These challenges impact negatively on policy implementation.

It is therefore recommended that the comprehensive strategy to maximize the health workers' motivation in the health sector has to involve a mix of financial and non-financial incentives, the provincial department of health and Social Development should open some communication lines with the service providers at grass root level in order to address some of the issues before they become chronic challenges, there should also be regular meetings where feedback about provincial and national issues are addressed to the service providers. The current system of dissemination of information from the province and national government to the hospitals is apparently not clear.

DEFINITION OF CONCEPTS

- Policy: A statement of intent that articulates basic principles to be pursued in order to attain specific goals and actions (Brynard, 2000).

- Batho Pele Priciples: People first. Citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered (Human Resource Development Strategy for the public service, 2002-2006).

- Oral Health Policy: South African (SA) oral health strategy that aims at improving the oral health of the SA population by promoting oral health and to prevent, appropriately treat, monitor and evaluate oral diseases (Government Gazette, Vol. 421, No. 21409, 28 July 2000).

- Radiation Control Policy: Policy that ensures that, employees, users, visitors, general public and the environment should be protected from exposure to accelerator-generated prompt ionizing radiation (Hazardous substances Act No. 15 of 1973).

- Capricorn District: One of the (sixth) districts in Limpopo (Department of Health & Social Development annual performance plan, health vote 7, 2005-06; 2007-08).

- Occupational Health & Safety: Regulation containing legal requirements that must be met (adhered to) by all workplaces under the inspection jurisdiction of work-safe (Government Gazette, Vol. 421, No. 21409, 28 July 2000).
- Smoke Free Policy: Policy regulating smoking in public and workplaces. The constitution guarantees people a constitutional right of non smoking environment.

- White Paper on the Transformation of the Health System: Present to the people of South Africa (SA) as a set of policy objectives and objectives and principles upon which the unified national health system of SA is based, and the various implementation strategies designed to meet the basic needs of all citizens with limited resources (Human Resources in South African Health Care System, 2006).

ABBREVIATIONS

- Legislation: Law making body
- CEO: Chief Executive Officer
- DOH: Department of Health
- DPSA: Department of Public Service and Administration
- PFMA: Public Finance Management Act
- HIS: Health Information System
- HRM: Human Resource Management
- HR: Human Resources
- HRD: Human Resource Development
- HPCSA: Health Professions Council of Southern Africa
- HRSC: Human Science Research Council
- HOD: Head of Department
- NGO: Non Governmental Organization
- OPD: Out Patient Department
- SETA: Sector Education & Training Authority
- STI: Sexually Transmitted Infections
- TPA: Transvaal Provincial Administration
- MDR TB: Multi Drug Resistant Tuberculosis
- PPP: Private-Public Partnership
- FET: Further Education and Training
- SA: South Africa

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CHAPTER 1

1.1 INTRODUCTION

This chapter focuses on the introduction, background information, problem statement, research question, hypothesis, aim of study, objectives of the study, organization of the subsequent chapters, as well as the conclusion.

1.2 BACKGROUND INFORMATION

This study emanates from the perceived need to investigate the policy implementation challenges facing health policy implementers in the public health sector in the Capricorn district in Limpopo that constrain them from rendering their managerial functions efficiently, and thus impact negatively on policy implementation and service delivery.

Since 1994, the post apartheid government and the Department of Health have developed a number of policies and pieces of legislation that impact directly and indirectly on the delivery of health services. South Africa has some of the world's best policies, however, it is sometimes difficult with the implementation (Couper, 2000: 277-292).

Numerous policy documents are timeously received by the hospitals from National Office, Provincial Departments and Local Government, but most of these policies have not been implemented. These policies have a bearing on the delivery of health services, general public health, health personnel, financial matters, transportation of medicines and foodstuffs (Couper, 2000: 277-292).

In response the policy implementers have tried to ease the impact of human resource and budgetary issues by embarking on cost reduction programs. The result of these programs have been restructuring the institutions, cuts in budgets, and even not filling non critical posts. As posts became vacant, upper-level management pressurized line managers to accomplish the same amount of work with fewer resources, either improving efficiency

or by upgrading performance requirements to a higher position on the learning curve (Blaauw et al, 2003: 65).

One point noteworthy is that personnel costs are more inflationary than the cost of equipment or facilities (Fourie, 1999: 17). There has also been a huge staff turnover over the past decade in the Capricorn district. The majority of the personnel who were recruited and resigned at the end of the year, were health professionals (Couper et al, 2000 125-129). There was no research conducted about this problem. This research, therefore, aims to explore the policy implementation challenges that constrain policy implementers from executing their management functions in the Capricorn district, in Limpopo.

The district is the biggest among the five districts and has eight functional hospitals which are under the leadership of Chief Executive Officers (CEO) whose key functions are, inter-alia, planning, organizing, staffing, leading, controlling, budgeting, policy formulation, policy analysis and monitoring the implementation of such policies within their institutions (Shannon, 2003: 361-618).

1.3 PROBLEM STATEMENT

The researcher has noted with concern that the health policy implementers in the Capricorn district are facing several challenges in their work environment that constrain them from rendering the managerial functions effectively. The biggest challenge is human resource problem and has a negative impact on policy implementation. Some hospitals in Limpopo are being threatened to be closed-up due to the non-implementation of polices. For example, non-compliance to the occupational health and safety and the radiation control policies.

1.4 RESEARCH QUESTION

What are the challenges facing policy implementers in the public health sector in the Capricorn district in Limpopo?

1.5 HYPOTHESIS

Health policy implementers in the Capricorn district face challenges that constrain them from rendering their managerial functions efficiently.

1.6 AIM OF STUDY

The aim of the study is to investigate the challenges faced by the health policy implementers in the public health sector in the Capricorn district.

1.7 OBJECTIVES OF THE STUDY

1.7.1 To identify the causes and challenges that constrain the implementation of health policy,

1.7.2 To assess the impact of these challenges on policy implementation and,

1.7.3 To identify strategies and formulate guidelines that will assist the department of health regarding policy implementation and also suggest possible solutions.

1.8 ORGANISATION OF THE SUBSEQUENT CHAPTERS

The subsequent chapters of this study will be organized as follows:

Chapter 2: describes the review of relevant literature pertaining to policy implementation challenges,

Chapter 3: outlines the methodology used in the study,

Chapter 4: presents data analysis and discussion of findings,

Chapter 5: contains the conclusions, limitations of the study and recommendations for future research.

1.9 CONCLUSION

In this chapter the researcher highlighted on the background information, purpose of the study, problem statement, the research question, hypothesis, aim of study, objectives of the study, organization of the subsequent chapters, as well as the conclusion.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The chapter is about the literature review. The study focuses on the introduction, background information, previous research on the subject, evaluation of the public health sector policy framework, namely, the National health act, White paper for the transformation of the health system, National skills development act, Policy of internship, Scarce skills and rural allowances policy framework, Policy on commuted overtime for medical and dental practitioners, Policy on recruitment, employment and support of foreign health practitioners, as well as conclusion.

2.2 BACKGROUND INFORMATION

Most of the sources used in this study are documentary material obtained from the Internet and the Government policy documents. The reason why these documents were used in this study is that there is much information written about this subject, but no empirical research has been conducted about it in the Capricorn district. Documents have always been used as source of information in social research, either as the only method or in conjunction with other methods. These documents are called secondary material and the analysis is called secondary analysis (Sarantakos, 2000: 274-275).

The study conducted by Fourie (1999) in Limpopo, identified human resources to be the major challenge that constrain the managers from executing their functions effectively. This challenge could impact negatively on policy implementation. This condition has existed before, but not to the degree that it exists today (Fourie, 1999).

2.3 PREVIOUS RESEARCH ON THE SUBJECT

Luoma and Crigler (2002: 5-26) conducted a study in the National Health sector. The study revealed that there is a serious human resource crisis in the health department,

especially in the rural areas. The challenges range between motivation, accommodation problems, brain drain, diversity and poor incentives for health professionals. According to Luoma and Crigler (2002: 18), the low motivation of health workers, experience and studies suggest that any comprehensive strategy to maximize health workers' motivation in the health sector has to involve a mix of financial and non-financial incentives.

Limpopo has been described as the second poorest province when compared to the other eight provinces. Young and talented health professionals leave the province in large numbers everyday to other provinces and even abroad for greener pastures. Brain drain can be described in terms of what occurs if emigration of tertiary educated persons, for permanent or long-stays abroad, reaches levels that are not offset by remittances, technology transfer, and investments or trade (Lowell & Findlay, 2001: 26). Thus a brain drain will reduce economic growth as investments into education are not recompensed and leads to depletion of a country's human capital assets.

It is understood that the migration of professionals is not necessarily a problem except where critical needed skills are lost to the source countries. A major concern is the impact on health services and the general hypothesis is that migration's overall effect to deliver services to the poorest communities is negative (Dovlo and Nyonator, 1999: 34-37). The decision to stay or leave is influenced by factors often termed "Push" and "Pull" factors.

Health workers retention is said to be influenced by a combination of factors that either "Push" or "Pull" professionals from the source countries or Pull them to a recipient country (Paradath et al, 2003: 9-26) . "Push" and "Pull" factors refer to influences that are felt by professionals within the source country that either creates an impetus to leave or an attraction to seek work in a recipient country. Pushes are the results of actions that originate from the source country whilst Pulls result from influences arising from recipient countries (Ross, 2004: 46(1), 5-6).

According to Dovlo (2002: 34-37); Martineau & Decker et al (2002: 2) the differences in the level of their influence in source and recipient countries create a gradient that

influences the decision to emigrate. Some of the influences they mentioned are an income or remuneration, job satisfaction, organizational environment/career opportunity, governance of country and health services, social security and benefits, the protection and occupational risk.

The study conducted by Couper et al (2002: 277-292) in Kwazulu Natal revealed that professional nurses have also been leaving the public sector into the private sector and abroad in large numbers. This move has lead to the loss of key senior nurses in district hospitals, representing a potentially more serious crisis than the loss of doctors. Such migration has been exacerbated by the exclusion from the scarce skills allowances of all but a few specialized categories of nurses, who would not commonly be found in district hospitals (Bucan et al, 2003: 29-35).

Health professionals must register with the relevant professional Council in any country they practice in, but this registration does not necessarily mean that the person is employed in that country. However, professionals give a good idea of foreign health professionals working in a country. Individuals wishing to work elsewhere need to confirm their original home country registration in order to be accepted on recipient countries' professional registers (Osegie et al, 2003: 4)

The register for health care professionals from the Health Professionals Council of South Africa (HPCSA) reveals that Limpopo has produced numerous health professionals more than other provinces, but these professionals are not serving their province, but are in other provinces and even abroad (HPCSA, 2006).

Schneider (2003) states that accommodation for staff is a huge challenge in government hospitals. Hospitals are getting more applicants especially clinical support staff every year, but struggle to accommodate them. Recruitment and retention of appropriate human resources required for health care services continues to be the biggest challenge in provinces. The performance and quality of a health system ultimately depend on the quality and motivation of health human resources (Couper & Hugo, 2000:277-292).

The key strategy to recruit and retain health workers was implemented in March 2004 and was in line with the recommendations of the World Health Report (2003) which suggests paying differently by reviewing non-financial benefits and also considering opportunities for rotation to rural areas (Smith, 2004).

The WHO (2003) further explained that whilst these allowances are a step in the right direction, and apparently do lead to changes in career plans, there are other issues that need to be addressed such as job satisfaction, working conditions, further training, and career opportunities. A number of hospital managers in rural areas indicated that their institutions do not qualify for the rural allowance due to the allocation being based on outdated lists of rural hospitals (De Villiers, 2005).

