Cape Peninsula
University of Technology

Retention strategies for Doctors and Nurses in Lesotho: an implementation framework

By

'Makong 'Makahlolo

Thesis submitted in fulfillment of the requirement of the degree

Master of Technology: Business Administration

in the Faculty of Business

at the Cape Peninsula University of Technology

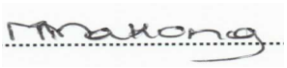
Supervisor: Dr Darlington Onojaefe

Cape Town

May 2017

Declaration

I hereby declare that the attached thesis is my own work and has not been submitted for any degree at any other tertiary institution before. I further declare that I have not copied the whole or any part thereof from any source whatsoever, and, where I have copied verbatim or otherwise, I have acknowledged and fully referenced the source so utilised. And I have been given consent by the CPUT ethical research committee to carry out this research.

‘Makahlolo		17/05/17
Candidate’s Name	Signature	Date

Dedication

This work is dedicated to my parents Rethabile Joseph and ‘Makabelo Henriette ‘Makong, my dear son Bakubung and husband Tsie Makhomarela for their support. Also to my siblings, Kabelo, ‘Mats’otetsi, Seloka, Mamankoe, Mats’eliso and Relebohile: and in particular, my superior Lira Ralebese and the Minister of Health Dr Monyamane for being the fountain that I drew strength when I needed to.

My ex colleagues from the Western Cape, Lucille Peterson-Van Zyl, Candice Thebus, Elaine Van den Heever, Mervyn Coetzee, Siseko Mtetwa, Charmaine Basson, Fazloen Zouity, Amiena Salie, Plaatjies Maribe, Pierre Le Roux, Mario Dacosta and the OMT department at large, my colleagues from Ministry of Law and Constitutional Affairs and Human Rights, particularly Costing Section, I don’t believe I could have made it without their moral support.

Acknowledgement

I am particularly grateful to the Almighty God, “Rock of ages” for granting me the opportunity, courage and strength to undertake this research work. Recognition must also be given to my supervisor, Dr Darlington Onojaefe and Co-supervisor Dr Corrie Uys, who have assisted me in the preparation of this thesis.

Dr Onojaefe gave me constant inspiration, encouragement and support, Doc thank you for guiding me through with this thesis, with those helpful comments, suggestions, corrections and positive criticism. Thanks to your hard work and dedication, I couldn’t have completed this thesis without you.

Fazloen Hoffman, thank you for proof reading my work, Salaam.

Mr Anthony Jacobs, thank you for proof reading my questionnaire, God Bless.

Mr Matjama, thank you for the assistance with the SPSS and statistics.

Mr Maile thank you for cordial and altruistic support, you stepped forward to assist me to obtain consent from the Ministry and further throughout my research.

Finally the Ministry of Health and Social Welfare and the Christian Health Association of Lesotho for granting me consent to continue with my research at Mohlomi, Bots’abelo and Scott Hospitals.

Abstract

This paper reviews retention strategies for Lesotho's doctors and nurses and presented an implementation framework to support and promote staff retention. . Based on the increasing necessity to retain doctors and nurses, the implementation framework becomes an essential element of retention strategy. A qualitative and quantitative research design technique using a self-managed questionnaire and interviews was adopted to gather data. The 120 doctors and nurses make up a sample. The information was statistically analysed using SPSS and grounded theory. Results identified that the current implementation strategy has failed to increase the retention rate of doctors and nurses. It is hoped that the implementation framework presented in this paper would help to achieve increased retention rate for doctors and nurses.

Table of Contents

Declaration i
Dedication ii
Acknowledgement iii
Abstract iv
Clarification of basic terms and concepts xi
Chapter 1 1
1.1 Introduction and background 1
1.2 Statement of research problem 4
1.3 Research problem background 4
1.4 Literature review 5
1.4.1 Retention concept 6
1.4.2 Importance of retention 7
1.4.3 Causes of health workers shortages 9
1.4.4 The influence of pull and push factors in the health sector 10
1.5 Research questions 10
1.6 Research objectives 10
1.6.1 Sub objectives 11
1.7 Research design and methodology 11
1.7.1 Design 11
1.7.2 Population 12
1.7.3 Sampling 12
1.7.4 Sampling technique 12
1.7.5 Data administration tool and design 12
1.8 Data Analysis Procedure 13
1.8.1 Quantitative data analysis 13
1.8.2 Qualitative data analysis 13
1.9 Delineation of the research 13
1.10 Significance of the research 14
1.11 Ethical consideration 14
1.12 Definition of Keywords 15
1.13 Chapter breakdown 16
Chapter 2 Literature review 17

2.1 Introduction 17
2.2 Implementation Framework defined 17
2.3 Importance of Implementation Framework 18
2.4 Synopsis of Lesotho's different implementation framework success and failure factors 19
2.4.1 Lesotho Health Workforce: Attraction and Retention Model 19
2.4.2 Incorporation of Lesotho success and failure factors in a revised framework 30
2.4.3 Total numbers and densities of the health workforce in Lesotho compared to African Region per 1000 population 33
2.5 Need for new implementation Framework in Lesotho 35
2.6 Framework to enhance retention rate 36
2.7 Framework for Retention Strategy 37
2.7.1 Discussion of the framework 38
2.8 Application of the retention strategies framework 40
Chapter 3 Research design and methodology 42
3.1 Introduction 42
3.2 Objectives of this research 42
3.3 Research Design 42
3.3.1 Qualitative method 43
3.3.2 Quantitative method 44
3.3.3 Justification for the use of qualitative and quantitative methods 44
3.4 Research Methodology 47
3.5 Population 47
3.6 Sampling 48
3.6.1 Sampling method 48
3.6.2 Sampling Size 48
3.6.3 Sampling technique 48
3.7 Data collection 49
3.8 Data collection methods 50
3.9 The research instrument 51
3.8.1 Questionnaires 52
3.8.2 Interviews 55
3.10 The researcher as an instrument 57
3.11 Research Procedure 58

3.11 Pilot Study 58
3.12 Data processing and analysis 59
3.12.1 Method of data analysis 59
3.12.2 Qualitative data analysis 60
3.12.3 Quantitative data analysis 60
3.13 Validity 60
3.14 Reliability 61
3.15 Research Ethics 62
3.16 Literature consulted 63
3.17 Summary 63
Chapter 4: Data analysis and interpretation 64
4.1 Introduction 64
4.2 Response rate 64
4.3 Organisation of the questionnaire 65
4.3.1 Descriptive Statistics 65
4.4 Quantitative Findings 68
4.5 Discussion of Key Findings 90
4.6 Qualitative Findings 93
4.6.1 Working conditions 93
4.6.2 Financial incentives 95
4.6.3 Personal Development 96
4.6.4 Recruitment related 97
4.6.5 Living conditions 98
4.7 Closing remarks 99
Chapter 5: Findings, conclusions and recommendations 100
5.1 Introduction 100
5.2 Conclusion resulting from literature 100
5.3 Conclusion on the research questions 101
5.4 Study objectives 102
5.5 Recommendations 103
5.6 Limitations of the study 105
5.7 Further research 105
6. References cited 106

Appendices.....119
Appendix A Survey questionnaire.....119

Table 1: Total number and densities of the health workforce in Lesotho, source: World Health Organization, 2006 33
Table 2: Response rate 64
Table 3: Biographical information of the respondents 66
Table 4: Financial Incentives 68
Table 5: Living Conditions 71
Table 6: Recruitment related 73
Table 7: Mentoring of Staff 76
Table 8: Personal Development 78
Table 9: Working Environment 81
Table 10: Implementation of current strategy 84
Table 11: Preference on implementation of current strategy 84
Table 12: Improving retention strategy for Doctors and Nurses 85
Table 13: Work duration 86
Table 14: Motivation 87
Table 15: Preferred change in your job 88
Table 16: Effective implementation strategy framework 89
Table 17: Can the framework attract Doctors and Nurses 90

Figure 1: Lesotho Health Workforce: Attraction and Retention Model (adapted from Ministry of Health and Social Welfare Government, 2010 20
Figure 2: Health Workforce in Lesotho, adapted from World Health Organization, 2006 34
Figure 3: Framework to enhance retention rate for doctors and nurses 37

Clarification of basic terms and concepts

The Network on Equity in Health in Southern Africa (EQUINET)
Ministry of Health and Social Welfare (MOHSW)
Human Resources Development and Strategic Plan (HRDSP)
Health Sector Strategic Plan (HSSP)
Health Sector Retention Strategy (HSRS)
Human Resource (HR)
Human Resource for Health (HRH)
Human Resource Information Systems (HRIS)
Human Resource Management (HRM)
Government of Lesotho (GoL)
Christian Health Association of Lesotho (CHAL)
World Health Organisation (WHO)
Millennium Development Goals (MDGs)
Queen Elizabeth II Hospital (QE II)
Lesotho Boston Health Alliance (LeBOHA)
Public Private Partnerships (PPPs)
International Finance Corporation (IFC)

Chapter 1

1.1 Introduction and background

Doctors and nurses retention is basic to health systems performance and a key issue is the means by which best to retain doctors and nurses. Two types of incentives have been distinguished by as vital to health workers retention. These are financial and non financial incentives (Dambisya, 2007:4). Onyango (2016:1) has discovered that the utilisation of financial and non financial incentives had been powerful in helping retention.

Lesotho health system is faces a diversity of human resource issues basically a general shortage of doctors and nurses which is decline by high quantities of skilled employees leaving the health sector to work in South Africa and abroad.

The main important resource of any organisation is the human capital, regardless of size or sector. A lack of them in this way endangers numerous parts of health care delivery. Accordingly doctors and nurses are important resources for health association and their services should have been kept up to guarantee quality health care given to patients.

Scott, Mohlomi and Bots'abelo hospitals are based in Maseru, the capital town of Lesotho. They are mandated to provide quality service to patients. However Lesotho health sector is currently faced with a high turnover rate of doctors and nurses. This increase in turnover has made the Lesotho health sector less effective: as it works to fulfill its service delivery mandate, a new implementation framework is needed to support retention strategies for doctors and nurses. This study identifies and examines a suitable implementation framework that can be used to support and sustain these retention strategies.

Moreover, those work forces that remain are discriminatory conveyed amongst urban and provincial ranges (Dambisya, 2007:1). The accessibility of health workers in

Africa is impressively more regrettable than in other African district of the world and it is one of the hindrance to conveyance of satisfactory health care (Onyango, 2016:1).

It can be assumed that the current retention strategies have failed to successfully retain its healthcare professionals in Lesotho and are allowed to continue failing despite the important contribution doctors and nurses could make to help realise the service delivery mandate of government. Doctors and nurses are classified as critical skill and the implementation framework that works to improve the retention rate would help address the problem of service delivery and control the scarce skilled nature of health care professionals in Lesotho. In the strategy document, the provision of incentives to doctors and nurses were made and implemented to ensure an increased retention rate (Ministry of Health and Social Welfare, Government of Lesotho, 2010:2). The effectiveness of some of these financial incentives has been reviewed by Dambisya (2007, 42) and fit into two categories:

Non-financial incentives: accelerated grade policy; continuing education; higher promotional prospects for rural HCW and bonding (student scholarship). Non-financial incentive as: Improvement in facilities and equipment; IT support; staff housing; staff security; transport; support centers; sabbatical leave; formal job upgrading; improved career management; better posting policy; streamlined HRM policies and procedures; HRIS (Dambisya, 2007: 42). While the financial incentives includes accelerated increment for rural workers; overtime and night duty allowances; mountain allowance; housing subsidy; top-up pay for Christian Association of Lesotho (CHAL) hospital workers (Dambisya,2007: 42).

The above strategies have been implemented by the government of Lesotho (GoL) for the past three years while implementation of the current retention strategy allows the payment of financial incentives to healthcare professionals in two mountains areas (Mokhotlong and Qacha’s Nek)(Schwabe, Lerotholi, and McGrath, 2004:17). This practice, although well-intentioned, has failed to achieve the desired effect because it is both discriminatory and exclusive; healthcare professionals working in other parts of the country do not qualify to receive such incentives. In addition to the

discriminatory and exclusive implementation of financial incentives, there are other payments such as occupational risk and on call allowance that helps to deepen discrimination and exclusion, to the detriment of wholesome retention that is both effective and proactive (Schwabe et al, 2004:16).

While the above strategy implementation has the potential to achieve limited retention, it is capable of creating apprehension amongst healthcare professionals that feel discriminated and excluded from the incentive payment. Furthermore, qualification rewards or incentives are paid to those with higher qualifications. Although this incentive payment is discriminatory, it is good to maintain a higher standard of qualification as well as promote the culture of continuous professional development; a necessary component of professionalism and quality assurance. . Maslow theory as cited in (Lin Yun, 2007:23) outlined that individual are no longer motivated by money as its power is limited. Hertzberg (1966) as cited in Mbah and Ikemefuna (2012:278) carried out the studies in line with these results. However Mrara (2010:7) argued that bonus award improved retention if structured with a rigid salary.

Moreover, bonding strategy is a non-financial incentive whereby students trained in South Africa, and abroad, are obliged to provide services in completion of their studies for the time same to the scholarship/bursary, but only few graduates' return (Schwabe et al, 2004:6). These graduates are more willing to refund the government costs instead of serving which indicates that this strategy is not comprehensive enough to attract graduates. From the above, it is concluded that the implemented retention strategy has failed to achieve expected retention, because Lesotho's health sector is still experiencing a high turnover of doctors and nurses. This is supported by Ministry of Health and Social Welfare, Government of Lesotho (2010:6) which indicates 15% of nurses leave the service every year, while about 90% of health centers operate without healthcare professionals. Right now, the nation is seriously reliant on non-national medical doctors (Schwabe et al, 2004:6), among which there is likewise high steady loss rate since they are utilising Lesotho as a venturing stone to South Africa. This circumstance obstructs long haul arranging and maintainability

of health service delivery and projects expected to enhance the talented human resource base (Ministry of Health and Social Welfare, 2013:29).

1.2 Statement of research problem

Currently, retention strategies implemented has not improved the retention rate for healthcare professionals and a new implementation framework to improve retention has become inevitable for the Lesotho health sector.

1.3 Research problem background

While the retention strategy is useful in retaining doctors and nurses, the Lesotho health sector would benefit from the expertise of their medical staff. This is true for the health sector that is confronted with a high percentage of staff leaving the organisation; the increase has forced the Lesotho health sector to operate with a limited number of healthcare professionals at the expense of the promised service delivery mandate (Ministry of Health and Social Development, 2010:10).

On the one hand, according to WHO (2017:1) the lack of medical schools for training in Lesotho accounts for most doctors and nurses who go abroad to study, especially in South Africa. It encourages healthcare professionals to look for better paying jobs overseas in completion of their studies, for example the current situation look like it is caused by countries such as United Kingdom (UK) and Australia by attracting and retaining doctors and nurses, while the health department has failed. On the other hand, the health sector has not managed to develop effective strategies for retention; this thus has a tremendous unconstructive effect on hospitals, clinics as well as community health centers. The argument here is that most of these facilities are understaffed and above all those that have been hired are overburdened as they are severely outnumbered by the amount of patients per day (Matamane, 2014:13).

The goal of this research is to identify the failure of the existing retention strategy for health professionals working at the Lesotho Health sector, with the opportunity of helping the sector in creating and implementing an effective retention strategy.

1.4 Literature review

A literature review is an explanation on a topic that has been published by recognized scholars and researchers. According to Rust (2012:33) an adequate literature review is required in all research projects. This should be all relevant published information regarding: the meaning of the concepts; the meaning in different contexts; perceptions or opinions about the topic; characteristics; advantages; disadvantages and developments in the field of study**.** Developing countries key concern is public health as a result of the lack of retention strategies and relocation of health workers; these have become important issues to the Ministry of Health and Social Welfare in Lesotho. In accordance with Dambisya (2007:1), the nature of the good framework relies on upon health of employees who are propelled about their occupations and in this way chooses to remain. The WHO (2006:18), outlined that 36 of the 57 countries in sub-Saharan Africa are challenged by shortages of health workers and millions are required to fill this crevice. Nations with the most noteworthy request have the least health employee supply. The Africa area has access to 3% of the world's health workforce however it experiences more than 24% of the worldwide weight of health (WHO, 2006:19).

However, World Health Organisation (WHO) has recommended at least one (2) doctor per 10,000 people (Naicker et al, 2010:62) and these numbers should cover rural and urban areas; according to relevant literature these doctors relocate from country to urban zones, leaving rural areas understaffed (WHO, 2010:14). The low-salary nations are attempting to prepare new health professionals to fill the workforce and are additionally attempting to hold the staff that they have effectively prepared; therefore movement is regularly an exit plan. Professionals first relocate from provincial regions to urban zones, then out of the nation (Ministry of Health and Social Welfare, 2013:7). In August of 2006, the Center for Global Development

distributed a database speaking to the primary orderly push to gather data on the reciprocal net streams of African-conceived doctors and medical attendants to nine vital goal nations. As indicated by this "cerebrum deplete" database, 60% of Lesotho specialists are working abroad (Clemens & Pettersson, 2007).

1.4.1 Retention concept

According to Humphreys, Wakerman, Pashen and Buykx (2009:7), retention is defined as 'the time span amongst initiation and end of work'. Kibui (2015:15) defines retention as an intentional move by an association to make a condition which draws in representatives for long period. However, retention is not eternal but identified as the minimum length of stay in the organisation (Das & Baruah, 2013:8). This minimum length is defined by a combination of profession, position and benefit, and relies on upon the area and qualities of the group that influences the simplicity with which the healthcare employees can be supplanted (Das & Baruah, 2013:8). Meanwhile Dambisya, Lipinge and Loewenson (2010:15) define retention as keeping health workers within the healthcare systems and are usually the result of strategies developed and applied that produce them. Further, within the levels and locations of the health system where needs are high, the challenge of health worker retention is exemplified by the fact that a large portion of the total populace lives in country zones, however most health workers live and work in urban areas as stated by the Ministry of Health and Social Welfare (2013:8).

Retention is thus an equity issue addressing equitable access to healthcare where efforts target areas and populations with greatest need. Health services in these areas must therefore focus on retaining health workers for as long as feasible through minimising avoidable turnover of staff and the associated high costs of their replacement *(*Russell et al, 2013:257). Health worker retention is also a policy response to avert the influence of push and pull factors favouring healthcare worker migration (Naicker et al, 2009:62). Also, Schuler and Jackson (2006) as referred to in Kassa (2015:15) characterise retention as everything a business does to support qualified and profitable workers to keep working for the association.

1.4.2 Importance of retention

The retention of staff in any work environment is an important human resource function and in this case, good workforce retention ensures effective health services for better service delivery. According to the researcher employees who have been in the organisation for many years are more experienced and have skills and knowledge to provide quality health care. But when they leave, these benefits are lost and this has an impact on the health systems and service delivery. . Given the versatility idea of capable workers, retaining them turns into a matter of fear to managers since, in the perspective of Buckingham (2000), their leaving implies a misfortune to the association of its scholarly capital or immaterial resources (Kassa, 2015:10-11).

The primary reason for retention is to keep the loss of skilful workers from the association as this could have unfriendly impact on profitability and service delivery (Samuel and Chipunza, 2009:411).Turnover is not only destructive to organisations, it is also costly. Every time an employee quits, a replacement must be recruited, selected, trained and permitted time on the job to gain experience. Apart from the costs that are directly associated with recruiting and training a new employee, other indirect costs exist (Samuel & Chipunza, 2009:411)

The major goal of retention is to prevent the loss of competent employees from the organization as this could have adverse effect on productivity and service delivery (Kassa, 2015:13). The researcher is of the opinion that a refinement amongst retention and turnover is vital on the grounds that retention is a measure, turnover is not. It is of higher value to retain experienced employees rather than new recruiting. The quality of service delivery is always good when the human resource is experienced; low retention shows that relatively few individuals are remaining sufficiently long to accomplish work authority (Kassa, 2015:10). Ideal workforce retention is crucial to productive working of health service and conveyance of enhanced health (Russell, Wakerman & Humphreys, 2013:257).

The unnecessary turnover is costly and impacts on the budget of an organisation. The high turnover rate incurs direct and indirect costs to businesses, and also a noteworthy loss of impressive aptitudes, ability and information for the organisation (Odubanjo, 2015:12). Sun (2012:7) is of the agreement that employee retention is a vital issue that has been addressed through literature. Many organisations understand that employee retention is complex but that it cannot be ignored (Borgohain, 2010:10). It's very challenging for managers to reduce turnover and keep their employees on board (Borgohain, 2010:12). Regardless of how economy is boosted and working conditions improved, employee turnover has an impact in both developing and developed countries (Samuel & Chipunza, 2009:411).

According to Phillips and Connell (2003) as cited in Guma (2011, 12) turnover negatively affects both the organisation as well as employees. And every individual in the organisation are affected by the consequences related to the turnover. Odubanjo (2015:12) puts forth that turnover causes the association a considerable measure of cash, especially controllable turnover: the loss of highly skilled and experienced employees; this will impact negatively on organisational goals and its clientele. The cost to turnover should not be underestimated because the organisation has to recruit and train new staff to be effective and efficient; the ideology is to have low turnover and maintain consistency (Odubanjo, 2015:12). Effective retention strategies can bring an organisation closer to achieving this ideal.

Mrara (2010:5) is in agreement that turnover impacts on health systems. Losing part of the health workforce impacts on performance and productivity and may result in either absence of some services or poor execution, mostly the community health care centers. The healthcare workers who remain in the systems are overworked and at times have to do double shifts or deliver services outside their scope of practice (Onyango, 2016:7). These employees are mistreated, not only by their workloads but also by being poorly remunerated, the lack of supervision, lack of training and limited career opportunities, forces these employees to leave for the private sector; thus creating vacancies that reflect a severe skills shortage (Mrara,

2010:19). The human capital is a valued resource, especially where skills and expertise are concerned (Kossivi et al, 2016:262). The success of many institutions relies on upon these workers with basic aptitudes (Kossivi et al, 2016:2016). To gain or lose ability can decide the achievement or disappointment of the institution (Sun, 2012:8).

Nkwocha and Iheriohanma (2012:201) maintain that controllable turnover impacts on institutional performance and this can be directly linked to productivity. It will also affect on the nature of administration conveyance. The voluntary leaving of critical skills is regarded as a serious problem to organisation stakeholders. Nkwocha and Iheriohanma (2012:201) claim that turnover is directly related to loss of expertise. Turnover of critical and scarce skills creates vacancies that it is difficult for a company to fill unlike entry-level positions. Turnover can also cause a conflict between management. Many organisations invest time and resources into recruiting the right employees.

The researcher is of the idea that employee retention is not dealt with properly. In her opinion, organisations don't actually recognise the factors that can retain employee retention. The consequence of employee retention was not clear even though some organisations have implemented strategies in place to reduce turnover but those strategies were irrelevant to the problem. According to the researcher it cannot be argued that every employee wants to work for the good organisation that pays better and where their needs are taken care of. And organisations are advised to be the best so that turnover can be reduced directly (Sun, 2012:8).

1.4.3 Causes of health workers shortages

The causes of health workforce shortages differ from country to country. Some of the regular explanations behind disappointment are postponed compensations, deferred advancements, absence of acknowledgment, and a powerlessness to bear the cost of the fundamental necessities of life; therefore migration is often a stepwise for health professionals to migrate to look for better situations (Naicker et al, 2010:62).

In Lesotho shortages of doctors and nurses are attributable in part to lack of local training capacity. The bonding strategy has failed (Dambisya, 2007:45) as the government is spending money for doctor's researcher to get training abroad and according to this strategy they have to come back and serve the country for certain years but only few comes back.

1.4.4 The influence of pull and push factors in the health sector

The health workforce choose to leave their employments decide to leave their jobs to due negative (push factors) or positive (pull factors) reasons (Gebremariam, 2010:20). Pull components are those that draw in people to new goals. Push elements are those that repulse the person from an area and drive them to leave their homes and occupations (Gebremariam, 2010:20). Turnover takes place when health professionals move from country to town, locally to abroad and even from government to NGO's (Matamane, 2014:25). The current literature uses push and pull factors as the concepts to describe the phenomena for decision to leave (WHO, 2010:19)

1.5 Research questions

1) What implementation framework would be effective in achieving desired retention strategies for Doctor and Nurses?
2) Can the new implementation framework be effective when it is used to attract and retain Doctors and Nurses?

1.6 Research objectives

The objective of this research is to provide retention strategy implementation framework that would help to improve retention rate of doctors and nurses in Lesotho.

1.6.1 Sub objectives

1) To address the issue of scarce skills in Lesotho health sector
2) To Improve service delivery through improved retention strategy implementation for doctor and nurses
3) Create attractive working environment through the development and implementation of a new retention strategy implementation framework.

1.7 Research design and methodology

1.7.1 Design

The design for this research was cross sectional, actualising both subjective and quantitative approach keeping in mind the end goal to answer the researcher questions and fulfill the research objectives. The subjective involved the facilitation of interviews with nine (9) respondents who were the essence of the three selected hospitals. A semi organised interview calendar was utilised to determine retention strategies so as to seek toward improve retention rate of doctors and nurses in Lesotho. These interviews were recorded and took place at the participant's normal workplace to decrease disruptions, noise and self-consciousness. This improved the quality of the recordings for transcription and permitted unrestricted dialogue from other employees.

On the other hand the quantitative technique involved the administration of one hundred and twenty (120) structured questionnaires. These questionnaires were distributed among doctors and nurses in their respective selected hospitals. The inquiries were replied in a 5-point Likert scale running from1=Strongly Disagree to 5=Strongly Agree. The researcher explained the procedure and instructions for completing the questionnaire. And also informed the participants the questionnaire was voluntarily to enable the collection of data from those willing to participate.