Couper et al (2000: 277-292) postulates that the biggest challenge facing district hospitals is personnel shortages in rural areas. Some of the district hospitals currently have staff shortages of ±50%. This results in existing staff having difficulty in fulfilling their duties, high level of absenteeism, and low levels of morale. The introduction of new policy changes are adding to the burden as staff not having time to adjust and cope with the ever changing environment. Ross & Reid (2004) also stated that apart from staff shortages, 80% of the population relies on the public health system for health care. This sector receives 40% of total expenditure on health.

The staff requires a specific retention strategy to keep them in service and reduce their sense of being overwhelmed and alienated. It has been suggested that in order to achieve a positive result, recruitment issues should be addressed separately from retention issues (Couper, 2002: 18). Despite the introduction of rural service incentives, it is still very difficult to attract professionals needed and retain them at the rural areas.

De Villiers et al (2005:5) states that Limpopo is about ninety one (91%) percent rural. The majority of the hospitals are thus situated in rural areas, which render these institutions unattractive and isolated in terms of their ability to recruit and retain health

professionals. Consequently, most of these institutions currently do not have adequate supply of health professionals, thus depriving the community access to service delivery and optimal patient care.

Ross and Reid (2004: 21) states that poor leadership styles by managers also pose a serious challenge in public health institutions. There seems to be little understanding by managers of how staff can be supported in fulfilling the roles better. A lot of management is to instruct and control where little listening or supporting is happening. This problem makes people delivering the service to be poorly informed about strategic direction and intention of the service delivery (Ross & Reid, 2004: 21).

Couper et al (2002: 23) states that a cadre of hospital managers have come into the system who do not necessarily understand the intricacies of the health care system, and who have often not been trained or equipped to recognize or deal with crises in human resources. When critical staff shortages occur, they are seldom addressed immediately or as a priority. This has had a significant impact on recruitment and retention of staff and the creation of a positive work environment which produces job satisfaction.

Apart from the poor leadership styles further challenges are eminent in the supervision of health professionals. Various categories of health professionals are not found at work in the afternoons. They run private practices while in full-time employment. They even extend their lunch and tea breaks way beyond the prescribed times (De villiers at al, 2005: 5).

Price (2001: 19) states that another important challenge facing health policy implementers on the job market come from the law. The main source of law is Government legislation. National Governments have become law making machines, creating a complex legal environment for business. The Government implement statutes for strategic reasons, ensuring that employees who are disciplined or dismissed are dealt with in a particular manner. Health Policy Implementers who therefore, fail to meet the legal obligations must compensate aggrieved individuals appropriately.

Apart from the legislative framework from the Government, policy implementers deal with well informed employees (Price, 2001). This demands managers to keep abreast of new developments in the areas of labour relations, financial management, people management, diversity management and other relevant regulations that govern the public service. Some managers find it difficult to keep on studying documents and as a result find management and policy implementation in this era to be stressful.

De Vries et al (2003: 93, 789-793) states that the employment of certain category of workers in the public service is done in a contractual manner. This exercise is expressed in formal or legalistic statements of obligation between the two, namely, employer and employee. This involves written employment contracts, job descriptions and performance objectives. Performance measurements ensure that the employee fulfils the contract.

The signing of performance measurement is not a simple process for policy implementers. Those managers taking personnel decisions on performance assessments have to be mindful of possible legal action on one of the two grounds. These are that validity, accuracy of assessment ratings as predictors of future performance, promotion potential, validity and accuracy of ratings as measures of past behaviour (Hugo, 2003: 45, (6): 4) .

Posts-vacancy rate also has a negative impact on hospital management in the district institutions. This challenge compels managers to delegate duties to persons who do not have the necessary skills or capacity to render such functions (Fourie, 1999: 3). Some of the consequences of the resultant labour shortages are increased wage pressures, job hopping and brain drain from the public health sector to the private sector.

Smith (2004) states that the level of capacity in administrative areas amongst health workers is a huge challenge. With the implementation of the Public Finance Management Act (PFMA), it became apparent that a lot of capacity development in terms of PFMA and HRM needs to take place.

Smith (2004) further explains that most of the policy implementers and their staff members did not receive any form of training in financial management nor human resource management. Before 1994, only senior managers and above were supposed to go for strategic planning exercises. Financial matters were handled by Accountants and human resource matters were handled by Human resource managers. Managers today are expected to know all and to supervise the responsible officers.

Luoma and Crigler (2002: 29-86) postulates that there is a lack of team-work and no sense of mutual responsibility and commitment. As long as Batho Pele principles remains nothing more than a poster on a hospital wall, quality of care cannot be achieved in district hospitals. Therefore, more formalized supervision of all categories of staff, including professionals, is required to address these issues.

To support good performance, health workers need clear job expectations, up-to-date knowledge and skills, adequate equipment and supplies, constructive feedback and a caring supervisor (Luoma and Crigler, 2002). Workers also need motivation, especially when some of the other factors that support good performance are lacking. Indeed, highly motivated individuals can often overcome obstacles such as poor working conditions, personal safety concerns and inadequate equipment.

More than 80% of our people depend on the public health sector. The clinical services in rural areas are provided almost entirely by nurses. Some of the major problems include high vacancy rates, high absenteeism, high turnover of staff, ageing staff and the increasing demands of new policies. Staff in rural areas has thus been subjected to continuing and increasing stress, often with very little recognition or reward. Many people do an amazing job with the resources available, but morale is generally not good (BuaNews, 2004).

2.4 EVALUATION OF THE PUBLIC HEALTH SECTOR POLICY FRAMEWORK

South Africa has made significant progress in producing policies supportive of a good quality of health for all residents. However, there are challenges and gaps in translating these policies into action. Probably the most important of these challenges is the lack of adequate human resources (Baron & Ljumba, 2002).

2.4.1 THE NATIONAL HEALTH ACT NO. 61 OF 2003

Potentially the most significant policy development was the promulgation of the National Health Act (Act No. 61 of 2003). Section 43 allows for monitoring the provision, distribution, development, management and utilization of human resources within the National Health System. The challenge posed by this policy is the lack of career pathing for Medical Specialists at the district hospitals.

2.4.2 WHITE PAPER FOR THE TRANSFORMATION OF THE HEALTH SYSTEM, 1977

The policy came to be the first pivotal policy document guiding health sector transformation. It established a number of important principles to guide human resource planning, production and management, the establishment of a national framework for the training and development of health personnel, skills, experiences and expertise of all health personnel which should be used optimally to ensure maximum coverage and cost-effectiveness (White Paper for the Transformation of the Health System, 1977).

2.4.3 NATIONAL SKILLS DEVELOPMENT ACT, 1999

The overall objective of the act is to revolutionize skills development by advancing the culture of excellence in skills development, by encouraging various government departments and agencies to establish learner-ships so that the unemployed youth can

gain some work exposure. Although a major step forward, this policy is not necessarily aligned to overall health policy of skills acquired through these learner-ships to future prospects of the youth receiving the skills training (Reid, 2002)

2.4.4 POLICY ON INTERNSHIP

The policy ensures the supervised training of certain designated newly qualified health professionals before they can register for independent practice. Although the aim is not to get extra pair of hands to do the work where there are shortages, studies done on internship show that these professionals are exposed to heavy workloads, sometimes without the necessary supervision and support. This adds to factors contributing to alienation to work in rural areas upon completion of mandatory internship (Couper et al, 2005).

2.4.5 SCARCE SKILLS AND RURAL ALLOWANCES POLICY FRAMEWORK

The department of Public Service and Administration (DPSA) provided all government departments with this policy as a guide to develop and implement departmental scarce skills policies (DPSA, 2006). This framework contextualized the problems being experienced with scarce skills employees in the public service in relation to the open labour market and it details possible strategies, which departments may adopt. These strategies are aimed at ensuring that in the long term the state as the employer possesses sufficient pool of skills from which to draw its human resources.

The challenge for the health sector is that due to low or poor salaries being paid to the health professionals in relation to high workloads, many health professional categories, backed by the labour unions are demanding that they be included in the framework and other retention strategies especially the non-financial incentives to keep health professionals within the public service.

2.4.6 POLICY ON COMMUTED OVERTIME FOR MEDICAL AND DENTAL PRACTITIONERS

This policy was developed and implemented to compensate medical and dental health professionals for the work overload they do outside their normal working hours. The challenge however has been the ability of departmental management at facility level to manage its implementation leading to some institutions making it a permanent fixture of their remuneration. This unintended consequence serves to boost or compensate the salary challenge that these professionals experience (Couper et al, 2005).

2.4.7 POLICY ON RECRUITMENT, EMPLOYMENT AND SUPPORT OF FOREIGN HEALTH PRACTITIONERS

The policy seeks to restrict the recruitment and employment of health professionals seeking work in South Africa. Health professionals with relevant qualifications and skills obtained in foreign countries that meet the minimum requirements of training and education of health professionals in South Africa are restricted to providing a service in the public health (De Villiers et al, 2005). The challenge in this area is how to ensure a seamless relationship between this policy and the human resource (HR) development policies that should ensure HR production that will be sufficient to supply the country's needs.

2.5 CONCLUSION

The chapter focused on background information, previous research on the subject, evaluation of the public health sector policy framework, namely, the National health act, White paper for the transformation of the health system, National skills development act, Policy of internship, Scarce skills and rural allowances policy framework, Policy on commuted overtime for medical and dental practitioners, Policy on recruitment, employment and support of foreign health practitioners, as well as conclusion.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter is about research methodology and focuses on the introduction, study site, study design, sampling, data collection, reliability and validity, ethical considerations as well as the conclusion.

3.2 STUDY SITE

The study was conducted in the Capricorn district, Limpopo Province, South Africa. The district has eight hospitals and is the biggest of all the five districts in Limpopo serving a population of 1,154,690 with a dependency ratio of 7.8 (Development index framework, 2003: 1). The total population mentioned does not take into account cross-border inflows of patients from neighboring countries. The district is situated in the centre of the Limpopo Province, sharing its borders with the four district municipalities: Mopani (east), Sekhukhuni (south), Vhembe (north) and Waterberg (west) (Limpopo Business – Capricorn district Municipality, 23 October 2007)

3.3 STUDY DESIGN

The research study is located within a quantitative framework. The quantitative approach assists in numerical measurement (Sarantakos, 2000: 140-141) whereas the qualitative approach assists on the meaning, experience and understanding of participants (Collins et al, 2000: 134). While the study is a quantitative study, it also included limited open-ended questions in order to improve the validity and reliability of the study.

3.4 SAMPLING

The study focused mainly on the Chief Executive Officers (CEO's), Nursing managers, Clinical managers, as well as Clinical Support managers in the Capricorn district. A total

of 32 questionnaires were distributed to the policy implementers in the Capricorn district institutions. A convenient sampling method was employed seeing that the total number of policy implementers in the Capricorn district is thirty-two and the whole thirty-two would conveniently form the sample population. A convenient sample method is convenience sampling where the investigator selects cases that are easily obtainable or where time constraints prevent much consideration of sampling processes (Sarantakos, 2000: 140-141). The sample was chosen on the basis of availability. This means that respondents were selected because they are accessible and articulate (Struwig & Stead, 2000).

3.5 DATA COLLECTION

There are several methods through which data can be collected, namely, participant observation, survey questionnaires, and in-depth interviewing techniques which are usually employed with qualitative research methodology. Taylor and Bogdan (1984) support the belief that not all techniques are usually suited for all purposes. The choice of research techniques should be determined by the research interest and practical constraints faced by the researcher.

Data was collected by the use of a self- administered questionnaire containing closed and open-ended questions. Collins et al (2000: 183) states that closed ended questions consist of questions with a fixed number of answers, whereas open-ended questions are used to encourage respondents to express their attitudes, emotions, ideas, sentiments, suggestions, or opinions in their own words.