1.7.2 Population

In this study populace comprise of all doctors and nurses working at Scott, Bots'abelo and Mohlomi hospital in Maseru district, Lesotho.

1.7.3 Sampling

As per Onyango (2016:18) sampling includes all units and the determination of investigation of modest number of occasions, articles or people to make a decision about something from the whole populace from where the sample is chosen. The examination utilised simple random sampling strategies to choose sample from the study.

1.7.4 Sampling technique

The simple random sampling technique was implemented by this study to choose respondents from the sample structure of Mohlomi, Bots'abelo and Scott hospital. This technique was selected because each employee of the hospital had an equivalent and autonomous possibility of being chosen for the study and that data was collected without bias in an efficient manner. Numbers were assigned to every name on the example structure. The bits of papers with composed number were then put in a compartment and blended altogether, and afterward the example size of 120 respondents was drawn. This was done deliberately to maintain a strategic distance from twice representation of the example.

1.7.5 Data administration tool and design

The total of 120 questionnaires was distributed on various days depending on the hospital's manager's permission to visit the hospital. And this was distributed during tea/break times and or dropped in their pigeonhole if they are on duty in order not to interfere with the daily tasks. The questionnaire was designed into two (2) sections, section I was demographic variables which includes occupation, age, gender, marital

status, language, job status, highest academic qualification and length of service of the respondents. Section II, consisted of six sub-sections detailing retention strategies listed from A-F. Respondents were likewise given open-finished inquiries, to express their assessments without being impacted by the specialist, and to support suddenness. This area was proposed to inspire reactions on their perspectives about the present retention system. The inquiries were replied in a 5-point Likert scale going from 1=Strongly Disagree to 5=Strongly Agree. The second phase was semi structured interviews comprising of ten (10) pre-arranged structure of questions which were used to ask the opinions and views of nine (9) health professionals on the effectiveness of the current retention strategy.

According to Iwu (2012:95) every instrument must be assessed before it's used for both legitimacy and unwavering quality purposes. The legitimacy and unwavering quality of the instrument were tested by conducting pilot study with 100 participants.

1.8 Data Analysis Procedure

1.8.1 Quantitative data analysis

The computer software Statistical Package for the Social sciences (SPSS) was used to analyse quantitative data. The researcher summarised figures as frequencies, and illustrated them by means of tables.

1.8.2 Qualitative data analysis

The qualitative data was analysed using content analysis. The researcher recorded the interviews. Coding was utilised through the content analysis.

1.9 Delineation of the research

Firstly, the scope of this study was limited to public and CHAL hospitals whose control and administration are straightforwardly under the legislature and private

hospitals were excluded in the research though they assume a vital part in supporting health workforce along with health systems, secondly, the study involved two cadres of health professionals which were doctors and nurses. Their responses were compared to determine which framework can be implemented to enhance retention of health workforce in Lesotho who seeks opportunities internationally, and lastly, the practical part of this study was limited to the capital town of Lesotho, Maseru geographical area. With the end goal of this study, the exploration was conducted at the following selected hospitals: Scott, Mohlomi and Bots'abelo hospital based in the different areas that forms part of the city Maseru.

1.10 Significance of the research

This is the first experiential study conducted to assist the health sector to develop an effective implementation framework to solve the problems of retaining doctors and nurses mainly in the Lesotho context. This study is important to the researcher in four main respects; (a) the health managers would understand and implement the framework that the study would identify to improve retention (b) the researcher would get better understanding into the problem of the framework to retain doctors and nurses and as a result add knowledge to university while at the same time fulfilling the requirement for Masters Business Administration (c), other stakeholders, such as the Ministry of Health, CHAL and its departments would also find the study significant, which could be applied to other districts in the country to effectively improve retention rate of doctors and nurses and (d) the consequences of the study will urge different researchers to investigate encourage regions that are not encased in this study.

1.11 Ethical consideration

It is a principle that confirms that moral thought is the guideline, which guides field of research and ought to follow in understanding, with affirmed measures in accordance with the exploration morals strategy of the department of health in Lesotho. The researcher obtained consent from department of health management

prior to conducting the study (ethical clearance approval). The researcher also explained the procedure and instructions for completing the questionnaire. In addition the members were educated that the questionnaire was deliberate and confidentiality statement that read ("information supplied will be utilised for stated reason for scholastic research only, furthermore will be kept in strict professional confidence) was included and anonymity was ensured.

1.12 Definition of Keywords

Employee Retention: An exertion by a business to keep up a workplace which underpins current staff in staying with the organization (Rader, 2012.).

Human resource for health: the person engaged in any capacity in the production and delivery of health services (Mercer, Dal Poz, Adams, Stilwell, Buchan, Dreesch, Zurn & Beaglehole, 2003)

Health Professionals: an individual who helps in distinguishing or anticipating or treating sickness or inability (http://wordnetweb.princeton.edu/perl/webwn?s=health%20professional)

Implementation Framework: refer to guidelines on how to carry out strategy implementation processes and connect the linking implementation factors appropriately (Okumus, 2003).

Millennium Development Goal: are eight advancement objectives that were built up taking after the Millennium Summit of the United Nations in 2000, after the reception of the United Nation (Bangdiwala, Fonn, Okeye & Tollman, 2010)

Retention: Methods for overseeing and holding skilled representatives utilising inventive retention programs (Phillip & Connell, 2003).

Service Delivery: the way sources of info are consolidated to permit the conveyance of a progression of intercessions or health activities (Robinson, 2010)

Hospital: is a health foundation that gets and treats individuals from the populace for social insurance related conditions (Mateus, 2007)

Strategies: According to Web definition, strategies is gathering of exercises to deliver yields required to accomplish arranged results.

Turnover: is characterised as the discontinuance of enrollment in an association by a person who got fiscal pay from the association (Odgers, 2008)

1.13 Chapter breakdown

Chapter 1 of the study provides discussions of the background of the problem of the study, why it should be researched and the purpose of conducting the research
Chapter 2 presents a wide literature review on retention strategy implementation framework,
Chapter 3 focuses on the research methods, and also discusses the population and sampling, data collection procedures, and instrumentation,
Chapter 4 deal with the data analysis as well as interpretation of the results and
Chapter 5 presents findings, conclusions and recommendations.

The researcher has intended to complete the thesis in December 2016.

Chapter 2 Literature review

2.1 Introduction

This section displays the analysis of writing on retention strategy for doctors and nurses. This review examined proposing and opposing arguments on retention strategies to highlight best practice and identify implementation challenges in line with a study plan. The plan of the literature review was to identify the research questions that would form the basis on which the study was conducted. The chapter begins with the definition of an implementation framework, the importance of implementation framework, synopsis of Lesotho's different implementation framework success and failure factors and how these factors can be incorporated in the revised and updated framework and the need for a new implementation framework in Lesotho.

2.2 Implementation Framework defined

Nyamwanza and Mavhiki (2014:3) defines strategy implementation as the way an organisation should build up, use and merge departmental structures, control frameworks and culture to take after systems that prompt to an upper hand and better execution. According to Li, Gouhui and Eppler (2008) as cited in Nyamwanza and Mavhiki (2014:3) technique execution is a key test for existing associations. Company achievement is administered further by how well strategies are implemented than by how great the methodology is in any case (Speculand, 2009:168); the execution of the system conveys returns, not the making of it (Speculand, 2009:167). Numerous structures have been created to assist procedure execution. Despite the fact that organisations appreciate the requirement for methodology and successful execution, the last frequently misses the mark concerning the objectives the association has set itself (Shah, 2005) as cited in Nyamwanza and Mavhiki (2014:3).

As per Voss (1995) as cited in Mellor (2014:36), implementation framework is defined as a simple lifecycle replica of the procedure of execution as far as a chronological game-plan consisting of three stages and provided three (3) features to the implementation range of study:

1) It is the study of a process over its lifecycle. It should be concerned with increasing understanding about the procedure and the contact of the procedure with the setting and others experiencing a similar procedure (Mellor, 2014:37).

2) It ought to be worried with the achievement and disappointment results of the procedure, and ought to be familiar with the varying meaning of achievement above the lifecycle (Mellor, 2014:37).

3) It ought to deal by way of classifying as well as, comprehension the elements affecting the procedure of usage and its prosperity and disappointment. These ought to incorporate (yet not be limited to) association, specialised arranging, business procedure plus administration (Mellor, 2014:37).

2.3 Importance of Implementation Framework

The implementation framework assists in restructuring upcoming employees at the same time sustaining and empowering the efficiency of the present employees (Government of Health Western Australia Department of Health, 2012:5). It is intended to draw in as well as preserve staff and meet existing and prospective demands by increasing the magnitude and nature of the future employees. It also promotes the design phase by promoting vigilant analysis of evidence, by assisting the projects that have a minimal opportunity to succeed not to waste insufficient resources (Health Workforce Australia 2011:6). According to the Centre for Mental Health (2012:8) the importance of an implementation framework is to take strategies to the next level by embracing the vision of the organisation, brings about the real and measurable improvements for people globally by decoding ideals into genuine action that can be used by the organisation.

2.4 Synopsis of Lesotho's different implementation framework success and failure factors

According to literature, lot of factors has an effect on methodology usage in an association and, thus, impacts on structural execution (Belbin, 2011:22). Plenty of components can possibly influence a complete plan; difficulties regularly occur in the consequent performance development (Li, Guohui & Eppler, 2008) as cited in Nyamwanza and Mavhiki (2014:2). Managers views are repeatedly blemished; consequently, the vast majority of times (9/10), they don't succeed to effectively execute the techniques they have created (Speculand, 2009:167). Speculand contends that managers continually think little of the challenges attached to actualising a procedure and therefore designate the procedure to others, redirecting their focus from what should be finished. For this reason, methodologies not succeed: not on the grounds that the technique is incorrect, rather in light of the fact that the implementation was ineffectively made (Speculand, 2009:168). The Lesotho retention approach depicted below has failed to achieve the retention rate for doctors and nurse because the implementation was poorly implemented (Ministry of Health and Social Welfare Lesotho, 2013:11).

2.4.1 Lesotho Health Workforce: Attraction and Retention Model

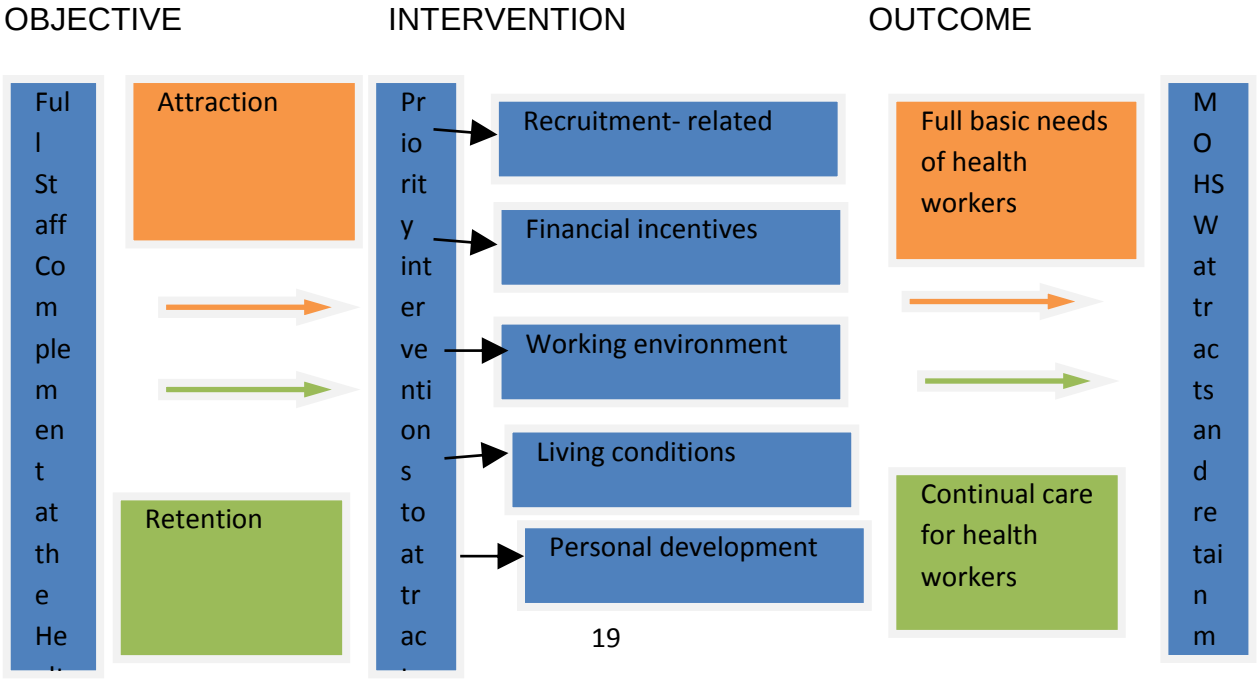


Figure 1: Lesotho Health Workforce: Attraction and Retention Model (adapted from Ministry of Health and Social Welfare Government, 2010

From the literature review it is evident that the retention strategy pictured above has failed to improve the retention rate for doctors and nurses in the country since there are not enough health professionals to deliver quality service to patients (Health Sector Strategic Plan (HSSP) 2012-2017:8). The researcher concluded that managers have failed to move from plan to action. This model was implemented without any practical base to guide the choice of intervention. The findings of its success and failure are outlined below.