The hospitals in the Capricorn district are geographically accessible and all the questionnaires were forwarded to the hospitals by hand addressed to the CEO's, who on receipt of the questionnaires, distributed them to the other management team members. The duly completed questionnaires were submitted to the CEO's who finally forwarded them back to the researcher. Questionnaire methodology was found to be uniquely suitable approach for this research as it is less expensive than other methods and can produce quick results (Collins, 2000: 183).

The advantages of the questionnaires are that:
They are less expensive than the other methods, can produce quick results, can be completed by respondents in their own time, can offer greater assurance and anonymity, offer less opportunity for bias and error caused by the presence or attitudes of the interviewer, offer a stable, consistent and uniform measure without variation, offer a considerable and objective view on the issue since respondents can consult their files, and many respondents prefer to write than talk, and are not affected by lack of physical presence (Sarantakos, 2000).

The disadvantages of questionnaire are that:
questionnaires do not allow probing, prompting and clarification of questions, do no offer opportunities for motivating the respondent to participate in the survey or to answer the questions, identity of the respondent and the conditions under which the questionnaire was completed, researchers are not sure whether the right person has answered the questions in the questionnaire or not, it is not possible to check whether the question order was followed, due to lack of supervision on the completion of the questionnaire, and partial response is possible (Sarantakos, 2000).

The researcher drafted questions that were non-invasive and non-threatening. Open-ended questions were also used and were regarded as the most appropriate for this study as it was anticipated that such items would allow the participants to provide an unlimited amount of information regarding the health policy implementation challenges in the Capricorn district.

Furthermore, their responses could be elaborated upon and be clarified. According to Babbie (1995) this type of approach allows for creativity and also enables the participants to contribute information that the researcher might not have thought of asking or not even have known about. The initial information in the questionnaire was the background information which gave the respondents directions regarding the completion of the questionnaire and assured them of the confidentiality of their responses. The first three questions required biographical information. The researcher believed that the

biographical information would allow the respondents to understand the perspective from which the research was approached. Questions regarding age, gender, work experience and level of education were asked.

The researcher also realized that by beginning with non-threatening questions and questions that are relatively easy to answer, the participants would not be discouraged from continuing with the completion of the questionnaire (Singleton, Straits and Straits, 1993). The last portion of the questionnaire was a "thank you message" to the respondents for their interest in participating in the research study. Anonymity and confidentiality at the end of the questionnaire was reiterated by the researcher.

The researcher identified himself and also stated the purpose of the research in writing. The respondents were assured about the confidentiality of the information given in the letter of consent (Sarantakos, 2000: 140-141). By so doing it allowed the respondents to participate freely and offer an informed consent.

3.6 RELIABILITY AND VALIDITY

3.6.1 Reliability

According to Terre Blanche and Durrheim (2004), reliability refers to the dependability of a measuring instrument and demands consistency over time. Furthermore, reliability refers to the fact that different research participants being tested by the same instrument at different times should respond identically to the instrument.

3.6.2 Validity

Uys and Basson (1999: 80) define validity as the degree to which an instrument measures what it is supposed to be measuring. Validity is regarded to be the main requirement for a data-collecting instrument and is considered to be the main criterion by which the quality of the instrument is evaluated. Validity therefore refers to the degree to which a measure does what it is intended to measure. To establish measurement validity, the researcher will determine whether the instrument provides a good operational definition of construct, and whether the instrument is suited to the purposes for which it will be used.

3.7 ETHICAL CONSIDERATIONS

The study was approved by the Ethics Committee of the University of Limpopo, Turfloop Campus. The study was conducted after approval of the research proposal by the committee of the school of health sciences. Permission to collect data was obtained from the department of health authority. Participants were informed about the aims, purpose, potential risks of the study and the discomfort it may entail.

The participants were also informed that the participation is voluntary and that they have the right to abstain from participation. Confidentiality of information collected from the participants will be maintained. Only those who completed the consent form were included in the study. Mouton (2005) states that the participant has the right to anonymity and the right to assume that data collected will be kept confidential. The participants' identity will not be linked, even by the researcher to their responses.

3.8 CONCLUSION

This chapter focused on the introduction, study site, study design, sampling, data collection, reliability and validity, ethical considerations as well as the conclusion.

CHAPTER 4

ANALYSIS AND PRESENTATION OF DATA

4.1 INTRODUCTION

This chapter deals with the analysis and the presentation of data. The chapter focuses on the introduction, data analysis, the results of the study, reporting and the utilization of results, significance of the study and the conclusion.

4.2 DATA ANALYSIS

Analysis of biographical data – age, gender, level of education, medical background and work experience.

4.2.1 Information Regarding Gender and Age Group of the Participants

Table 4.1 reveals that (46.5%) participants were males managers between the ages of 28-49 and 30.8% were males between the ages of 50-62. (54.5%) were female managers between the ages of 28-46 and (69.2%) were female managers between the ages of 50-62. The results reveal that the majority of managers in Capricorn district hospitals were females between the ages of 50-62 (see table 4.1 below).

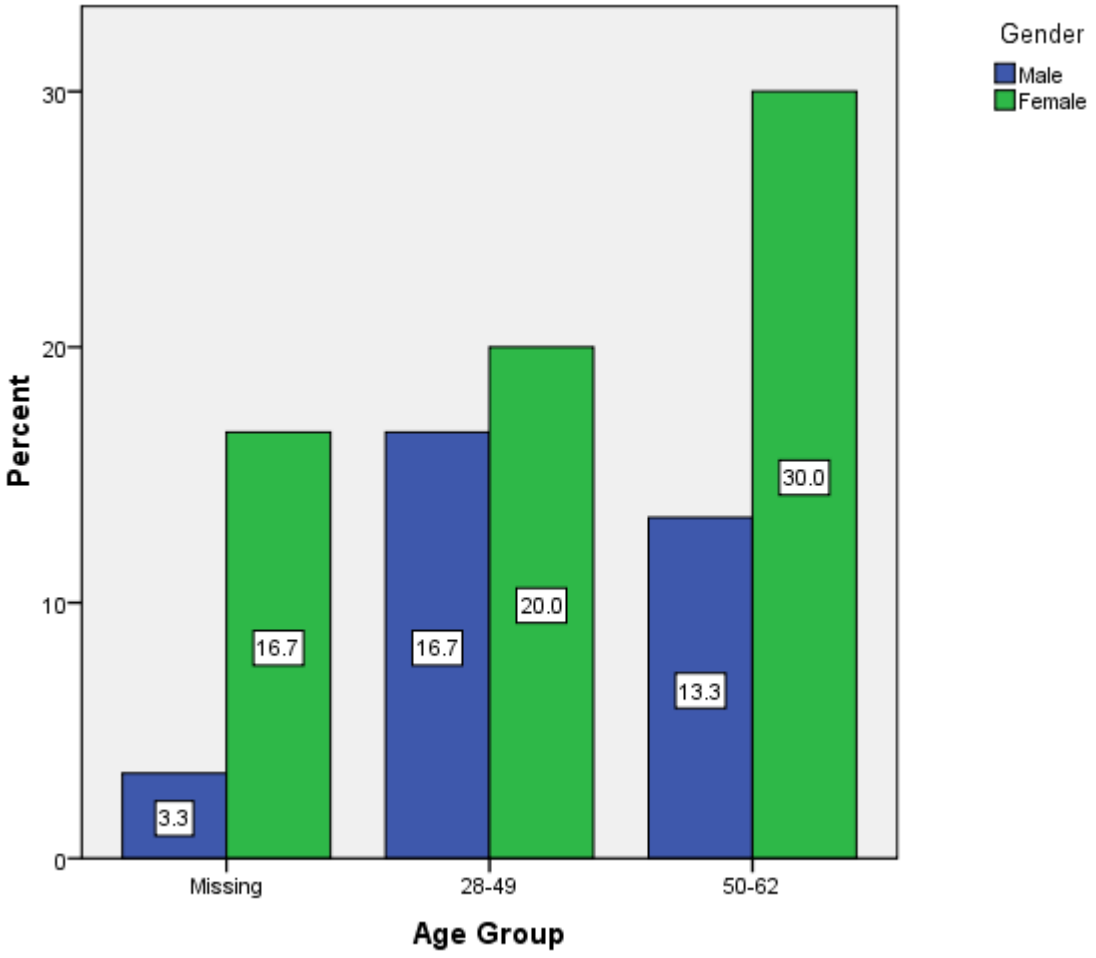
Table 4.1 Gender & Age Group Tabulation

			Age Group			
			Missing	28-49	50-62	Total
A1Gender	Male	Count	1	5	4	10
		% within Age Group	16.7%	45.5%	30.8%	33.3%
	Female	Count	5	6	9	20
		% within Age Group	83.3%	54.5%	69.2%	66.7%
Total		Count	6	11	13	30
		% within Age Group	100.0%	100.0%	100.0%	100.0%

4.2.2 Gender and Age Group of Participants.

Figure. 4.1 shows that (30%) of the participants were female managers between the age of 50-62 years and (13.3%) were males between the ages of 50-62 years. (20.0%) were females between the ages of 28-49 and (16.7%) were males between 28-49 years. (16.7%) females and (3.3%) males did not provide the information about their ages. This means that the majority of managers in Capricorn district are female managers between the ages of 50-62 (see fig. 4.1 below).

Figure 4.1 Gender & Age Group Tabulation



4.2.3 Level of Education & Age Group of Participants

Table 4.2 shows that (10.0%) participants had diplomas where (0.0%) were between the age group of 28-49. (6.7%) participants had degrees where (9.1%) were between the age group of 28-49 and (7.7%) were between the age group of 50-62. (83.3%) had post graduate qualifications where (90.9%) were at the age group of 28-49 and (69.2%) were between the age group of 50-62. The findings reveal that the most of the managers in Capricorn district have post graduate qualifications and the majority of them were between the age group of 28-49 years (see table 4.2 below).

Table 4.2 Education & Age Group

			Age Group			Total
			Missing	28-49	50-62	
A3Educ	Diploma	Count	0	0	3	3
		% within Age Group	.0%	.0%	23.1%	10.0%
	Degree	Count	0	1	1	2
		% within Age Group	.0%	9.1%	7.7%	6.7%
	Post-grad	Count	6	10	9	25
		% within Age Group	100.0%	90.9%	69.2%	83.3%
Total		Count	6	11	13	30
		% within Age Group	100.0%	100.0%	100.0%	100.0%

4.2.4 Medical Background of the Participants

Table 4.3 reveals that (40.0%) of the participants were nurses, (33.3%) were the Clinical Support staff and (26.7%) were medical officers. The findings reveal that the majority of managers who participated in this study were those with a nursing background (40.0%). (See table 4.3 below)

Table 4.3 Medical Background

			Age Group			Total
			Missing	28-49	50-62	
A4Medic	Med.Officer	Count	1	2	5	8
		% within Age Group	16.7%	18.2%	38.5%	26.7%
	Nurse	Count	3	2	7	12
		% within Age Group	50.0%	18.2%	53.8%	40.0%
	Support Officer	Count	2	7	1	10
		% within Age Group	33.3%	63.6%	7.7%	33.3%
Total		Count	6	11	13	30
		% within Age Group	100.0%	100.0%	100.0%	100.0%

4.2.5 Information regarding Service Background

Table 4.4 shows that (35.7%) participants had 0-3 years of service, (35.7%) had 4-6 years of experience, (3.6%) had 7-9years, (10.7%) had 10-12years, and (14.3%) had more than 13 years of experience in hospital management. The results also revealed that the medical officers are the majority of managers with less experience (71.4%), followed by the clinical support staff (44.4%), and the nurses made up a small percentage (8.3%). (see table 4.4 below).

Table 4.4 Service Background

			A4Medic			
			Med.Officer	Nurse	Support Officer	Total
B1Time	0-3	Count	5	1	4	10
		% within A4Medic	71.4%	8.3%	44.4%	35.7%
	4-6	Count	1	5	4	10
		% within A4Medic	14.3%	41.7%	44.4%	35.7%
	7-9	Count	0	1	0	1
		% within A4Medic	.0%	8.3%	.0%	3.6%
	10-12	Count	1	2	0	3
		% within A4Medic	14.3%	16.7%	.0%	10.7%
	13+yrs	Count	0	3	1	4
		% within A4Medic	.0%	25.0%	11.1%	14.3%
Total		Count	7	12	9	28
		% within A4Medic	100.0%	100.0%	100.0%	100.0%

4.2.6 Information regarding - Staff Complement for Doctors

Table 4.5 shows that (20.8%) participants indicated that they had adequate doctors in their institutions, (45.8%) said that they are under-staffed, and (33.3%) said that they are badly staffed. The results therefore revealed that there was a huge shortage of Doctors in the Capricorn district (See table 4.5 below).

Table 4.5 Staff Complement - Doctors

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Adequate	5	16.7	20.8	20.8
	Understaffed	11	36.7	45.8	66.7
	Badly staffed	8	26.7	33.3	100.0
	Total	24	80.0	100.0	
Missing	System	6	20.0		
Total		30	100.0		

4.2.7 Information regarding - Staff Complement for Nurses

Table 4.6 shows that (16.0%) participants indicated that they had adequate nurses in their institutions, (12.0%) said fairly staffed, (52.0%) said understaffed and (20.0%) said they were badly staffed. The results revealed that there is a huge shortage of nurses in the Capricorn district (see table 4.6 below).

Table 4.6 Staff Complement - Nurses

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Adequate	4	13.3	16.0	16.0
	Fair	3	10.0	12.0	28.0
	Understaffed	13	43.3	52.0	80.0
	Badly staffed	5	16.7	20.0	100.0
	Total	25	83.3	100.0	
Missing	System	5	16.7		
Total		30	100.0		

4.2.8 Information regarding - Staff Complement for Clinical Support Staff

Table 4.7 shows that (14.8%) participants indicated that they had adequate staff, 18.5 said that they are fairly staffed, (48.1%) said they were under-staffed, and (18.5%) said they were badly staffed. The results therefore reveal that there is a huge shortage of clinical support staff in the Capricorn district (see table 4.7 below).

Table 4.7 Staff Complement - Clinical Support Staff

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Adequate	4	13.3	14.8	14.8
	Fair	5	16.7	18.5	33.3
	Understaffed	13	43.3	48.1	81.5
	Badly staffed	5	16.7	18.5	100.0
	Total	27	90.0	100.0	
Missing	System	3	10.0		
Total		30	100.0		

4.2.9 Information regarding - Staff Turn-Over

Table 4.8 shows that (82.1%) participants indicated that the staff turn-over had been very high over the past three years and (17.9%) indicated that the staff turn-over had not been high over the past three years. The results therefore reveal that the staff turn-over had been very high over the past three years (see table 4.8 below).

Table 4.8 Staff Turn-Over

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	23	76.7	82.1	82.1
	No	5	16.7	17.9	100.0
	Total	28	93.3	100.0	
Missing	System	2	6.7		
Total		30	100.0		

4.2.10 Information regarding - Staff Resignations from Public Sector to Private sector

Table 4.9 shows that (48.0%) participants indicated that more health workers left the public service going to the private sector and abroad whereas (52.0%) said that they did not go into private practice and abroad (see table 4.9 below).

Table 4.9 Staff Resignations

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	12	40.0	48.0	48.0
	No	13	43.3	52.0	100.0
	Total	25	83.3	100.0	
Missing	System	5	16.7		
Total		30	100.0		

4.2.11 Information regarding - Staff recruitment for Community Service

Table 4.10 shows that (47.8%) participants indicated that more staff will be joining the hospitals as community service officers in January and (52.2%) said that the statement was not true (see table 4.10 below).

Table 4.10 Staff recruitment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	11	36.7	47.8	47.8
	No	12	40.0	52.2	100.0
	Total	23	76.7	100.0	
Missing	System	7	23.3		
Total		30	100.0		

4.2.12 Information regarding - Part Time Service

Table 4.11 shows that (4.0%) respondents indicated that most employees have been working part time and (98.0%) said that it was not true (see table 4.11 below).

Table 4.11 Part Time Service

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1	3.3	4.0	4.0
	No	24	80.0	96.0	100.0
	Total	25	83.3	100.0	
Missing	System	5	16.7		
Total		30	100.0		

Table 4.2.13 Information regarding - Threats of Resignations

Table 4.12 shows that (65.2%) participants indicated that most of the employees are threatening to leave the public service and (34.8%) said that it was not true (see table 4.12 below).

Table 4.12 Threats of Resignations

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	15	50.0	65.2	65.2
	No	8	26.7	34.8	100.0
	Total	23	76.7	100.0	
Missing	System	7	23.3		
Total		30	100.0		

4.2.14 Additional information regarding - other Reasons for Staff Resignations

Table 4.13 shows that (12.5%) participants indicated that health workers resigned from the hospitals because they got higher posts in other departments, (25.0%) said that there is a moratorium on filling of posts in the health department, (37.5%) said that they left due to lack of promotions and poor salaries, (6.3%) said they left due to red tapes, (6.3%) complained of work over-load, and (12.5%) complained of lack of study leaves (see table 4.13 below).

Table 4.13 Other Reasons for Staff Resignations

		Responses		Percent of Cases
		N	Percent	
B3 Other[a]	1	2	12.5%	16.7%
	2	4	25.0%	33.3%
	3	6	37.5%	50.0%
	4	1	6.3%	8.3%
	5	1	6.3%	8.3%
	6	2	12.5%	16.7%
Total		16	100.0%	133.3%

4.2.15 Information regarding – Additional Reasons for Staff Resignations

Table 4.14 shows that (17.4%) participants said that the health professionals resigned because of lack of accommodation, (30.4%) said that the staff joined other departments on higher posts, (13.0%) said that there is no upward mobility in health department, (4.3%) said that there are no rewards for good performance, (4.3%) said that there is poor human relations with other staff members within the institutions, (4.3%) said that some staff members left hospitals after when they were charged with misconducts, (4.3%) said that they left because of poor working conditions, (4.3%) said that they left due to work overload, (4.3%) said that they left due to budget constraints, (4.3%) said that they left because of unfair benefits that they receive at the PHC – clinics and health centres, and (4.3%) said that they left because of their social responsibilities and wanting to work near home (see table 4.14 below).

Table 4.14 Additional Reasons for Staff Resignations

		Responses		Percent of Cases
		N	Percent	
B4Other[a]	1	4	17.4%	22.2%
	2	7	30.4%	38.9%
	3	3	13.0%	16.7%
	4	1	4.3%	5.6%
	5	1	4.3%	5.6%
	6	1	4.3%	5.6%
	7	1	4.3%	5.6%
	8	1	4.3%	5.6%
	9	1	4.3%	5.6%
	10	1	4.3%	5.6%
	11	1	4.3%	5.6%
	12	1	4.3%	5.6%
Total		23	100.0%	127.8%

4.2.16 Information regarding staff resignations - Staff going Abroad

Table 4.15 shows that (23.3%) participants indicated that staff went abroad when resigned and (40.0%) said that health professional staff did not go to oversees when they resigned (see table 4.15 below).

Table 4.15 Staff resignations - Abroad

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	7	23.3	36.8	36.8
	No	12	40.0	63.2	100.0
	Total	19	63.3	100.0	
Missing	System	11	36.7		
Total		30	100.0		

4.2.17 Information regarding Staff resignations - Staff going into Private Practice

Table 4.16 shows that (40.0%) indicated that health professionals went for private practice when they resigned and (30.0%) said they did not go for private practice (see table 4.16 below).

Table 4.16 Staff resignations - Private Practice

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	12	40.0	57.1	57.1
	No	9	30.0	42.9	100.0
	Total	21	70.0	100.0	
Missing	System	9	30.0		
Total		30	100.0		

4.2.18 Information regarding Staff resignations - Staff going Back to School

Table 4.17 shows that (6.7%) said that staff went back to school when resigned and (63.3%) said the staff did not go back to school (see table 4.17 below).

Table 4.17 Staff resignations - Back to School

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	2	6.7	9.5	9.5
	No	19	63.3	90.5	100.0
	Total	21	70.0	100.0	
Missing	System	9	30.0		
Total		30	100.0		

4.2.19 Information regarding staff resignations - Staff want to do sessions

Table 4.18 shows that (21.1%) participants indicated that health professionals wanted to serve the hospitals on sessional basis when they resigned and (78.9%) disagreed with the statement (see table 4.18 below).

Table 4.18 Staff resignations – Do sessions

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	4	13.3	21.1	21.1
	No	15	50.0	78.9	100.0
	Total	19	63.3	100.0	
Missing	System	11	36.7		
Total		30	100.0		

4.2.20 Information regarding resignations in Rural Areas

Table 4.19 shows that (75.0%) participants indicated that the staff did not want to work at the rural areas and (25.0%) disagreed with the statement. The results therefore reveal that health workers did not want to work at the rural areas (see table 4.19 below).

Table 4.19 Resignations - Rural Areas

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	18	60.0	75.0	75.0
	No	6	20.0	25.0	100.0
	Total	24	80.0	100.0	
Missing	System	6	20.0		
Total		30	100.0		

4.2.21 Information regarding resignations - Unsure

Table 4.20 shows that (66.7%) of the respondents said that they were unsure and (33.3%) said No. The results therefore revealed that they were unsure about the reasons for staff resignations (see table 4.20 below).

Table 4.20 Resignations - Unsure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	4	13.3	66.7	66.7
	No	2	6.7	33.3	100.0
	Total	6	20.0	100.0	
Missing	System	24	80.0		
Total		30	100.0		

4.2.22 Information regarding Exit Interviews

Table 4.21 shows that (75.0%) indicated that resignations were due to poor working conditions the hospitals and (25.0%) disagreed that they were not due to poor working conditions (see table 4.21 below).

Table 4.21 Exit Interviews

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	18	60.0	75.0	75.0
	No	6	20.0	25.0	100.0
	Total	24	80.0	100.0	
Missing	System	6	20.0		
Total		30	100.0		

4.2.23 Information regarding Exit Interviews - Poor Working Conditions

Table 4.22 shows that (70.8%) said that staff resigned because of lack incentives in the public sector and (29.2%) said staff resignations are not due lack of incentives in hospitals (see table 4.22 below).

Table 4.22 Exit Interviews - Poor Working Conditions

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	17	56.7	70.8	70.8
	No	7	23.3	29.2	100.0
	Total	24	80.0	100.0	
Missing	System	6	20.0		
Total		30	100.0		

4.2.24 Information regarding Exit Interviews - Low staff Morale

Table 4.23 shows that (91.3%) indicated that staff resigned due to staff low morale and (8.7%) said that it is not due to low staff low morale (see table 4.23 below).

Table 4.23 Exit Interviews - Low staff Morale

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	21	70.0	91.3	91.3
	No	2	6.7	8.7	100.0
	Total	23	76.7	100.0	
Missing	System	7	23.3		
Total		30	100.0		

4.2.25 Information regarding Exit Interviews - Prefer to Do Sessions

Table 4.24 shows that (78.3%) participants indicated that there are no promotions in the public health sector whereas (21.7%) disagreed with the statement that health professionals want to serve hospitals on sessional basis (see table 4.24 below).