2.4.1.1 Financial incentives

Monetary motivations have for some time been held to positively affect how successfully staff may add to the association (Kayimba, 2011:36). The possibility of money influence was borne from the logical administration hypothesis somewhere around 1890 and 1930.According to Schwabe, Lerotholi and McGrath (2004:16) the Human Resource for Health Strategic Plan (HRSDP) prepared by the department of health have outlined efforts to retain staff by promoting fairness and decency among employees, as far as pay, stipend and motivations. The incentives come in the form of salaries and allowances (WHO, 2000:61). The payment of salary incentives and allowance in Lesotho was initially inequitable and unfair; fair and equitable initiatives was introduced and implemented with support from the Global Fund and other donors over a five (5) year period (Lipinge, Dambisya, Loewenson, Chimbari, Ndetei, Munga, Sibandze & Lugina, 2009:17).

The initiative also known as HRSDP's financial stimulus such as mountain stipend was extended to incorporate other doctors and nurses working in Mokhotlong and Qacha's Nek districts (Lesotho) (Schwabe, Lerotholi & McGrath, 2004:3-17). As part of the initiative the payment of risk allowance usually meant for psychiatric patients to incorporate those tending for people suffering from HIV/AIDS and different irresistible illnesses (Dambisya, 2007:14).

When interviewed on 16 July 2015, Chobokoane confirmed that the Global Fund ended in 2014, other initiatives would be needed by the government as retention procedures to preserve the entire employees within government system. In addition to the incentive mentioned above, doctors and nurses receive two (2) increases per annum, one of which is rewarded on the yearly commemoration of administration and the other rewarded to every single government employee at the yearly spending perusing (Kaplan, Dominis, Palen & Quain, 2013:8). While this is commendable, it might not be sufficient compared to the benefits afforded to doctors and nurses in South Africa, Britain, and America.

There has been a delay in the provision of a four (4%) percent increase which was supposed to be given in April 2014 following the budget reading. The delay in implementing such a salary prompted a strike at Mamohato Memorial Service, the hospital operating under South African Netcare (Ts'epong) (Public Eye, 2014). Health workers were unhappy. Apart from the delay, they feel that this percentage increase is too little to supplement their salaries (Public Eye, 2014).

Another inadequate compensation is cited as follows: certain doctors and nurses are paid above the minimum notch if they possess additional qualifications (Schwabe et al, 2004:16). This practice, though well intended has failed to achieve its desired objective because it is both inequitable and exclusive, as specific doctors and nurses who do not hold additional qualifications are not entitled to such a top-up. As a result salary scales are unbalanced (Kaplan et al, 2013:8). This compensation helps to deepen discrimination and exclusion. According to the researcher, money related motivating forces are influential retention approach, but are not as efficient as they should be because the problems with remittances is their disintegration after some time due to the negative impact of inflation. According to Kaplan et al (2013:8) the Health System Assessment (HAS) reinforced that Lesotho is adjusting to inflation annually and as a result had pay rates that are little when contrasted with others in the district. It is evident that financial incentives are less effective in holding these health professionals. The questionnaire conducted by Health System Strengthening (HSS) between October 1, 2012 and March 31, 2013; couple of workers was content

with their income (a minor 7.7% (2012: 5.2%). No noteworthy changes support the idea (Ministry of Health and Social Welfare Lesotho, 2013:3).

2.4.1.2 Personal development

According to Dambisya (2007:16) the Lesotho Health and Social Welfare is offering bursaries/scholarships to students who are contemplating towards acquiring medical education in South Africa and other countries because there are no medical schools in Lesotho (Lesotho Health Sector Strategic Plan 2012/13-2016/17, 2013:18). This is in a form of a bonding agreement whereby graduates are required to serve the division for a time that is equivalent to the length of their education programs (Schwabe et al, 2004:7). This was believed to be a good retention strategy to absorb them into the public service pool during the agreement, however, it gives the idea this is insufficient as some of these doctors and nurses are set up to pay back the departmental expenses, rather than working for it (Dambisya, 2007:45). According to the Minister of Health, Dr Manamolela, the government of Lesotho has been investing millions of maloti into the training of both medical doctors and nursing staff, only to lose them to other countries, mainly South Africa (Public Eye: 2014). Most local doctors on completion of their training in South Africa are automatically absorbed into their Health System (Murman & Sullivan, 2008:3). This is beyond the control of the government of Lesotho because South Africa offers better remuneration and other incentives (Smith & Stark, 2009:13); including the provision of conducive working environment for staff (World Bank report, 2005:12). In addition, these professionals are either prepared to refund the government the costs rather than coming to serve or seek greener pastures in developing countries such as UK, USA and Australia (WHO, 2009:10).

When interviewed on 10 May 2015 Rankhone indicated that Lesotho was expected to work diligently with the South African government to guarantee the recovery of the money spent on the training of doctors currently employed in the neighbouring country. National Manpower Development Secretariat (NMDS) was established in 1978; due to various obstacles the NMDS on its own has failed to effectively collect

enough money so that further training programmes could be financed (Rankhone, personal communication 10 May 2015). In addition over the years the rise in the cost of education dropped considerably. In August 2012 the government of Lesotho, through the Ministry of Development Planning, awarded JAMALE Holdings a contract to collect monies owed to the government by previous beneficiaries of the fund (Public Eye, 2012). JAMALE holdings began the process in September 2012 and still have a long way to go before the funds can be fully recovered (Public Eye, 2012).

The minister of health, Dr Manamolela expressed a wish for training to be focused in its neighbouring country with a specific end goal to deal with an easy absorption of graduate doctors into the South African system (Public Eye, 2014). In 2012 up to 20 student doctors were sent to Nigeria for medical training but unfortunately due to political instability for the past four decades (Public Eye, 2017) in that country, only two remained, therefore it was proposed by the current Health Minister Dr Ramatlapeng, to return those students to the country once training facilities under construction are completed. Moreover, Lesotho made an agreement with the Zimbabwean government to have their students undergo training at the Zimbabwe School of Medicine (Mwase, Takondwa, Kariisa, Doherty, Hoohlo-Khotle, Kiwanuka-Mukiibi & Williamson, 2010:49). The previous Minister of Health Dr Manamolela outlined that since 2012, students from Lesotho were sent to Zimbabwe for medical training and others trained in other countries.

However, numerous students after graduation didn’t come back home and therefore the country should rearrange its framework and satisfactorily get ready for the arrival of their qualified specialists. It is a challenge at the moment to gather more information, as it is not accessible (Rankhone, personal communication 10 May 2015). It would require having to trace all Lesotho doctors and see if something can be worked out (Rankhone, personal communication 10 May 2015). Dr Manamolela in 2012 required the fortifying of local participation and other multi-dimensional intercessions to rejuvenate health frameworks and guarantee the manageability of a 'necessities orientated' health administration conveyance in Lesotho. She said: “We

need to implement a new system that would ensure that graduates return home after training and find the sector equally attractive" (Public Eye, 2012). From the above information it can be concluded that the bonding strategy is apprehensive with problems. It is difficult to enforce and easy to undermine. Lesotho is not politically stable with deteriorating relationships with several funding partners. This situation is further exacerbated by a lack of qualified and experienced administrative staff to capacitate resources required for a Bonding Strategy (Health Sector Strategic Plan 2012/13-2016/17, 2013:17).

The success or failure to improve retention largely depends on the implementation. Bonding agreement in Lesotho is not effective with regards to retention, because only few qualified health professionals obliged to the conditions of the agreement after completion of their training (Chobokoane, personal communication 16 July 2015). These employees usually want to refund government and seek "greener pastures" abroad. The NMDS has also failed to follow up and monitor students sent outside the country to study due to budget constraints (Rankhone, personal communication 10 May 2015). As a result, the education and health sector is unable to deal with this problem.

2.4.1.3 Career/Promotion

Proceeding with training additionally turned out to be an esteemed retention procedure (Kayimba, 2011:35). A portion of the outcomes demonstrated that employees are energetic about chances to keep on enhancing their level of learning (Kayimba, 2011:35). Not just can authentications assist health professionals get advancements, it is additionally a technique for certifying their insight while decreasing their wish to go. However in Lesotho there is lack of opportunity to continue studies in the government health department even if in-service training is provided (Schwabe et al, 2004:15).

The Lesotho HSAs showed that in-administration preparing is by and large unmanaged and dependent on non-legislative organisation (NGO) contribution

(Ministry of Health and Social Welfare, Government of Lesotho, 2013:2). Likewise, the in-administration preparing is not required and therefore probably not going to be finished. There is a glaring lack of career advancement in nursing; the profession hierarchy is restricted and progressive (Schwabe et al, 2004:13). In the case of the doctor's cadre, the succession inside the Medical Doctor unit from Medical Officer to Specialist is small by territorial and worldwide measures (Schwabe et al, 2004:14). The Health Sector Human Resources Needs Assessment uncovered this exposed the high extent of non-nationals in the Medical Officer occupation in Lesotho (Schwabe et al, 2004:14). Whilst the nation effectively amped up health specialist preparing, the new health laborers have not been adequately consumed into the workforce on the grounds that the Ministry of Health (MOH) and the Public Service Commission had not achieved concurrence on making new positions(Lesotho Health Sector Strategic Plan 2012/13-2016/17 (2013:18) . Like many other Sub-Saharan countries, Lesotho depend broadly on group health specialists to give basic administrations in country and remote regions yet don't have measures set up to sufficiently remunerate them or advance their professions(Ministry of Health and Social Welfare, 2013:1-2).

2.4.1.4 Working environment

Various studies have been directed to clarify the workplace with perspectives, for example, employee retention (Alnaqbi, 2011:38). Workplace is viewed as a standout amongst the most vital calculates worker retention (Nguyen, 2012: 31). A bad workplace may make distress a few workers who may end up being pulled in to different organisation with improved working state of affairs (Mrara, 2010: 23). Work environments should encourage proficient independence, work assortment, directing to manage stress, and companion response. For many years, infrastructure in Lesotho such as clinics and the main transfer hospital, Queen Elizabeth II in Maseru, was worse and the increasing population continued to apply pressure on both inadequate staff and facilities (Coelho & O'Farrel, 2011:36). In addition, several services were unavailable through the Lesotho public health system and patients were transferred to South African facilities for treatment at premium prices (Public

Eye, 2012). Moreover, the national referral hospital (QE II) turned 100 years old, and as a result required either replacement or extensive refurbishment (Netcare Limited Annual integrated report, 2013:42).

The replacement was achieved through public/private joint venture (PPP) understanding between Ts'epong (a consortium involving South Africa's Netcare and a Basotho organisation) and the government of Lesotho through an 18-year PPP contract (Kaplan, Dominis, Palen &Quain, 2013). The PPP managed to replace the aging QEII and also improved the network of urban filter (Satellite) clinics (Mwase, Takondwa, Kariisa, Doherty, Hoohlo-Khotle, Kiwanuka-Mukiibi and Taylor Williamson, 2010:12). The contract was pilot tested with a single building that was constructed and completed in November 2007 (Downs, Montagu, da Rita, Brashers & Feachem, 2013:16). The initial success of a smaller project and the experience gained through the process was sufficient to give the government of Lesotho confidence to pursue a PPP option to replace the aging QE II with the new hospital (Kaplan et al, 2013:12). Other infrastructures such as finishing of repairs and extensions of Mohlomi Mental Health Hospital, funded by African Development Bank (ADB), completion of ART clinics in Thaba-Tseka (Paray Hospital) and Botha-Bothe assisted by the Global Fund, World Bank and ADB, laboratory expansions and renewals in Mafeteng and Quthing, and extension of the National Drug Stockpile Warehouse were developed in 2010 (International Finance Corporation, 2009:2).

According to Coelho and O'Farrell (2011:24) the new referral hospital that has replaced QE II was built at Bots'abelo in Maseru district and named Mamohato Memorial Service (Ts'epong). This hospital comprises of 425 beds, of which 35 are private wards and 390 the general wards (Netcare Limited Annual integrated report, 2013:43). The improvement to the healthcare system of Lesotho increased the scope of administrations and acquired very qualified staff though few and particular restorative gear, permitting specialists to perform mediations locally as opposed to sending patients to South Africa for specific techniques. For example, Dr Ashim Chowdhury fulfilled the primary neurosurgical techniques in June 2013, which was beforehand difficult to treat in Lesotho. He got education at Netcare Universitas

Academic Hospital in Bloemfontein (Netcare Limited Annual Integrated report, 2013:42). Mamohato Memorial Service provided significantly better: high quality publicly supported health care services even though it's operating with cheap labour that doesn't dispute any incentives put in place. This hospital also functions as the key clinical training facility for all health professionals, even though certain physicians are still sent to Bloemfontein for training. Currently the country only has less than seven (7) specialists, relies heavily on foreigners and the country is spending on remittance (Downs, Montagu, da Rita Brashers & Feachem, 2013:41).