Table 4.24 Exit Interviews - Prefer to Do Sessions

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	18	60.0	78.3	78.3
	No	5	16.7	21.7	100.0
	Total	23	76.7	100.0	
Missing	System	7	23.3		
Total		30	100.0		

4.2.26 Information regarding Exit Interviews - Better Salaries in Private Sector

Table 4.25 shows that (78.3%) participants said that staff resigned because there are better salaries in the private sector and (21.7%) disagreed with the statement (see table 4.25 below).

Table 4.25 Exit Interviews - Better Salaries in Private Sector

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	18	60.0	78.3	78.3
	No	5	16.7	21.7	100.0
	Total	23	76.7	100.0	
Missing	System	7	23.3		
Total		30	100.0		

4.2.27 Information regarding Exit Interviews - Good Packages Abroad

Table 4.26 shows that (55.0%) said that the staff resigned because there are competent packages abroad and (45.0%) disagreed with the statement (see table 4.26 below).

Table 4.26 Exit Interviews - Good Packages Abroad

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	11	36.7	55.0	55.0
	No	9	30.0	45.0	100.0
	Total	20	66.7	100.0	
Missing	System	10	33.3		
Total		30	100.0		

4.2.28 Additional Information regarding Reasons for Resignations on Exit Interviews

Table 4.27 shows that (12.5%) indicated that the staff complained of accommodation, (31.3%) said staff shortage, (12.5%) complained of working in rural areas, (6.3%) complained of unfair labour practice, (6.3%) burn out, (6.3%) wanted to change the work environment, (12.5%) said lack of career mobility, (6.3%) complained of OSD, and (6.3%) complained of low salaries (see table 4.27 below).

Table 4.27 Additional reasons for Resignations

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2	6.7	12.5	12.5
	2	5	16.7	31.3	43.8
	3	2	6.7	12.5	56.3
	4	1	3.3	6.3	62.5
	5	1	3.3	6.3	68.8
	6	1	3.3	6.3	75.0
	7	2	6.7	12.5	87.5
	8	1	3.3	6.3	93.8
	9	1	3.3	6.3	100.0
	Total	16	53.3	100.0	
Missing	System	14	46.7		
Total		30	100.0		

4.2.29 Information regarding Staff Meetings

Table 4.28 shows that (3.3%) participants indicated that they seldom held meetings with their staff members, (6.7%) said sometimes, (60.0%) said often, and (30.0%) said they very often hold meetings with their staff. The results reveal that meetings were held regularly with the staff members (see table 4.28 below).

Table 4.28 Staff Meetings

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Seldom	1	3.3	3.3	3.3
	Sometimes	2	6.7	6.7	10.0
	Often	18	60.0	60.0	70.0
	Very often	9	30.0	30.0	100.0
	Total	30	100.0	100.0	

4.2.30 Additional Information regarding Staff Complaints

Table 4.29 shows that (1.4%) participants indicated that the department should implement the OSD, (2.9%) said that the department should give them study leaves, (11.4%) complained of lack of accommodation, (27.1%) complained of staff shortage, (11.4%) complained of lack of upward mobility, (10.0%) complained of poor salaries, (1.4%) complained of impulsive service consumers, (2.9%) complained of blame shifting management style, (4.3%) complained of unfair labour practice, (5.7%) complained of poor working relationships, (8.6%) complained of increased work-load, (1.4%) complained of budget constraints, (1.4%) complained of bureaucracy, (1.4%) complained of poor management and supervision style, (1.4%) complained of no professional recognition, (1.4%) complained of moratorium on filling of posts, (1.4%) complained of OSD disparities, (1.4%) complained of policy analysis and implementation, and (1.4%) complained of lack of senior posts for clinical support staff (see table 4.29 below).

Table 4.29 Staff Complaints - Other Reasons

		Responses		Percent of Cases
		N	Percent	
B7Complain[a]	1	1	1.4%	3.3%
	2	2	2.9%	6.7%
	3	8	11.4%	26.7%
	4	19	27.1%	63.3%
	5	8	11.4%	26.7%
	6	7	10.0%	23.3%
	7	1	1.4%	3.3%
	8	2	2.9%	6.7%
	9	3	4.3%	10.0%
	10	4	5.7%	13.3%
	11	6	8.6%	20.0%
	12	1	1.4%	3.3%
	13	1	1.4%	3.3%
	14	1	1.4%	3.3%
	15	1	1.4%	3.3%
	16	1	1.4%	3.3%
	17	1	1.4%	3.3%
	18	1	1.4%	3.3%
	19	1	1.4%	3.3%
	20	1	1.4%	3.3%
Total		70	100.0%	233.3%

4.2.31 Information regarding Staff Accommodation

Table 4.30 shows that (24.3%) participants said that there is no accommodation at their hospitals at all, (10.3%) participants said that the accommodation is inconsistent, (55.2%) said they had some accommodation, and (10.3%) said they had adequate accommodation. The results indicate that there is some form of accommodation in hospitals and only few hospitals have no accommodation at all (see table 4.30 below.

Table 4.30 Staff Accommodation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not at all	7	23.3	24.1	24.1
	Inconsistent	3	10.0	10.3	34.5
	Some	16	53.3	55.2	89.7
	Adequate	3	10.0	10.3	100.0
	Total	29	96.7	100.0	
Missing	System	1	3.3		
Total		30	100.0		

4.2.32 Information regarding the Condition of Accommodation

Table 4.31 shows that (57.7%) participants said that the accommodation was fair, (19.2%) said it was poor, (7.7%) said they did not have accommodation and (15.4%) had a problem with accommodation. The results therefore indicate that in most hospitals the accommodation was fairly good whereas very few hospitals have no accommodation at all for staff (see table 4.31 below).

Table 4.31 Condition of Accommodation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Fair	15	50.0	57.7	57.7
	Poor	5	16.7	19.2	76.9
	None	2	6.7	7.7	84.6
	Problem	4	13.3	15.4	100.0
	Total	26	86.7	100.0	
Missing	System	4	13.3		
Total		30	100.0		

4.2.33 Information regarding Policies received

Table 4.32 shows that (10.0%) participants indicated that they received policies in their institutions, (13.3%) said sometimes, (53.3%) said often, and (23.3%) said they received policies in their institutions very often (see table 4.32 below).

Table 4.32 Policies received

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Seldom	3	10.0	10.0	10.0
	Sometimes	4	13.3	13.3	23.3
	Often	16	53.3	53.3	76.7
	Very often	7	23.3	23.3	100.0
	Total	30	100.0	100.0	

4.2.34 Information regarding Policy Implementation - Analyze & monitor implementation

Table 4.33 shows that (87.0%) participants said that they analyzed and monitored the implementation of policies and (13.0%) did not implement them (see table 4.33 below).

Table 4.33 Policy Implementation – Analyze & Monitor Implementation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	20	66.7	87.0	87.0
	No	3	10.0	13.0	100.0
	Total	23	76.7	100.0	
Missing	System	7	23.3		
Total		30	100.0		

4.2.35 Information regarding Policy Implementation - Distribute to relevant sections

Table 4.34 shows that (100.0%) participants indicated that they distributed the questionnaires to the relevant sections within their institutions for implementation (see table 4.34 below).

4.2.36 Table 4.34 Policy Implementation - Distribute to relevant sections

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	26	86.7	100.0	100.0
Missing	System	4	13.3		
Total		30	100.0		

4.2.37 Information regarding Policy Implementation - Not Possible

Table 4.35 shows that (20.0%) said that the policies were not implement able and (80%) said no, policies were implement able (see table 4.35 below).

4.2.38 Table 4.35 Policy Implementation - Not Possible

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	4	13.3	20.0	20.0
	No	16	53.3	80.0	100.0
	Total	20	66.7	100.0	
Missing	System	10	33.3		
Total		30	100.0		

Table 4.2.37 Information regarding Policy Implementation - Lack of Budget

Table 4.36 shows that (50.0%) participants said that there was a lack of dedicated budget for policy implementation and (50.0%) said there was no problem of dedicated budget for policy implementation (see table 4.36 below).

Table 4.36 Policy Implementation - Lack of Budget

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	12	40.0	50.0	50.0
	No	12	40.0	50.0	100.0
	Total	24	80.0	100.0	
Missing	System	6	20.0		
Total		30	100.0		

4.2.38 Information Regarding Policy Implementation - Lack of Human Resources

Table 4.37 shows that (50.0%) participants said that there is a lack of human resources to implement the policies and (50.0%) said that there is no human resource challenge that impede the implementation of policies (see table 4.37 below).

Table 4.37 Policy Implementation - Lack of Human Resources

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	11	36.7	50.0	50.0
	No	11	36.7	50.0	100.0
	Total	22	73.3	100.0	
Missing	System	8	26.7		
Total		30	100.0		

4.2.38 Information regarding Policy Implementation - Other Reasons

Table 4.38 shows that (20.0%) participants indicated that they did not do anything with them due to some technical problem, (40.0%) said that the policies were not implemented due to some material and financial constraints, and (40.0%) said that the challenge was lack of commitment on the side of managers (see table 4.38 below).

Table 4.38 Policy Implementation - Other Reasons

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	3.3	20.0	20.0
	2	2	6.7	40.0	60.0
	3	2	6.7	40.0	100.0
	Total	5	16.7	100.0	
Missing	System	25	83.3		
Total		30	100.0		

Table 4.2.40 Information regarding Policies' Implement ability

Table 4.39 shows that (26.7%) participants said that the policies were sometimes implementable, (53.3%) said they were partially implementable, and (20.0%) said that they were implementable. The results indicate that the policies that were received were implementable (see table 4.39 below).

Table 4.39 Policies' Implement ability

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Sometimes	8	26.7	26.7	26.7
	Partially	16	53.3	53.3	80.0
	Implementable	6	20.0	20.0	100.0
	Total	30	100.0	100.0	

Table 4.2.41 Information Regarding Policy Implementability - Lack of Staff Cooperation

Table 4.40 shows that (15.4%) participants indicated that there was a lack of cooperation among the staff members (very important), (89.2%) said important, (7.7%) were unsure, (7.7%) said statement is not important. The results reveal that there was a lack of cooperation among the staff members when coming to policy implementation (see table 4.40 below).

Table 4.40 Policy Implementability - Lack of Staff Cooperation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	V.Important	2	6.7	15.4	15.4
	Important	9	30.0	69.2	84.6
	Unsure	1	3.3	7.7	92.3
	Not important	1	3.3	7.7	100.0
	Total	13	43.3	100.0	
Missing	System	17	56.7		
Total		30	100.0		

4.2.42 Information Regarding Policy Implementability - Poor staff Communication

Table 4.41 shows that (25.0%) participants indicated that there was lack of communication between management and the staff at grass-root level (very important), (50.0%) said important, (6.3%) were unsure, (12.5%) they were unimportant, (6.3%) said they not important at all. The results therefore reveal that there was a lack of communication between the management and the staff members at grass-root level (see table 4.41 below).

Table 4.41 Policy Implementability - Poor Communication

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	V.Important	4	13.3	25.0	25.0
	Important	8	26.7	50.0	75.0
	Unsure	1	3.3	6.3	81.3
	Not important	2	6.7	12.5	93.8
	Not at all	1	3.3	6.3	100.0
	Total	16	53.3	100.0	
Missing	System	14	46.7		
Total		30	100.0		

4.2.43 Information Regarding Policy Implementability - Union Members

Table 4.42 shows that (25.0%) participants indicated that policies were not implement able due to interference by union members (very important), (31.3%) said important, (25.0%) were unsure, (12.5%) said interference by union members was not important, (6.3%) said not at all (see table 4.42 below).

Table 4.42 Policy Implementability - Union Members

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	V.Important	4	13.3	25.0	25.0
	Important	5	16.7	31.3	56.3
	Unsure	4	13.3	25.0	81.3
	Not important	2	6.7	12.5	93.8
	Not at all	1	3.3	6.3	100.0
	Total	16	53.3	100.0	
Missing	System	14	46.7		
Total		30	100.0		

4.2.44 Information Regarding Policy Implementability - Lack of Human Resources

Table 4.43 shows that (50.0%) participants indicated there was a lack of skilled personnel to implement policies (very important), (28.6%) said important, (21.4%) were unsure (see table 4.43 below).

Table 4.43 Policy Implementability - Human Resources

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	V.Important	7	23.3	50.0	50.0
	Important	4	13.3	28.6	78.6
	Unsure	3	10.0	21.4	100.0
	Total	14	46.7	100.0	
Missing	System	16	53.3		
Total		30	100.0		

4.2.45 Information Regarding Policy Implementation - Lack of Budget

Table 4.44 shows that (35.7%) participants indicated that policies received were not budgeted for and as a result they were not implemented (very important), (42.9%) said important, (14.3%) said they were unsure, (7.1%) said it was not important. The results reveal that the policies that were received by the institutions were not budgeted for and as a result they were not implemented (see table 4.44 below).

Table 4.44 Policy Implementation - Lack of Budget

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	V.Important	5	16.7	35.7	35.7
	Important	6	20.0	42.9	78.6
	Unsure	2	6.7	14.3	92.9
	Not important	1	3.3	7.1	100.0
	Total	14	46.7	100.0	
Missing	System	16	53.3		
Total		30	100.0		

Table 4.2.46 Information Regarding Policy Implementation - Numerous Contradicting Policies

Table 4.45 shows that (15.4%) participants indicated that many contradicting policies were received timeously (very important), (46.2%) said important, (15.4%) were unsure, (7.7%) said not important, and (15.4%) said not important at all. The results reveal that contradicting policies were received by the hospitals as from time to time and therefore they were not implemented (see table 4.45 below).

Table 4.45 Policy Implementation - Numerous Contradicting Policies

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	V.Important	2	6.7	15.4	15.4
	Important	6	20.0	46.2	61.5
	Unsure	2	6.7	15.4	76.9
	Not important	1	3.3	7.7	84.6
	Not at all	2	6.7	15.4	100.0
	Total	13	43.3	100.0	
Missing	System	17	56.7		
Total		30	100.0		

Table 4.2.47 Additional Information Regarding Policy Implementation

Table 4.46 shows that (50.0%) participants indicated that there was a lack of commitment from managers to implement policies and (50.0%) said that there was a lack of support systems within the department that would enhance policy implementation (see table 4.46 below).

Table 4.46 Policy Implementation - Other Reasons

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	3.3	50.0	50.0
	2	1	3.3	50.0	100.0
	Total	2	6.7	100.0	
Missing	System	28	93.3		
Total		30	100.0		

4.2.48 Information Regarding Race

Table 4.47 shows that (6.1%) participants indicated that they were coloreds, (18.0%) were Indians, (57.8%) were blacks, (9.1%) were whites, and (9,1%) were other. The results reveal that the majority of health professionals in the Capricorn district were Blacks, followed by Indians and Whites are the minority group (see table 4.47 below).

Table 4.47 Race

		Responses		
		N	Percent	Percent of Cases
B14Race[a]	Colored	2	6.1%	10.0%
	Indian	6	18.2%	30.0%
	Black	19	57.6%	95.0%
	White	3	9.1%	15.0%
	Other	3	9.1%	15.0%
Total		33	100.0%	165.0%

4.2.49 Information Regarding Diversity Management - Open ended question

Table 4.48 shows that (39.4%) participants indicated that they accepted different opinions within the work place, (6.1%) said that they implemented the policies in case they experienced some cultural conflicts, (3.0%) said that they improved the accessibility and even worked on the physical infrastructure, (9.1%) said that they conducted in-service training to the staff about diversity management, (3.0%) said that they used the open door policies, (12.1%) said that they held regular meetings and shared some information about the topic, (15.2%) said that they conducted team building exercises, (3.0%) said that there was no control on diversity, (6.1%) said that they involved workers in problem solving

and decision making and (3.0%) said that they only had black people in their institutions, so diversity management is not a problem (see table 4.48 below).

Table 4.48 Diversity Management

		Responses		
		N	Percent	Percent of Cases
B15Diversity[a]	1	13	39.4%	61.9%
	2	2	6.1%	9.5%
	3	1	3.0%	4.8%
	4	3	9.1%	14.3%
	5	1	3.0%	4.8%
	6	4	12.1%	19.0%
	7	5	15.2%	23.8%
	8	1	3.0%	4.8%
	9	2	6.1%	9.5%
	10	1	3.0%	4.8%
Total		33	100.0%	157.1%

4.2.50 Information Regarding the Effects of HIV/AIDS on Staff

Table 4.49 shows that (40.0%) participants indicated that they disagree with the statement that the institutions lose young and talented officers in large numbers due to HIV, (35.0%) were neutral, (15.0%) agreed with the statement, and (10.0%) strongly agreed with the idea. The results therefore revealed that institutions in the Capricorn district are not losing young and talented officers in large numbers due to HIV/AIDS pandemic (see table 4.49 below).

Table 4.49 Effects of HIV/AIDS on Staff

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	8	26.7	40.0	40.0
	Neutral	7	23.3	35.0	75.0
	Agree	3	10.0	15.0	90.0
	S.Agree	2	6.7	10.0	100.0
	Total	20	66.7	100.0	
Missing	System	10	33.3		
Total		30	100.0		

4.2.51 Information on the Effects of HIV/AIDS on Staff Performance

Table 4.50 shows that (26.3%) participants indicated that they strongly disagreed that the disease had any effect on staff performance, (31.80%) disagreed, (26.3%) were neutral, and (15.8%) agreed with idea. The results revealed that the HIV/AIDS status did not have any effect on staff performance (see table 4.50).

Table 4.50 Effects of HIV/AIDS on Staff Performance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	S.Disagree	5	16.7	26.3	26.3
	Disagree	6	20.0	31.6	57.9
	Neutral	5	16.7	26.3	84.2
	Agree	3	10.0	15.8	100.0
	Total	19	63.3	100.0	
Missing	System	11	36.7		
Total		30	100.0		

4.2.52 Additional Information Regarding the Effects of HIV/AIDS on Staff

Table 4.51 shows that (16.7%) participants indicated that they strongly disagreed that only a mall number of employees were affected by the disease and it did not make a difference. (11.1%) participants disagreed with the statement, (50.0%) were neutral, (16.7%) agreed with the statement, and (5.6%) strongly agreed with the idea. The results revealed that the managers were neutral to the statement that only a small number of employees were affected by the disease and it did not even made a difference (see table 4.51 below).

Table 4.51 Effects of HIV/AIDS on Staff – Additional Information

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	S.Disagree	3	10.0	16.7	16.7
	Disagree	2	6.7	11.1	27.8
	Neutral	9	30.0	50.0	77.8
	Agree	3	10.0	16.7	94.4
	S.Agree	1	3.3	5.6	100.0
	Total	18	60.0	100.0	
Missing	System	12	40.0		
Total		30	100.0		

4.2.53 Information Regarding the HIV/AIDS - Contingency Plan

Table 4.52 shows that (5.0%) participants indicated that they strongly disagreed that the management is aware of the problem and the contingent plan is in place, (15.0%) disagreed, (40.0%) were neutral, (30.0%) agreed, and (10.0%) strongly disagreed. The results revealed that the managers were neutral that they were aware of the problem and a contingent plan was in place (see table 4.52 below).

Table 4.52 HIV/AIDS - Contingency Plan

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	S.Disagree	1	3.3	5.0	5.0
	Disagree	3	10.0	15.0	20.0
	Neutral	8	26.7	40.0	60.0
	Agree	6	20.0	30.0	90.0
	S.Agree	2	6.7	10.0	100.0
	Total	20	66.7	100.0	
Missing	System	10	33.3		
Total		30	100.0		

4.2.54 Information Regarding the Effects of HIVAIDS on Staff - Unsure

Table 4.53 shows that (37.5%) participants indicated that they strongly disagreed that they were unsure, (25.0%) said they were neutral, (25.0%) said they were unsure, and 12.5% strongly agreed that they are unsure. The results revealed that the managers strongly disagreed that they were unsure (see table 4.53).

Table 4.53 Effects of HIVAIDS on Staff - Unsure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	S.Disagree	3	10.0	37.5	37.5
	Neutral	2	6.7	25.0	62.5
	Agree	2	6.7	25.0	87.5
	S.Agree	1	3.3	12.5	100.0
	Total	8	26.7	100.0	
Missing	System	22	73.3		
Total		30	100.0		

4.2.55 Information Regarding the Effects of HIV/AIDS on Staff - None of the Above

Table 4.54 shows that (75.0%) participants indicated that they strongly disagreed with the statement – none of the above and (25.0%) were neutral. The results therefore revealed that the managers strongly disagreed with all reasons given about the effects of HIV/AIDS on staff performance (see table 4.54 below).

Table 4.54 Effects of HIV/AIDS on Staff - None of the Above

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	S.Disagree	3	10.0	75.0	75.0
	Neutral	1	3.3	25.0	100.0
	Total	4	13.3	100.0	
Missing	System	26	86.7		
Total		30	100.0		

4.2.56 Additional Information Regarding the Effects of HIV/AIDS on Staff

Table 4.55 shows that (100%) participants indicated that the workers do not disclose their HIV/AIDS status (see table 4.55 below).

Table 4.55 Effects of HIV/AIDS on Staff - Other Reasons

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	4	13.3	100.0	100.0
Missing	System	26	86.7		
Total		30	100.0		

4.2.57 Suggestions Regarding Remedying the Problem of those who Engage in Private Practice

Table 4.56 shows that (18.8%) participants indicated that they encouraged the officers to declare their financial status, (31.3%) said that they would apply policies that govern remunerative work outside the public service (RWOPS), (15.8%) said that they would take drastic steps against the perpetrator, (3.1%) said that they would train and orientate

the officer on what is expected of him, (6.3%) said that they would refer the officer for an employee wellness programme, (9.4%) said that they authorize private practice, (3.1%) said that the issue of private practice is very difficult to control and it should be left like that, (3.1%) said that they would make the staff to work overtime, (9.4%) said that they would keep on monitoring those officers who engage themselves in private practice. The majority of the managers indicated that they would implement the policies that govern the RWOPS in the public sector in order to remedy the situation (see table 4.56 below).

Table 4.56 Private Practice - Remedy

		Responses		
		N	Percent	Percent of Cases
B16Private[a]	1	6	18.8%	20.7%
	2	10	31.3%	34.5%
	3	5	15.6%	17.2%
	4	1	3.1%	3.4%
	5	2	6.3%	6.9%
	6	3	9.4%	10.3%
	7	1	3.1%	3.4%
	8	1	3.1%	3.4%
	9	3	9.4%	10.3%
Total		32	100.0%	110.3%

4.2.58 Information Regarding the Management Style

Table 4.57 shows that (32.0%) participants indicated that they used democratic leadership style, (4.0%) said that they use free-rein style, (58.0%) said they use the combination of all management styles, (4.0%) said they don't use any of the mentioned management styles, and (4.0%) were unsure. The results revealed that the majority of managers adopted the combination of all the management styles (see table 4.57 below).

Table 4.57 Management Style

		Responses		
		N	Percent	Percent of Cases
B17Style[a]	2	8	32.0%	34.8%
	3	1	4.0%	4.3%
	4	14	56.0%	60.9%
	5	1	4.0%	4.3%
	6	1	4.0%	4.3%
Total		25	100.0%	108.7%

4.2.59 Information Regarding Brain Gain for Doctors

Table 4.58 shows that (56.3%) participants indicated they appointed between 1-4 professionals coming from outside the RSA, (12.5%) said they appointed 5-9, (6.3%) said 10-12, and (25.0%) said they appointed more than 13. The results revealed that there had been some professionals who were appointed coming from outside the RSA (see table 4.58 below).