This is the first PPP project structure for the health sector in Africa and this project is obliged to ensure that costs for referring patients to South Africa are reduced and similar to the previous national referral hospital (Coelho & O'Farrel, 2009:1). The new health system has enhanced nature of care and availability and gives enhanced working conditions, education and proficient advancement programs for doctors and nurses (World Bank, 2013:11). The new hospital is expected to help the country in retaining and attracting doctors and nurses as it gives enhanced working state of affairs and expert advancement programs (Coelho & O'Farrel, 2009:1). It also provides workplace wellness programmes (WWP) to help doctors and nurses openly influenced or contaminated by sicknesses because of the way of their work in place. Usage of the Continuing Education Strategy, with enhancements to the National Health Training College, has likewise started. Respective relations with Cuba and China have acquired extra specialists as an intervention to the shortage of doctors, and the United Nations volunteer doctors have been invited to supplement simple medical services (Sunday Express, 2010).

2.4.1.5 Living conditions

Living conditions are usually well thought out to affect staff retention. However, most support efforts to improve living conditions for Lesotho has not yet been implemented (Ministry of Health and Social Welfare, 2013:3). Nurses in Lesotho are staying at residences that are not in good condition, while doctors are staying at better places with basic furniture but heat and electricity is a challenge for

(Dambisya, Lipinge & O Dulo, 2013:20). According to the revised 2013 retention strategy, these professionals were supposed to receive heat and electricity. They have to spend for amenities (water, electricity) (Ministry of Health and Social Welfare, 2013:27). Doctors and nurses are entitled to a housing allowance of 10% of their salaries (Sunday Express, 2010) (Maloti).Should they choose an allowance, it is taxable. Non-nationals are benefiting more than locals because they are employed on a contract of two years that allows for a gratuity of M10000 (Maloti), whereas locals are employed on a permanent basis and are not entitled to such benefit. According to Dambisya (2007:14) workers in urban areas were supposed to receive housing subsidies while those in the rural areas are provided with free housing. However, nurse's houses are in poor conditions with cracked walls and leaking roofs. The only success factor is staff transport that is available and reliable to transport those health professionals working on evening/late shifts (Dambisya, 2007:15).

2.4.1.6 Recruitment related

According to (WHO, 2017:1) Lesotho has formed an alliance with Boston University called Lesotho Boston Health Alliance (LeBOHA) in an effort to improve recruitment of health professionals as approach to retain them. LeBOHA has collaborated with every significant partner such as the World Health Organization, JICA, and Global Health Workforce Alliance in order to guarantee that AGA methodologies are executed to boost retention (WHO, 2017:1). LeBOHA offers the Family Medicine Speciality Training Program (FMSTP) created in order to provide registrars with the skills essential to be efficient region doctors following four years of preparing (Smith and Stark, 2009:4). From the time the program began in 2011 just a single specialist graduated and met all requirements to be an expert, while a few understudies dropped out (Smith & Stark, 2009:29). Likewise, as far back as the program began, more than 30 specialists have connected to come back to Lesotho to join the Family Medicine Speciality Training Program (FMSTP) but only three students were absorbed (WHO, 2017:1). This is considered ineffective because there is a need for more health professionals in the country at the moment. Moreover, according to research conducted in Maseru, health professionals reinforce that a person who

trains as a family medicine specialist can be a good general practitioner (GP) not a specialist; therefore professionals are still sent to other countries for training (Smith & Stark, 2009:20).

LeBOHA hasn't succeeded in getting on a correspondence operation in the media to advance the arrival and retention of doctors, in an effort to attract Basotho doctors back to the country (Rankhone, personal communication 10 May 2015). LeBOHA has also failed to assist the government of Lesotho in drawing a database in order to trace medicinal students, understudies and specialists in the neighbouring country (South Africa) in an effort to comprehend the target audience of the campaign (Rankhone, 2015). This responsibility was given to the ministry of health that failed in this endeavour (Chobokoane, personal communication 16 July 2015). It was then transferred to National Manpower Development Secretariat, an institution responsible for allocating scholarships to Lesotho students (Chobokoane, personal communication 16 July 2015). However, they have also failed to draw the correct database to track interns and practitioners in South Africa since establishing the NMDS in 1978 (Rankhone, personal communication 10 May 2015). According to the NMDS Public Relations Officer (PRO) Mr Rankhone, NMDS doesn't have a database of medical students enrolled in other countries.

However, LeBOHA has succeeded in bringing Basotho Medical trainees jointly in Lesotho at its yearly therapeutic training conferences (Smith & Stark, 2009:20). Lesotho doesn't have medicinal schools and the certification of their programs is impossible (WHO, 2017:1). Currently accreditation standards and systems for the planned further education programs are assisted by LeBOHA and Lesotho Medical Council (Smith & Stark, 2009:21). During 2008, LeBOHA created and funded the Lesotho Nursing Council to Continuing Education for Nurses through MOHSW, in the country (WHO, 2017:1). The program was highlighting site-based guidance that does not pull nurses far from their posts and uses the current limit and assets, with the mean to enhance nature of care and occupation fulfillment. Under the proceeding with instruction for medical attendants, week after week nursing rounds were actualized alongside the foundation of Clinical Supervisor posts. The nursing

intercessions have brought about a 41% change in nursing abilities (Lesotho-Boston Health Alliance, 2011:1). Through the coordination of various AGA techniques, LeBOHA and the MOHSW have possessed the capacity to create and manage critical and compelling activities to address the HRH emergency in Lesotho (Lesotho-Boston Health Alliance, 2011:1).

After the medical student conferences in 2008, medicinal graduates from the University of KwaZulu Natal formed an association called the Lesotho Medical Students Association (LEMSA) (Smith & Stark, 2009:28). In a bid to extend its tactics to increase to all universities with Lesotho medical students, LEMSA has succeeded and expanded to the following universities: Medical Students of South Africa (MEDUNISA), University of Pretoria (UP), University of Witwatersrand (WITS), University of Free State (UOFS), Walter Sizulu (WUSO), University of Cape Town (UCT) as well as membership from Zimbabwe and Malawi which has the largest membership at the moment (Smith & Stark, 2009:28). LEMSA is functioning willingly with LeBOHA; particularly in attracting Basotho graduating medical students back to Lesotho by paying regular visits to address problems they encounter and monitor the process and co-hosting the annual medical student caucuses (Smith & Stark, 2009:29).

2.4.2 Incorporation of Lesotho success and failure factors in a revised framework

2.4.2.1 Financial incentives

As indicated by Kossivi, Xu and Kalgora (2016:263) the connection amongst pay and retention has been the subject of many studies Researchers are not consistent about the effect of pay on retention. For a few, fulfillment with pay emphatically connects with the representative choice to remain in the organisation. For others, pay does not impact on retention (Kossivi et al, 2016:263. It is imperative that the revised framework will undertake to eliminate inequality and discrimination by not considering equity of pay within Lesotho but also in comparison with neighbouring countries and/or Africa. In terms of salary inequality, doctors and nurses should be

paid for their competencies, not additional qualifications they possess; they are a team that requires full participation and expertise of both. The updated and revised framework should also comprise the provision of education allowance for health workers' children in order to supplement their salaries, waive entry exams to school graduates wishing to study towards health related qualification, provide postgraduate education to young general practitioners, provide subsidised mortgages and homes in areas with a shortage of health workers, provide health workers with supplemented income from donor projects and the MOHSW to implement new incentive programs that will be vital to monitor results and lessons learned to be disseminated to other countries (Kaplan et al, 2013).

2.4.2.2 Personal development/ Career and promotion

Proficient improvement is not a slightest retention cause (Kossivi, Xu & Kalgora, 2016:262). Hiltropp (1999) as referred to in Kossivi et al (2016:262) related see professions achievement and organisation capacity to make representatives remain in their employments. Individual and expert development is a deciding element of retention and advancement openings expands representative responsibility regarding stay (Kossivi et al, 2016:262). Leidner (2013) is likewise of the view that representative reliability is enhanced through guidance and growth (Kossivi et al, 2016:265). It is essential that in a revised framework the ministry of finance should, for the sake of consistency, bring some standardisation to the layout of bond understanding and questionnaire the conditions contained in the attach to make them more unequivocal and exhaustive for the gatherings to know about the different ramifications of breach of understanding, a bank guarantee to ensure that expenditure incurred for sponsorship/traineeship can be easily recouped in case of breach of obligations, employees to subscribe to a bank guarantee and its service charges and the graduate certificates to be verified after the proof of service.

In its response Lesotho should provide clearly defined and transparent career paths, promote them and also open new medical schools by training new therapeutic

schools via preparing new units of health professionals and bringing in doctors as a temporary solution.

2.4.2.3 Working environment

As per Kossivi, Xu and Kalgora (2016:264) a helpful workplace has all the earmarks of being fundamental figure worker retention. Spence, Leiter, Day, and Gilin (2009) as referred to in Kossivi, Xu and Kalgora (2009:264) assembled confirm supporting the way that ideal workplace adds to representative retention. A helpful situation can be characterised as an adaptable environment where working knowledge is agreeable, assets are sufficiently given. On the other hand, the researcher suggests that for further working condition improvement the Department of Health should invest in improved equipment such as telemedicine to permit medical providers in remote locations to consult with experts about diagnoses and treatment.

2.4.2.4 Living conditions

The revised framework should provide benefits that are similar to non-nationals, improve living condition for doctors and nurses and their relatives by putting resources into framework and administrations (sanitation, broadcast communications, pre schooling and childcare's etc.), provide subsidies for water and electricity and guarantee security and protection for doctors and nurses both at and off work.

2.4.2.5 Recruitment related

The revised framework should propose the construction of a medical school in the country so that Lesotho will be able to produce enough doctors and nurses to address the issues of its populace. Moreover, a strong enlistment bundle and a coordinated enrollment and retention procedure - consolidated with the aggregate cooperative energy of the MOHSW systems and objectives - ought to work couple to address the more extensive enrollment and retention needs. Foundation of projects

and administrations to bolster enlistment and retention set up best practices to educate and bolster groups, draw in MOHSW restorative graduates, exiles and universal graduates to advance professions in the country which will all serve to enhance the capacity of MOHSW to pull in and keep the specialists it requires.

2.4.3 Total numbers and densities of the health workforce in Lesotho compared to African Region per 1000 population

Table 1: Total number and densities of the health workforce in Lesotho, source: World Health Organization, 2006

Health workforce	Total number Lesotho	Density per 1000 Lesotho	Density per 1000 African Region
Physicians	89	0.049	0.217
Nurses and Midwifes	1123	0.623	1.172
Dentists and Technicians	16	0.009	0.035
Pharmacists and Technicians	62	0.034	0.063
Environmental and Public health workers	55	0.031	0.049
Laboratories technicians	146	0.081	0.057
Other health workers	23	0.013	0.173
Community health workers	n.a	n.a	0.449
Health management and support	18	0.010	0.411
Sum total	1532	0.850	2.626

Figure 2 (Bar Chart)

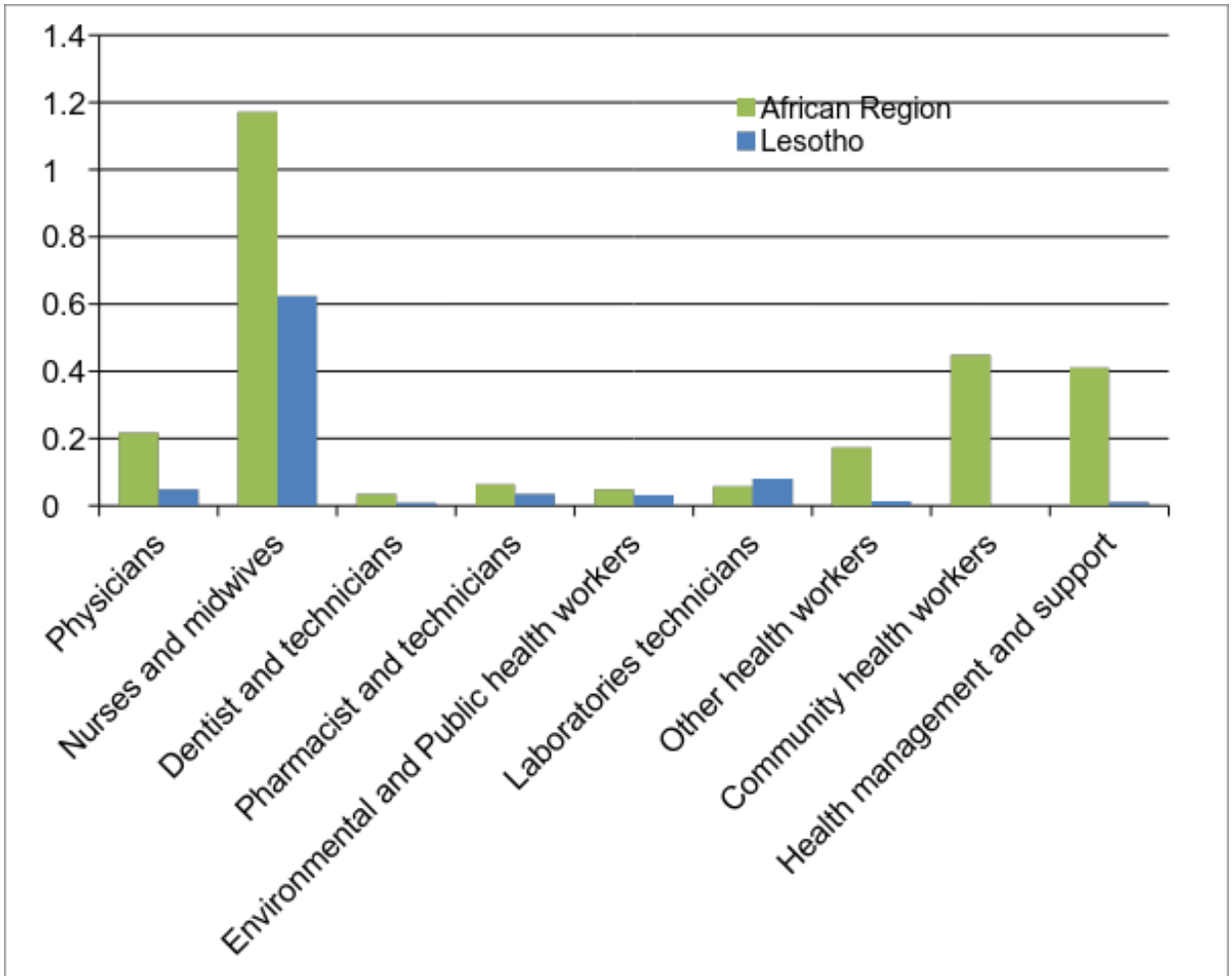


Figure 2: Health Workforce in Lesotho, adapted from World Health Organization, 2006

Not unlike other Sub-Saharan countries, Lesotho is currently faced with incredible challenges to retain doctors and nurses (Ministry of Health and Social Welfare, 2013:1). The results of the current framework implemented by the Minister of Health is represented in the table and chart above, giving a clear picture of poor health professions to population densities compared to other African countries (World Health Organization, 2006:6). This makes the Lesotho health sector less effective in delivering quality health services to its nation (Ministry of Health and Social Welfare, 2013:1). The World Health Organization (WHO) has recommended a minimum of two physicians per 10,000 populations (Naicker et al, 2009:3); this is seven times more than the situation in Lesotho (Public Eye, 2014).

Lesotho has only one-third doctor per capita (Lesotho Health Sector Strategic Plan 2012/13-2016/17, 2013:18). According toMurman and Sullivan (2008:3) 20000 people in Lesotho are overseen by one doctor. It should be noted that Lesotho has implemented the retention strategy in 2010 in an effort to retain its doctors and nurse but the current state of affairs shows that it has failed. Regardless of those efforts made by the Minister of Health, the current density of doctors and nurses is low compared to other countries in Africa. The researcher is of the idea that Lesotho as yet has not increased its numbers, but rather experienced a shortage of doctors and nurses despite their crucial responsibility, since the implementation of a retention strategy in 2010, and this trend will continue if interventions are not done immediately.

Due to this current state of affairs the public health service delivery is in an even more critical condition (Lesotho Health Sector Strategic Plan 2012/13-2016/17, 2013:17). At this moment, it can be accepted that there are other factors hindering the development of access to priority health intervention in Lesotho. In order to achieve the delivery of quality service, including Millennium Development Goals (MDGs) (Lesotho Health Sector Strategic Plan 2012/13-2016/17, 2013:18).The crucial prerequisite is to deal with human resources for health. Otherwise this trend will carry on to be the most significant obstacle to effective and efficient service delivery. Developing a new retention strategy implementation framework to improve the retention rate for doctors and nurses should be given more attention in order to achieve adequate numbers in health services.

2.5 Need for new implementation Framework in Lesotho

Lesotho health sector is an employer of approximately 8,600 staff members (Ministry of Health and Social Welfare, Government of Lesotho, 2009:4). Like any other Sub-Saharan country, Lesotho is currently faced with incredible challenges to retain doctors and nurses (Ministry of Health and Social Welfare, 2009:11). The population of Lesotho is roughly 2 million (WHO, 2009:3), which includes a devastatingly high HIV/AIDS rate of 24%- a severe shortage of health professionals (Lesotho national

strategic development plan 2012-2017, 2013:8). According to the information outlined in Figure 1 and chart 1, it is evident that the Lesotho health sector is less effective in delivering quality health services to its nation due to the current state of affairs (Ministry of Health and Social Welfare, 2009:11).

Very few doctors and nurses are serving the wide range of seriously ill patients (Smith & Stark, 2009:13), who requires intensive care. In a nutshell, an effective implementation framework is required to improve the retention rate of doctors and nurses, in order to accomplish the country vision 2020 which its vision statement: “By the year 2020, Lesotho shall be a stable democracy, a united and prosperous nation at peace with itself and its neighbours (Lesotho National Vision 2020,2004:4). It shall have a healthy and well-developed human resource base. Its economy will be strong, its environment well managed and its technology well established (Lesotho National Vision 2020, 2004:5). In order to make this vision a reality, the framework should focus on improving retention which will lead to effective service delivery, thus individuals utilising health administrations along with their families should access the support as well as treatment they may need at all the times (Lesotho National Vision 2020,2004:5).

2.6 Framework to enhance retention rate

The framework for retention strategies for doctors and nurses presented below is based on the conclusion resulting from the literature review. It is expected with the aim of this framework would enhance the retention rate of doctors and nurses and improve service delivery in the organisation, particularly, the hospitals through the implementation of retention factors acknowledged to be effective in improving retention and service delivery. Figure 3 is the framework to enhance the retention rate of doctors and nurses.

2.7 Framework for Retention Strategy

Figure 3: Framework to enhance retention rate for doctors and nurses

2.7.1 Discussion of the framework

The framework is extracted from some of the gaps found during the review of literature and the empirical findings that consist of the following factors: financial incentives, working environment, personal development, recruitment, and living conditions. The results of the effective implementation of these factors are improved retention of doctors and nurses as well as effective delivery of service.

The review more over demonstrates that a variety of retention activities might be essential for retention strategy framework implementation. For that reason, analysis of the factors is crucial towards a result of retention for doctors and nurses and achievement of the framework implementation. These strategies are needed for the management of the health sector.

From the framework, financial incentives refer to salaries and allowances. The way doctors and nurses are compensated influences the nature of their work, their state of minds towards patients also their intent to stay in the current job. Paying higher and/or remuneration comparative to that of rivals can guarantee that the hospitals attract also retain its workforce. From the framework, incentive benefits are related to job contentment and intent to stay in the current job. If the incentive system is desirable, it may impact positively on retention of doctors and nurses.

Work environment in the framework is referred to a clean and hygienic environment, accessible wards, security, stock and supplies, and functionary equipment to perform the job and deliver effective services. Doctors and nurses feel responsible for the care of patients and the ability to perform their duties effectively on a daily basis, it is important to enhance a positive work environment by hospital management. A structured work environment includes the above characteristics and, as a result, it is required to improve the standard for retention and the nature of administrations provided.

Personal development/career advancement of doctors and nurses is one of the retention implements used to update and upgrade professional skills. Personal development in the context of the framework implicates the specialised advancement, in-administration preparing, the accessibility of postgraduate reviews and the accessibility and usage of health retention approaches and methodology. The health procedure ought to guarantee that all doctors plus nurses are sufficiently prepared, therefore expanding their effectiveness and enhancing their execution, which may thusly bring about improved retention.

Recruitment in the framework is referred to the attraction of doctors and nurses which includes introducing and placing an organisation as a workplace of choice and developing and implementing recruiting policies. Designing reasonable pay structures helps to attract doctors and nurses. It is presumed that paying the market rate, irrespective of job evaluation or grading, is the best implementation to secure and retain doctors and nurses services.

Living conditions in the perspective of this framework denotes good residential accommodation that includes appropriate infrastructure, water, sanitation, electricity communication and transportation (organisation shuttle). The benefits to achieve a minimum standard of living by doctors and nurses appear to be substantial in improving retention.

Communication/feedback in the framework referred to the backbone of supportive supervision between health professionals and supervisors. It is imperative that management talk with doctors and nurses often on a one-to-one basis to find out what matters to them, implement their views to avoid the attitude of job-hopping. This helps management to understand that one need "different strokes for different folks" –in other words, different employees will perceive things differently and will be retained by different strategies. If the health sector uses the information accordingly, doctors and nurses' expectations can be achieved, thereby improving retention.

It is anticipated that the health sector would induce the results of the planned structure with the intention to improve the retention rate of doctors and nurses and thereby deliver effective services. To conclude, retention strategy has a bearing on service delivery through some of the variables of retention, such as: financial incentives, working environment, personal development/career advancement, recruitment, and living conditions (See section 2.3 of the study).

This framework enhances an innovative aspect to, and recognises the retention strategy management actions by looking at how these actions fit together in all the factors of the framework. The findings of this research, which are put up in this framework, recommend that improved retention strategy management engagements are essential in all the variables which may not have existed in the prior process of the retention strategy. This definitely made an effort in the organisational information in the area of retention, mainly the framework to enhance the retention rate of doctors and nurses.

2.8 Application of the retention strategies framework

There is the need to provide good access to appropriate health care to patients as an important service delivery. Effective service delivery can be used to sway doctors and nurses' decision-making and behaviour and thus increase their retention decision in different contexts with the aim of satisfying their needs and requirements. The framework can be used to show that medical practice should be grounded in doctors and nurses meeting the needs of the patients to optimise patient outcome.

The retention factors in the framework could be applied to both doctors and nurses. For example, communication strategy is used by managers on daily basis to know doctors and nurses concerns and be able to solve them hence improve retention rate. The purpose of this framework is to ensure that doctors and nurses functions are aligned with quality service delivery cutting across the health sector activities determining increased access to care and enhance retention of the adoption process. It supports the challenges that doctors and nurses face that has become

imperative with the increase of new demands of patients for effective service, and sustainable health care.

With increased disease emerging daily, changes in patients care and life style in the context of hospitals, this framework can be used to communicate the requirements and qualities of patients and their relative's impact and help along with attributes and skills of doctors and nurses. According to American Association of Critical Care Nurses (2013) as cited in Liego (2013:10) whilst the needs of the patient are matched with doctors and nurses characteristics and competencies then synergy occurs and outcomes are improved. By so doing, hospitals would benefit from the application of the framework.

Chapter 3 Research design and methodology

3.1 Introduction

This part describes the kind of research plan that was utilised, the means that were followed in leading the research, the respondents of the study, and the research instruments used.

3.2 Objectives of this research

The objectives of this study are specifically identified with the research issue. It communicated what the researcher wished to accomplish with the research concerning taking care of the research issue. The goals of this research are as per the following:

- To develop a retention strategy implementation framework that would help improve the retention rate of doctors and nurses in Lesotho.
- Recommend measures to enhance the retention rate of the Lesotho health sector.
- To improve service delivery through an improved retention strategy implementation for doctors and nurses.
- Increase the number of doctors and nurses through the development and implementation of a new implementation framework.

3.3 Research Design

The research configuration is a diagram of the study the researcher used to obtained responses to the research questions. Responses were obtained following a pilot study to elicit more information to a deeper understanding of the research objective. According to a research design is about the arrangement for completing an investigation (Creswell, 2013) as referred to in Holland (2015:89). Yin (2009) as referred to in Holland (2015:89) described research outline as the rationale that associates the information to be gathered with the research question. Yin (2009:26)

as referred to in Holland (2015:89) additionally draws that research design is a blue print that takes into consideration “what research questions to study…what data are relevant…what data to collect and how to analyse the results. The outline for this study is subjective and quantitative.

3.3.1 Qualitative method

Subjective research highlights the active; complete, furthermore singular parts of the human experience and endeavors to catch those viewpoints in their completeness, inside the setting of the individuals who are encountering the activities (Iwu, 2012:10488). It includes the analysis and interpretation of data by observing how people perform and speak (Sellers, 2012:2). The subjective outline is most appropriate as it facilitates flexibility and allows employees to depict their observations from their own experience. Cronje, 2010; Liamputtong and Ezzy, 2005 (in Iwu, 2012:10489) agree that subjective methodologies are valuable when the researcher tries to improve a comprehension of human marvels and to explore the importance given to occasions that individuals encounter.