Table 4.58 Brain Gain - Doctors

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-4	9	30.0	56.3	56.3
	5-9	2	6.7	12.5	68.8
	10-12	1	3.3	6.3	75.0
	13+	4	13.3	25.0	100.0
	Total	16	53.3	100.0	
Missing	System	14	46.7		
Total		30	100.0		

4.2.60 Information Regarding Brain Gain for Nurses

Table 4.59 shows that (71.4%) participants said 1-4 nurses who coming from outside the RSA were appointed, (14.3%) said 5-9, (14.3%) said more than 13 were appointed (see table 4.59 below).

Table 4.59 Brain Gain - Nurses

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-4	5	16.7	71.4	71.4
	5-9	1	3.3	14.3	85.7
	13+	1	3.3	14.3	100.0
	Total	7	23.3	100.0	
Missing	System	23	76.7		
Total		30	100.0		

4.2.61 Information Regarding Brain Gain for Clinical Support Staff

Table 4.60 shows that (81.8%) participants indicated that 1-4 officers coming from outside the RSA were appointed and (18.2%) said 5-9 officers were appointed. The results revealed that few clinical support staff coming from the outside the RSA were appointed in the Capricorn district hospitals (see table 4.60 below).

Table 4.60 Brain Gain for Clinical Support Staff

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-4	9	30.0	81.8	81.8
	5-9	2	6.7	18.2	100.0
	Total	11	36.7	100.0	
Missing	System	19	63.3		
Total		30	100.0		

4.2.62 Additional Information Regarding Brain Drain

Table 4.61 shows that (4.1%) participants indicated that the department should implement OSD, (6.1%) the department should give study leaves to the staff, (12.2%) accommodation problem should be sorted out, (10.2%) the department should intensify its effort on recruitment and retention strategy of health workers, (2.0%) the department should develop some staffing norms for the hospitals, (2.0%) the department should exercise an equitable division of labour, (2.0%) women should be empowered, (2.0%) the department should uplift the moratorium on the filling of posts, (2.0%) there should be a room for managers to work at full capacity, (14.3%) working conditions should be improved, (6.1%) the issue of brain drain is difficult to control and should be ignored, (6.1%) the departments should give more bursaries to health workers, (2.0%) the departments should obtain more inputs from workers about the topic, (2.0%) there should be a skill development programs for workers, (2.0%) the department should have pay progression opportunities, (12.2%) the department should outsource the recruitment service, (2.0%) salaries should be improved, (4.1%) department should increase budgets for procurement of equipment, (2.0%) staff establishments should be enlarged, (2.0%) there should be a rural allowance for nurses, and (2.0%) there should be an improvement on supervision skills, improvement on resources, and the induction and orientation of new staff (see table 4.61 below).

Table 4.61 Brain Drain – Additional Information

		Responses		Percent of Cases
		N	Percent	
B19BrainD[a]	1	2	4.1%	7.4%
	2	3	6.1%	11.1%
	3	6	12.2%	22.2%
	4	5	10.2%	18.5%
	5	1	2.0%	3.7%
	6	1	2.0%	3.7%
	7	1	2.0%	3.7%
	8	1	2.0%	3.7%
	9	1	2.0%	3.7%
	10	7	14.3%	25.9%
	11	3	6.1%	11.1%
	12	3	6.1%	11.1%
	13	1	2.0%	3.7%
	16	1	2.0%	3.7%
	17	6	12.2%	22.2%
	18	1	2.0%	3.7%
	19	2	4.1%	7.4%
	20	1	2.0%	3.7%
	21	1	2.0%	3.7%
	22	1	2.0%	3.7%
	23	1	2.0%	3.7%
Total		49	100.0%	181.5%

4.2.63 Suggestions Regarding the Improvement of Performance Management System

Table 4.62 shows that (11.4%) participants indicated that PMS should reward outstanding performance, 2.9% said that there should always be adequate budget for cash bonuses, 5.7% said that PMS should be outcomes based, 37.1% said that the current PMS is disorderly and therefore promotes biasness. New system is recommended and should be developed by relevant stakeholders, 2.9% said that more doctors are needed than PMS, 2.9% said that there is too much paper work in current PMS, 11.4% said that the PMS should be structured to suit the objectives of the department and be supported by the effective delegation of duties, 8.8% said that more education should be done to the workers about PMS, 8.8% said that the system is suitable for health professionals but administrative staff. This means that the PMS for health professionals should be developed. 2.9% said that instead of paying bonuses for PMS, the money should be used for capacity building and procurement of equipment, 5.7% said that proper staffing

should form the basis for PMS and supervision. The results revealed that there are several challenges that relates to the performance management system (PMS) (see table 4.62 below).

Table 4.62 Performance Management System – Other Suggestions

		Responses		
		N	Percent	Percent of Cases
B20Performance[a]	1	4	11.4%	13.8%
	2	1	2.9%	3.4%
	3	2	5.7%	6.9%
	4	13	37.1%	44.8%
	5	1	2.9%	3.4%
	6	1	2.9%	3.4%
	7	4	11.4%	13.8%
	8	3	8.6%	10.3%
	9	3	8.6%	10.3%
	10	1	2.9%	3.4%
	11	2	5.7%	6.9%
Total		35	100.0%	120.7%

4.2.64 Information Regarding the Reasons for Leaving the Public Sector

Table 4.63 shows that (7.2%) said that the biggest problem is accommodation, (28.1%) said that poor salaries, (2.9%) said poor hospital infrastructure and leadership, (5.8%) said no senior posts for clinical support staff, (7.2%) said poor human relations, (15.9%) said lack of resources such as human resources and finance, (4.3%) said impulsive service consumers, (15.9%) said poor working conditions, (2.9%) said low staff morale, (4.3%) said social issues, (1.4%) said lack of study leaves, and (1.4%) said lack of upward mobility, and (4.3%) said no career pathway.

The results therefore revealed that there are numerous challenges that constrain policy implementers from implementing policies in the Capricorn district. The challenges ranges, inter-alia, between accommodation, hospital infrastructure and leadership problems, lack of senior posts, poor human relation, lack of physical and financial resources, impulsive service consumers, low staff morale, lack of upward mobility and career pathways. The majority of the participants complained of lack of job satisfaction. Ashish P et al (2008: 2) states that job satisfaction is one of major factor by which staff feels commitment to the organization where they work (see table 4.63 below).

Table 4.63 Reasons for Leaving the Public Sector

	Responses	Percent of

		N	Percent	Cases
B21Leave[a]	1	5	7.2%	17.2%
	2	18	26.1%	62.1%
	3	2	2.9%	6.9%
	4	4	5.8%	13.8%
	5	5	7.2%	17.2%
	6	11	15.9%	37.9%
	7	3	4.3%	10.3%
	8	11	15.9%	37.9%
	9	2	2.9%	6.9%
	10	3	4.3%	10.3%
	11	1	1.4%	3.4%
	12	1	1.4%	3.4%
	13	3	4.3%	10.3%
Total		69	100.0%	237.9%

4.3 THE RESULTS OF THE STUDY

The aim of the study is to investigate the challenges faced by the health policy implementers in the public health sector in the Capricorn district and the objectives of the study is to identify the causes and challenges that constrain the implementation of health policy, assess the impact of these challenges on policy implementation, identify strategies and formulate guidelines that will assist the department of health regarding policy implementation, and also suggest possible solutions.

The study revealed the following:

- There is a serious human resource crisis in the Capricorn district especially in the rural areas. The challenge is between motivation, accommodation problems, brain drain diversity and poor incentives for health professionals. The Joint Learning Initiative (2004: 9-10) states that concerning the low motivation of health workers, experience and studies suggest that any comprehensive strategy to maximize health workers' motivation in the health sector has to involve a mix of financial and non-financial incentives.

- The recruiting and retention of the right staff are key challenges for health policy makers in the Capricorn district. Professional nurses have been leaving the district hospitals into the private sector and abroad in large numbers (Bucan, 2003: 22). This move has lead to the loss of key senior nurses in district hospitals, representing a potentially more serious crisis than the loss of doctors. The Joint Learning Initiative (2004: 9-12) states that such migration has been exacerbated by the exclusion from the scarce skills allowances of all but a few specialized categories of nurses who are not commonly found in district hospitals.

- That poor leadership styles by managers also pose a serious challenge in Capricorn district institutions. There seems to be little understanding by managers of how staff can be supported in fulfilling roles better. A lot of management is to instruct and control where little listening or supporting is happening. Couper et al (2002) states that poor leadership makes people delivering the service to be poorly informed about strategic direction and intention of the service delivery.

- In order for managers to support good performance, health care workers therefore need clear job expectations, up-to-date knowledge and skills, adequate equipment and supplies, constructive feedback and a caring supervisor. They also need motivation, especially when some of the other factors that support good performance are lacking. Luoma and Crigler (2002) states that indeed, highly motivated individuals can often overcome obstacles such as poor working conditions, personal safety concerns and inadequate equipment.

- Apart from poor leadership styles, further challenges were eminent in the supervision of health professionals. Various categories of health professionals were not found at work in the afternoons. The run private practices while on full time employment. They even extended their lunch and tea breaks way beyond the prescribed times.

- The biggest challenge facing the Capricorn district hospitals is personnel shortage in rural areas. Some of the district hospitals have staff shortages of up to ±50%. This result in existing staff having difficulty in fulfilling their duties, high level of absenteeism, and low level of morale. Padarath et al (2004: 25) states that recruitment issues therefore should be addressed separately from retention issues.

- There is a lack of team work and no sense of responsibility and commitment amongst health professionals in the Capricorn district. As long as Batho-Pele principles remains a nothing more than a poster on a hospital wall, quality of care cannot be achieved in district hospitals, and

- To support good performance, health workers need clear job expectations, up to date knowledge and skills, adequate equipment and supplies, constructive feedback and a caring supervisor. This means that workers also need motivation, especially when some of the other factors that support good performance are lacking. Luoma and Crigler (2002) states that indeed, highly motivated individuals can often overcome obstacles such as poor working conditions, personnel safety concerns and inadequate equipment.

- The mal-distribution of health professionals between rural and urban areas in South Africa demands specific strategies to address the imbalance. Reid (2002) states that financial and non-financial incentives have been used in other countries to recruit and retain health professionals in areas of need, and in 1994 a rural recruitment allowance was instituted in SA. However, this allowance was granted only to medical doctors and dentists, and remained at the same fixed rate since the time of its inception. It was perceived to be ineffective as an incentive for retention of professional staff, and despite the introduction of community service for all health professionals except nurses, it remains difficult to recruit and retain professional staff at rural hospitals, health centers and clinics

4.4 REPORTING AND UTILIZATION OF RESULTS

Data reporting and dissemination of information included the following:

4.4.1 mini – dissertation,

4.4.2 presentation at conferences,

4.4.3 seminars and to professional colleagues, and

4.4.4 publication in peer reviewed journals.

4.5 SIGNIFICANCE OF THE STUDY

Findings of the study were established regarding the challenges facing health policy implementers in the health sector in the Capricorn district in Limpopo. The study also suggested some possible solutions towards such challenges.

4.6 CONCLUSION

The chapter focused on the introduction, data analysis, the results of the study, reporting and the utilization of results, significance of the study and the conclusion. All statistical analysis was performed using a computer soft ware called statistical product for service solutions (SPSS). Nvivo was used for qualitative aspects.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter is about conclusions, limitations and the recommendations. It focuses on the introduction, evaluation, limitations of the study, implications of the study, namely, the implications for future research, implications for policy implementers, recommendations and the conclusion.