This study included association with the members (employees) at their normal work environment and was coordinated towards understanding what they believed was significant with respect to retention methodologies that were currently actualised at the Health department in Lesotho. Alongside this comprehension, the phenomenological type of subjective plan is considered most suitable for this research. It permits the researcher to understand the participant’s behaviour and reasons for such conduct (Morey, 2004:20). The researcher engaged a subjective research strategy on account of the accompanying attributes:

- It does not give well-ordered directions and a permanent formula to pursue. The plan is adaptable and maybe adjusted through the research;
- One technique for information gathering utilised is interviews. This data source improved the trustworthiness of the data;

- Data gathering needs to be continuous until information is soaked; that is, information accumulation will be proceeded until the researcher did not hear any new data;
- The researcher did not begin the experimental study with speculation but rather with an research questions;
- The researcher got to be drenched in the wonder concentrated on and the researcher was the fundamental information gathering instrument;
- Qualitative research was setting bound; it was likewise called field research since it was directed away from the characteristic setting of the members, and
- Qualitative research strategy is taken after in light of the fact that information to be translated and examined would reveal the encounters of the subjects as far as the retention techniques that are executed at Department of Health.

3.3.2 Quantitative method

In this study, a quantitative research configuration was viewed as most appropriate to examine doctors and nurses retention procedures actualised at the Department of Health in Lesotho. A quantitative research configuration was settled on fundamentally to comprise the 120 doctors and nurses so that uniform data would be gathered from subjects under study, making generalisation achievable, and to effortlessly classify the overall movements regarding doctors and nurses retention strategies implemented at the department. These recognised movements, in any case, were by and large limited to shallow decisions in view of profoundly skillful information collecting procedures. Onyango (2016:19) outlined that Quantitative strategy involves strategies and measures that create discrete numerical information.

3.3.3 Justification for the use of qualitative and quantitative methods

This research is a quantitative and subjective study. This methodology is the mainly suitable on the way to attain data based on the insight from doctors and nurses regarding retention strategies implemented at department of health Lesotho. Quantitative study technique is possibly the most technical accessible to those in

sociologies intrigued by gathering unique information for objective assessment and the extent of approaches as well as introductions established in a large populace (Balbie, 1979:317).

The researcher was inspired to utilise quantitative study in view of its use of logical apparatuses, for example, organised questionnaires that permitted the researcher to have admittance to data that is not specifically noticeable. On the other hand, quantitative study was selected because of the usage of semi-structured interview that permitted the researcher to have entry to data that is straight forwardly noticeable. The quantitative research study technique is decided for the accompanying reasons:

❖It attempts to understand the overall environment being explored;

❖It gives a chance to the researcher to form knowledge into the essential parts of human recognition, conduct and state of mind;

❖The “sampling unit”, that is the objective populace to be studied such doctors and nurses at department of health Lesotho, can be genuinely simple to characterise;

❖Because data is frequently given namelessly, respondents will probably be honest in their reactions to the inquiries brought up in the questionnaire;

❖The researcher can utilise logical research devices, for example, a questionnaire to gather information and break down it by method for PC factual projects; and

- ❖ It gives some measure of objectivity, in light of the fact that the mathematical and statistical techniques for research are free from subjective predisposition.

Kukano (2011:49) draw the accompanying attributes of a subjective approach:

- ❖ The researcher endeavors to achieve a direct comprehension of marvels of enthusiasm by method for an adaptable arrangement of issue plan and information gathering;
- ❖ Qualitative procedure lays on the presumption that valuable comprehension can be increased through collected information procured direct by a solitary researcher.

The subjective researcher is hence worried with seeing instead of clarification; naturalistic perception as opposed to controlled estimation; and the subjective investigation of reality from the point of view of an insider.

Accordingly, a subjective study is worried with non-measurable strategies and little examples regularly deliberately chose (Kukano, 2011:48). Kukano (2011:48) further outline that subjective methodologies are suitable at the point when the researcher plans to comprehend human marvels and explore the significance given to occasions that individuals encounter. This is a realistic analysis that goes for comprehension wonders as they actually happen. Morris (2009:75) states that both subjective and quantitative strategies can be utilised as a part of a similar study. This is differently called multi-, blended or various techniques inquire about, in spite of the fact that there is a move to institutionalise language and utilise the name blended strategies examine for studies consolidating subjective and quantitative techniques. The accompanying were reasons that validate the utilisation of blended technique in this research;

❖ Qualitative and quantitative methodologies were utilised on the foundation of the sort of information utilised (literary or numeric; organized or unstructured), the judgment drew in (inductive or deductive), the kind of research (exploratory or corroborative), the technique for investigation (interpretive or factual);

❖ The emphasis was on the utilisation of part (parallel or successive) plans in which the distinctive components were kept separated or partitioned, in this manner permitting every component to be consistent with its own particular paradigmatic and outline necessities;

❖ It was considered to use diverse approaches to accomplish the similar drive, with a view that supports prove for the decisions made, for example, a method of collaboration;

❖ The two techniques permitted articulation of various actualities of learning and experience (Iwu, 2012:10489). For instance, employees reacting to interviews or open finished inquiries raised very unique issues to those accommodated in an organized questionnaire asking basically a similar question;

❖ Mixed strategies in this study consolidated nomothetic and idiographic methodologies trying to fill the double needs of speculation and top to bottom comprehension to pick up a review of social regularities from a bigger sample while understanding the other through a point by point investigation of a little example; and

In this study, varied techniques were utilised to enhance comprehension of a know-how or subject through validation of conclusions, addition of learning, or by starting new ways of rationalising the subject of the research.

3.4 Research Methodology

According to Rust (2012:35) strategy is an arrangement to apply an assortment of consistent strategies and practices in the organised quest for learning. It incorporates the information gathering arrangement that sets out the complete approach for gathering information. That is: the place, when, how and from whom (Kukano, 2011:41). As indicated by Tseng (2010:104) the objective of a reasonable research configuration is to give outcomes that are judged to be reliable. Reliability refers to the extent to which the results estimated actuality and are judged to be truthful also realistic. A profile impacting retention of Health department staff including doctors and nurses was created. Besides, a profile on the retention requirements of the respondents was the worry of this study.

3.5 Population

Population refers to the total of cases that meet an assigned arrangement of criterion. Kawesa (2004:56) outlines that a populace refers to a gathering of items, occasions or people having a few shared features that the researcher is fascinated in examining. For this research, the populace comprised of doctors and nurses employed at three hospitals in Maseru city, Lesotho.

3.6 Sampling

Rust (2012:80) defines sample as the way toward selecting a section that represents the entire people of interest. As illustrated by Moodley (2011: 59), it makes sense that it is impossible to base research that incorporates whole target populace. Consequently, an example is drawn that is illustrative of that (contained within the example) to demonstrate the similar features of the objective populace. This procedure is called inspecting and Rust (2012:80) approves the substance of Kawesa'sposition.

3.6.1 Sampling method

Testing indicates the procedure of choosing a section that represents the entire population of interest. This study implemented the random sampling technique to select doctors and nurses from the three (3) selected hospitals .The support for this procedure, depended on the way that it enabled each subject in the examining edge to have level with circumstance, to be chosen without predisposition in an efficient way. According to Onwuegbuzie and Leech (2007:242), the random selection of appropriate elements in a sub-group is based on its ratio within the population.

3.6.2 Sampling Size

The sample size for this research was the list of all employees working at Mohlomi, Bots'abelo and Scott hospital. A sum of one hundred and twenty (120) respondents were utilised for this study drawn from both doctors and nurses of Mohlomi, Bots'abelo and Scott hospital. The minimum of forty (40) per hospital was chosen due to the capacity and population of the hospital.

3.6.3 Sampling technique

The simple random sampling technique was implemented by this study to choose respondents from the sample structure of Mohlomi, Bots'abelo and Scott hospital.

This technique was selected because each employee of the hospital had an equivalent and autonomous possibility of being chosen for the study and that data was collected without bias in an efficient manner. Numbers were assigned to every name on the example structure. The bits of papers with composed number were then put in a compartment and blended altogether, and afterward the example size of 120 respondents was drawn. This was done deliberately to maintain a strategic distance from twice representation of the example.

3.7 Data collection

According to Rust (2012:28), information gathering included the compilation of data about the factors in the research. Onyango (2016:19) is of the idea that information accumulation is gathering particular data intended for demonstrating or discrediting a few truths. The researcher selected an extensive choice of procedures with methods for gathering information from the participants. Qualitative research includes a variety of procedures furthermore, in this research plan the researcher utilised a varied selection of methodologies of analysis (Moodley, 2011:55). These techniques contrasted, contingent upon the motivations behind the study, the nature of the research question and the aptitudes and assets at the researcher's transfer. In this way, information accumulation includes applying the chose measuring instrument/s to the example or cases selected for the research (Tiam, 2011:13). In any case, first the researcher needed to settle on significant choices about the issue of testing.

Data collection begins on 31 March and finished 20 June 2015. The researcher went by Scott, Mohlomi and Bots'abelo hospital in Maseru region. This study utilised qualitative and quantitative techniques for research. For this situation the researcher utilised interviews and questionnaires to acquire data on the success and failure aspects related with a organised overview measuring the retention strategy implemented at Scott, Mohlomi and Bots'abelo hospitals. The questionnaire was self regulated and respondents filled them autonomously and the researcher gathered them. For the inquiries they respected individual they didn't answer the question/s rather, they returned it without reacting. The respondents were educated that

questionnaires were unknown. The questionnaire was close ended with a specific end goal to give more organised reactions which at that point encouraged substantial proposal. Reactions were evaluated utilising 5 point Likert scale. This made the information to be in a frame that is quantifiable and could be effectively subjected to calculation on SPSS. The interviews were semi structured. The researcher directed interviews with doctors and nurses (matrons, clarifying the plan and purpose of this research to them and to circulate questionnaire.

3.8 Data collection methods

Kukano (2011:60) distinguished that facts gathering exists in the utilisation of a multiplicity of approaches and methods of information accumulation in a particular study. Mtengezo (2008:15) retains that information ought to fit the necessities of a subjective or quantitative research outline or a plan comprising a mix of these methods. The information gathering techniques in this study consolidated these two methodologies. With an end goal to obtain diverse aspects of a similar issue of the members (Chobokoane, 2015) and achieve additional effective outcomes in the study, the accompanying two techniques will be utilised to gather information: questionnaires and interviews.

The time of data collection was 10 weeks, between 31 March and 20 June 2015. Over the 10 week time span, a random sample of 40 members was drawn from every hospital. The technique for quantitative research considered suitable for the main stage in this research self-regulated study. The researcher was by and by in charge of the allocation and accumulation of all questionnaires. Because of the way of move work in a hospital the researcher allocated two hours consistently to gather questionnaires from day staff and hour for night staff. The objective was a normal of 12 questionnaires each week over the ten week time frame. Information was then caught electronically with the end goal of investigation. The second period of the review comprises of subjective semi structured interviews. The interviews occurred in April 2015 and endured around 30 minutes to one hour in doctor's lounge. Permission was granted by the participants to record the interviews. This was gone

for limiting disturbances to the interviews enabling the participants to talk unreservedly about all matters relating current retention strategies. Interviews were led according to interview guide utilising semi organised approach permitting the participants answers to direct the stream of the interview. Participants were urged to examine any point with the researcher that they felt were significant inline of addressing, or critical for the researcher to know. Sources were additionally urged to ask the researcher any question with respect to the review that they may have. Every one of the answers were recorded and incorporated into the investigation. Preceding initiating the interview, the sources were given research ethics

3.9 The research instrument

Two strategies were utilised for information accumulation as a part of this research. The principal stage was a self-fulfillment sort of questionnaire that was distributed to 120 doctors and nurses. The questionnaire was divided into 2 sections: section 1 dealt with demographic variables such as place of work, age, gender, and marital status, home language, position, job status, educational attainment and years of work experience of the respondents. Section 2 consisted of 6 sub-sections detailing retention strategies listed from A-F, each question was followed by a number of indicators. Respondents were likewise given unlimited inquiries to express their sentiments without being affected by the researcher and to persuade naturalness. This area was planned to evoke reactions of their views of the implementation of the current retention strategy. The inquiries were replied in a 5-point Likert scale running from 1=Strongly Disagree to 5=Strongly Agree. The second phase was semi-structured interviews. The interview guide consist 4 questions. Interviews were conducted with 9 participants (3 from each hospital) that were asked their opinions and views on specific issues as far as retention strategy is concerned. This was done to approve the reactions acquired from the questionnaires.

3.8.1 Questionnaires

In support of several respectable explanations, the self-administered questionnaire is the best broadly utilised method for getting data from standardised data in the sample subjects (Rodrigues, 2008:69). Kukano (2011:60) note that a questionnaire is reasonably cost effective, has similar inquiries for all subjects and can guarantee secrecy.