5.2 EVALUATION

The objective of the study was to explore the policy implementation challenges facing health policy implementers in the Capricorn district in Limpopo. The researcher wished to investigate the possible causes and nature of this challenges that face the policy implementers and subsequently come up with possible solutions.

The study revealed that there are challenges that constrain the policy implementers from rendering their functions effectively. The challenges range between motivation, brain drain, diversity, poor incentives for health professionals, poor supervision and accommodation problems.

With regard to brain drain, the researcher noted that the health workers are influenced by a combination of factors such as "Push-Pull" factors. These factors are felt by professionals within the source country that either creates an impetus to leave or an attraction to seek work in a recipient country. Meeus (2003: 29) states that brain drain can therefore be described in terms of what happens if emigration of tertiary educated, for permanent or long stays abroad, reaches levels that are not offset by remittances, technology transfer, investment or trade. It reduces economic growth as investments into education are not recompensed and leads to depletion of a country's human capital assets.

5.3 LIMITATIONS OF THE STUDY

A critical evaluation of the research and its procedures revealed several limitations which need to be acknowledged:

- some participants did not complete all the questions provided in the questionnaire. Some important information in the questionnaires was left out more especially on open ended questions and did not provide their ages,

- the results of this study cannot be extrapolated and be generalized to other contexts when given the exploratory nature of this research and the small sample size, therefore, these results can only be used as a working hypothesis for further studies (Silverman, 1985: 185),

- this research is contextually based because the researcher also belongs to the district being studied and is out of the context of the study. Some participants felt that as a staff member within the district, I already new all the challenges within the district,

- some participants were introverts. They were not willing to reveal all the challenges that they face within their work place. They anticipated that the outcome of the research may not be favorable to them and may affect them in one way or another, and

- the researcher was contacted by several participants who had concerns about the challenges they face within their work environments. The majority wanted to explain further regarding the problems that they come across. Taylor and Bogdan (1984) state that since participants are expected to open up completely, there has to be some reciprocal exchange from the researcher. It is therefore unwise for the researcher to hold back his/her feelings completely. The researcher tried to explain how he foresees the research findings being disseminated to the managers of the institutions in the Capricorn district, and the ultimate impact it might have on better service delivery strategies.

5.4 IMPLICATIONS OF THE STUDY

Apart from the above methodological limitations, the researcher believes that the findings of this study will help in identifying the challenges that the policy implementers are encountering within their work environments and will ultimately make a contribution to addressing them.

5.4.1 IMPLICATIONS FOR FUTURE RESEARCH

The results of this study cannot be extrapolated and generalized to other contexts when given the exploratory nature of this research and the small sample size. Therefore these results can only be used as a working hypothesis for further studies (Silverman 1985).

5.5 IMPLICATIONS FOR POLICY IMPLEMENTERS

This study described the nature and causes of different challenges that employers come across within their work environments, Assesses the impact of these challenges on policy implementation, promoted policy implementation strategies, formulated guidelines that could assist the department of health regarding policy implementation and even suggested possible solutions.

5.6 CONCLUSION

The aim of the study is to investigate the challenges faced by the health policy implementers in the public health sector in the Capricorn district. The objectives of the study is to identify the causes and challenges that constrain the implementation of health policy,

- assess the impact of these challenges on policy implementation,
- identify strategies and formulate guidelines that will assist the department of health regarding policy implementation,
- and also suggest possible solutions.

The research study is located within a quantitative framework. The quantitative design was used in this study as the strategies used by the researcher were in numeric form.

Terre Blanche and Durrheim (2004:42) described quantitative research as when a researcher collects data in a form of numbers and use statistical types of data analysis. The methodology entailed the distribution of self-administered questionnaires containing closed and open ended questions to the management of Capricorn district hospitals.

The results obtained in this study revealed that there are numerous challenges that constrain policy implementers from implementing health policies effectively and efficiently in their work environments. These challenges range between the following:
- poor incentives,
- lack of equipment,
- lack of office space,
- lack of dedicated transport for outreach,
- budget constraints,
- shortage of resources – human and physical,
- lack of career mobility,
- poor working conditions,
- communication problems and poor supervision style.

These challenges impact negatively on policy implementation.

5.7 RECOMMENDATIONS

It is therefore recommended that the comprehensive strategy to maximize the health workers' motivation in the health sector has to involve a mix of financial and non-financial incentives. The provincial department should also open some communication lines with the service providers at grass root level in order to address some of the issues before they become chronic challenges. There should also be regular meetings where feedback about provincial and national issues are addressed to the service providers. The current system of dissemination of information from the province and national government to the hospitals is apparently not clear.

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LETTER OF CONSENT

P.O BOX 946
LADANA
0704
23RD MARCH 2009

Dear Respondent:

Thank you for your interest in participating in this research project. I am currently enrolled for a Master of Public Health with the University of Limpopo, Turfloop Campus. The purpose of the research is for study purposes towards the completion of my degree.

The attached questionnaire has about 20 questions and may take about 15 minutes of your time to complete it. The questionnaire consist of straight forward questions where some of the questions will require you to mark with an "X" on the blank spaces provided giving one or more than one answer whereas some of the questions require some detailed information. Kindly give as much information as possible.

The information provided will help in identifying reasons for non-implementing of public health policies in the public sector and even suggest some possible solutions. I also wish to inform you that the information provided will be highly appreciated and will be treated confidentially. The duly completed questionnaire should be forwarded to Patric Baloyi at the above address.

Many thanks.
Yours faithfully
J.P Baloyi.
Contact cell number: 082 256 9279

Signature

Supervisor

Dr. M.B.L Mpolokeng

Contact information: Tel 015 268 3404/3507

Fax: 015 268 3384

Appendix A

QUESTIONNAIRE

1. Identifying Information

1.1 Gender

Male	1	Female	2

1.2 Age----------

1.3 Level of Education

Grade 12	Grade 12 + Diploma	Degree	Post-graduate	Other
1	2	4	4	5

1.4 Medical Background

Medical Officer	Professional Nurse	Clinical Support Officer	Other
1	2	3	4

2. Service Background

2.1 How long have you worked as a CEO / Matron / Clinical Manager/ Clinical Support Manager in your institution?

0 – 3 Years	4 – 6 Years	7 - 9 Years	10 – 12 Years	13 Years or more
1	2	3	4	5

2.2 Do you have adequate Doctors, Nurses, and Clinical Support staff in your hospital?

Doctors	Adequate	1	Understaffed	2	Fair	3	Badly staffed	4
Nurses	Adequate	1	Understaffed	2	Fair	3	Badly staffed	4
Clinical support staff	Adequate	1	Understaffed	2	Fair	3	Badly staffed	4

2.3 If "Yes", what was the case with staff recruitment and retention in the past three years in your institution? **(Yes - 1** and **No - 2)**

A	There has been adequate human resources in the hospital	Yes	1	No	2
B	Staff turnover has been very high	Yes	1	No	2
C	More employees left the public service to private and abroad	Yes	1	No	2
D	More staff will be joining the hospital as Community service officers in January	Yes	1	No	2
E	Most employees have been working part time	Yes	1	No	2
F	Most employees are threatening to leave the public service	Yes	1	No	2
G	Other reasons. Specify -	Yes	1	No	2

2.4 According to your knowledge, what do you think are the reasons for the staff resignations? **(Yes - 1** and **No - 2)**

A	Staff going abroad	Yes	1	No	
B	Staff going for private practice	Yes	1	No	
C	Staff going back to school	Yes	1	No	
D	Want to serve the hospital on sessional basis	Yes	1	No	
E	Staff don't want to stay at the rural areas	Yes	1	No	2
F	Unsure	Yes	1	No	2
	Other reasons. Specify -	Yes	1	No	2

2.5 Regarding staff resignations, what were their comments during exit interviews? **(Yes - 1** and **No - 2)**

A	Poor working conditions	Yes	1	No	2
B	Lack of incentives in the public sector	Yes	1	No	2
C	Low staff morale	Yes	1	No	2
D	No promotions in the public sector	Yes	1	No	2
E	Better salaries in the private sector	Yes	1	No	2
F	Competent packages abroad	Yes	1	No	2
G	Other reasons. Specify -	Yes	1	No	2

2.6 Do you sometimes hold staff meetings?

Never	Seldom	Sometimes	Often	Very often
1	2	3	4	5

2.7 If "Yes" what do they complain about?

2.8 Do you have adequate accommodation for staff in your institution?

Not at all	Some accommodation	Inconsistent	Adequate	Unsure
1	2	3	4	5

2.9 If "Yes" how is the condition of the accommodation?

Good	Fairly good	Poor quality	No staff accommodation in hospital	Problem beyond the hospital control
1	2	3	4	5

2.10 Do you receive policies and other pieces of legislation from National, Provincial and Local Government in your institution?

Never	Seldom	Sometimes	Often	Very often
1	2	3	4	5

2.11 If "Yes" what did you do with them?

A	Analyzed and monitored the implementation	Yes	1	No	2
B	Distributed them to relevant divisions	Yes	1	No	2
C	Polices were not implement able	Yes	1	No	2
D	Lack of dedicated budget for policy implementation	Yes	1	No	2
E	Lack of human resources to implement the policies	Yes	1	No	2
	Other	Yes	1	No	2

2.12 Based on your managerial experience, were the policies implement able?

Not at all	Sometimes	Partially	Implementable	Unsure
1	2	3	4	5

2.13 If "No" what do you think was the contributing factor? **(Very Important - VI; Important - I; Unsure/Don't know - U; Not Important - NI; Not Important at all – N).**

		VI	I	U	NI	N
A	Lack of staff cooperation	1	2	3	4	5
B	Poor communication between management and the grass-root level	1	2	3	4	5
C	Interference by union members	1	2	3	4	5
D	Lack of skilled personnel to implement the policies	1	2	3	4	5
E	Policy not budgeted for and as a result, no dedicated budget	1	2	3	4	5
F	Many contradicting policies are received timeously	1	2	3	4	5
	Other	1	2	3	4	5

2.14 What percentage of each race is represented in your institution?

Coloured	Indian	Black	White	Other
1	2	3	4	5

2.15 How do you manage diversity in your institution?

2.15 HIV/AIDS is rife in South Africa. How does the epidemic affect your staff performance? **(Strongly Disagree – SD; Disagree – D; Neutral – N; Agree – A; Strongly Disagree – SA).**

		SD	D	N	A	SA
A	Institution losses young and talented officers in huge numbers	1	2	3	4	5
B	Disease does not have any effect on staff performance	1	2	3	4	5
C	Only a small number of employees are affected and it does not make a difference	1	2	3	4	5
D	Management is aware of the problem and a contingent plan is in place	1	2	3	4	5
E	Unsure	1	2	3	4	5
F	None of the above	1	2	3	4	5
	Other	1	2	3	4	5

2.16 In spite of signed performance agreements, numerous health professionals are engaged with private practice meanwhile employed on full time basis. If this problem could happen in your hospital, how would you solve the problem?

2.17 Which leadership/management style do you use in managing your institution?

A	Autocratic leadership	1
B	Democratic leadership	2
C	Free-rein style leadership	3
D	Combination of the three	4
E	Non of the above	5
F	Unsure	6
	Other	7

2.18 Apart from "brain drain", there is "brain gain". How many health professionals did you get from outside the Republic of South Africa after losing the local professionals in the past three years?

Categories	Between 1 – 4 professionals	5 - 9	10 - 12	13 & above
Medical Officers	1	2	3	4
Professional Nurses	1	2	3	4
Clinical Support staff	1	2	3	4

2.19 Looking at the problem of brain drain, what do you suggest the Department should do to alleviate the problem in Limpopo?

2.20 Regarding performance management, what do you suggest the Department should do to improve the system and the seriousness to the health professionals?

2.21 In your view, what are the main issues that make health professionals to leave their province and go and settle in other provinces and even abroad?