A self-regulated questionnaire was planned by the researcher and was utilised to gather applicable institutionalised information from all subjects in the sample. McNamara (1997:105) as referred to in Kukano (2011:60) depicts the organised or close finished thing as the backbone of study research. The rationalisation for utilising this instrument is that questionnaires had several advantages that are easy to quantify and analyse with slight manipulation of raw data, moderately sparing, has similar inquiries for all subjects, can guarantee secrecy, and can access a large sample which places minimal demands on employees.

The instrument's things, configuration and methods was taken from Kukano (2011) and Lennie (2008); be that as it may, a few changes were made by the researcher to fit to the present review. The questionnaire comprised 39 items. The first part of the instrument contained a mission statement and bearings, and was intended to gather biographical or individual information that incorporate place of work, age, gender, and marital status, home language, position, job status, educational attainment and years of work experience with Scott, Mohlomi and Bots'abelo hospital.

The second part of the questionnaire comprised headings and 29 five point Likert-scale items for rating the present retention strategies actualised by the Ministry of health with a specific end goal to enhance retention rate of doctors and nurses in Lesotho. The items requested that member’s rate the degree to which they concurred or couldn't help contradicting certain parts of their retention at their separate hospitals. The rating scale had the accompanying assignments: 5=strongly agree; 4=agree; 3=neutral; 2=disagree; 1=strongly disagree. The Likert sort scale

was utilised in light of the fact that it gave more noteworthy adaptability since the scale portrayals fluctuated to fit into the way of the question (Kukano, 2011:62).

In this review, all the one hundred and twenty (120) questionnaires were distributed among doctors and nurses in their respective selected hospitals during tea break and after departmental interviews. The questionnaire contained close ended questions and 8 open ended questions addressing various aspects of retention and how improvement could be made to the present system on retention strategies implemented at the hospitals. The close ended questions ranged from financial incentives, living conditions, recruitment related, mentoring, personal development, to working environment.

3.8.2 Development and focus of the items in the questionnaire

The development of the items in the questionnaire was formulated from each retention variable which had their base in the literature review in chapter 2 and the items were spread out as follows:

(a) Financial Incentives

This variable was measured by 5 items which were related to compensation; remuneration, allowances as well as benefits. These items measured specific benefits that were used as incentives. Items measuring non-cash incentives were developed from section 2.4.1. Each was score in 5 point Likert scale ranging from 5=strongly agree; 4=agree; 3=neutral; 2=disagree; 1=strongly disagree.

(b) Living conditions

This variable was measured by 5 items which were related to the actual accommodation. These items measured condition of residence, availability of utilities, additional residential benefits and security. Each was score in 5 point Likert

scale ranging from 5=strongly agree; 4=agree; 3=neutral; 2=disagree; 1=strongly disagree.

(c) Recruitment related

This variable was measured by 5 items which were related to the career development. The items measured doctors and nurses satisfaction with promotion, conditions of employment, and additional pay. Each was score in 5 point Likert scale ranging from 5=strongly agree; 4=agree; 3=neutral; 2=disagree; 1=strongly disagree.

(d) Mentoring

This variable was measured by 4 items which dealt with loyalty and socialisation into health profession and atmosphere.

(e) Personal development

This variable was measured by 5 items. These items measured personnel developmental needs for training and continued opportunities for growth. These items were related to personal and professional growth as formulated from the related literature in section 2.7. Each was score in 5 point Likert scale ranging from 5=strongly agree; 4=agree; 3=neutral; 2=disagree; 1=strongly disagree.

(f) Working environment

This variable was measured by 5 items which were related to the context or environment of the work. The items measured doctors and nurses satisfaction with fringe benefits, physical environment, administrative support and the work itself. Each was score in 5 point Likert scale ranging from 5=strongly agree; 4=agree; 3=neutral; 2=disagree; 1=strongly disagree.

The supervisor and co-supervisor were given copies of the questionnaire comprising the purposes of the research to determine whether the instruments calculated what it was intended to assess, furthermore to verify the wording, understandability and phrasing of the announcements.

A modest number of proposed adjustments were rolled out and the improvements were fused into the rendition of the instrument which was sent to an expert at CPUT. The expert proposed changes, alterations and refinements to the instrument which was then pilot tested to guarantee validity and reliability.

3.8.2 Interviews

In addition to regulating the questionnaire, semi organised interviews were carried out with (1) the matron and two doctors of Mohlomi hospital, (2) the doctor and two matrons of Bots'abelo hospital and (3) the doctor who is likewise the medical superintendent and two matrons of Scott hospital. The interviews were directed after the study and investigation of information, to help the researcher to ask more significant questions that additionally illuminate the overview comes about. The interviews occurred at the doctor’s lounge. The Researcher acquired the reaction in an innocuous and soothing condition that enhanced the nature of the recordings for translation and allowed unlimited discourse from the members which expanded the social occasion of information. Interviews were recorded with the assent of the respondents in order to aid the study of information. Reactions were utilised for study of the information and they were available to interviewees with a specific end goal to upgrade the reliability of the information and to guarantee that the perspectives of the members were precisely reflected.

Interviews have the advantage that they are adapted towards research subject, and can be utilised to access source's activities, encounters, words and translation that can't be watched straightforwardly (Robinsons, 2010:104). In addition Interviews gives a researcher a method for taking advantage of the subjective encounters of individuals which generally might be hard to get to (Holland, 2015:103). Through

utilising semi organised interviews a comprehension of the center ideas of the research can be accomplished in a generally brief time period. Hospitals records and other data that was connected to the review was broke down specifically and contrasted with the study information to touch base at a finish of this review. In this review, the researcher led the semi organised interviews. The accompanying steps were taken:

Step 1. Get ready for the interviews; there was three (3) interviews led every day which kept going 30 to an hour for every session with three (3) delegates from each of the three (3) hospitals. Nine (9) was the greatest number met. The researcher was the facilitator of the interviews.

Step 2. Building up the interview guide; this contained the inquiries which were asked to the members amid the conversation session. In this review, the researcher directed the interviews as an open discussion in which members had the odds to broaden their contemplations, clear up their viewpoints and perceive what they see as basic parts. The following questions were covered during the interviews: (i) what conditions exist in Scott/Bots'abelo/Mohlomi hospital that influences your choice to stay and work as Senior Nursing Officer/Doctor, etc.? , (ii) What retention strategies, have you known, are implemented by Scott/Bots'abelo/Mohlomi hospital? (iii). what are your suggestions to enhance health professional retention at Scott/Bots'abelo/Mohlomi hospital? (iv) of the suggestions in (3) above, which one do you feel are considered most important in increasing health professional retention for Scott/Bots'abelo/Mohlomi hospital to give focus and attention? And (v) what do you think are the reasons why some health professionals left Bots'abelo hospital? Do you consider their reason as barriers to health professional's retention?

Step 3. Save a period and place; this was done well ahead of time. Doctor's lounge was booked for roughly two (2) hours. This time was utilised to set up the room preceding the interviews.

Step 4. Hardware required; the researcher cellphone was utilised as a sound recorder to record the interview session. This enabled the researcher to questionnaire the sound rapidly, find remarks and record the correct data. Note taking was additionally done as a method for recording the data.

Step 5. Determination of the interview members; Simple random sampling was utilised to choose 3 delegates from each of the 3 hospitals. The names of the considerable number of doctors and matrons were doled out a numerical number and these numbers were composed on little bits of paper. The papers doled out were put in a tube shaped compartment, shaken and a bit of paper was drawn from it. The paper taken from the compartment was isolated. This system was rehashed until the required number of 3 is picked among the doctors and nurses. A similar technique was led for the rest of the hospitals until the required number of nine was accomplished.

Step 6. The interview session; the conversation room was prepared when the members arrive. The members and the researcher sat at a table. The researcher drew out data by empowering the strength of free dialog and participation that may deliver thoughts past the inquiries and remarks. The researcher kept the discussion on track without repressing the stream of thoughts from members.

Step 7. After the session, the facilitator composed a short report amid her extra time to sum up the conversation.

3.10 The researcher as an instrument

The researcher was the primary research instrument in this research. The responsibility of the researcher was to gather and collect information from the questionnaire and to inspire data for the duration of interviews. The researcher additionally guaranteed that moral measures were kept up all through this study as talked about in section 3.5.Participants therefore were free to disclose information about success and failure factors of strategies currently implemented by department

of health Lesotho. As a result, the information will be used to develop a new implementation framework that would help enhance the retention rate of doctors and nurses in Lesotho.

3.11 Research Procedure

The researcher firstly visited the Ministry of Health and Social Welfare to seek permission from Research and Ethics committee. And secondly, obtain consent prior to conducting the research (ethical clearance approval).The character and aim of the research was disclosed to hospital managers, discussion to be directed and how to manage the questionnaire. The total of 120 questionnaires was distributed on various days depending on the hospital supervisor's authorisation to visit the hospital. The researcher explained the procedure and instructions for completing the questionnaire to participants. In addition the members were additionally educated that the questionnaire was intentional and the confidentiality statement that read: “information supplied will be used for the stated purpose of academic research only and will be kept in strict professional confidence” was included.

3.11 Pilot Study

The questionnaire was pilot-tried in three hospitals to be specific Scott, Mohlomi and Bots’abelo hospital. Health professionals were haphazardly selected from the populace reflected in the research yet were not part of the example and not involved in the key research. The researcher distributed the questionnaire to each doctor and nurse. The doctors and nurses were educated that it was a pilot trial of the instrument and therefore assured confidentiality of their responses. The respondents were encouraged to provide response to the researcher of any challenges they had with the things. By timing every question, it was likely to recognise questions that showed up unnecessarily troublesome and a consistent guess of the foreseen fulfillment time was then gotten. The pilot test concentrated on the implemented retention strategy of health professionals. Therefore, the feedback from the pilot

study enabled the researcher to make amendments. The expert in the health ministry was provided with the revised questionnaire**.**

3.12 Data processing and analysis

Information analysis is the step in the study where the researcher decreases the facts gathered toward subjects along with classifications in controlling, collation, classifying also, condensing it with the support of a classifying method, to enable explanation and acquire responses to the study inquiry(s) (Mrara, 2010:58). It began with data processing: rephrasing the research proceedings and generating records that began during data collection (Mrara, 2010:58). Information handling includes duet types of procedures, specifically information decrease, amid which the quantitative and subjective information are briefed and information investigation which comprises subjective and quantitative research (Kawesa, 2004: 54). Information was classified and arranged for preparing, to which end field notes were prepared also combined, summarised, and operated, furthermore in principle condensed to allow expressive research.

3.12.1 Method of data analysis

Through subjective research, information study was isolated from information gathering (Godwin, 2012: 39).For instance data collected from doctors and nurses at three selected hospitals, a steady analysis of how to address adequately the issue of doctors and nurses retention at the Department of Health was completed. Information investigation and information accumulation occurred all the while in such a procedure; the two were directed independently. Kukano (2011:73) supports that the approach to data enquiry ranges from a simple counting of votes; to refined measurable strategies and getting records of the impact estimate. For this situation, comes about or the unprocessed information of every section study was coordinated.

3.12.2 Qualitative data analysis

To analyse text based answers to open-ended questions from the nurses and doctors, and in addition to acquire enhanced comprehension of the study outcomes, content analysis was utilised. Matamane (2014:54) describe content analysis as a research method following an orderly approach that might be utilised to analyse written audio data from surveys, observation, tests and past investigations. Delgado and Gutierrez (2007) as referred to in Matamane (2014:54) express that content analysis might be foreseen as an instrument of decreasing and arranging qualitative data, and it concentrates on the unique circumstance and the importance of the content. Coding was utilised through the content analysis. It is referred to as the way toward decreasing text into controllable sections of analysis (Patton, in Miles and Huberman, 2013) as referred to in Matamane (2014:54).

3.12.3 Quantitative data analysis

A software or statistical tool is available which is known as SPSS (Odubanjo, 2015:38). This instrument is usually used by many researchers carry out quantitative study. SPSS can be utilised to analyse the collect responses from the survey respondents so as to understand and find out which retention factors is seen as essential and the collected information was analysed with the use of descriptive statistics. For the purpose of this study, data from the questionnaire study was analysed by means of the Statistical Package for Social Sciences (SPSS) software in the direction of computing frequencies and percentage. The variables are presented in patterns of tables along with interpretations.

3.13 Validity

Validity of an instrument signifies to whether the instrument measures what it is stretched out to quantify (Mateus, 2007:6). When an instrument is legitimate, it genuinely mirrors the ideas that it must gauge. In any case, an instrument can't quantify in a legitimate way the trait being referred to on the off chance that it is

differing, indistinguishable and vague (Mateus, 2007:6). As indicated by Polit et al (2004:291-292) as referred to in Mateus (2007:22) there are a wide range of sorts of validity. The most vital are content validity, criterion validity, construct validity and face validity. The researcher include that despite the fact that face validity is valuable, substance, basis and develop legitimacy are more critical in a research instrument.

For this review content and face validity were connected. Content validity signifies to the precision with which an instrument measures the certainties or circumstances under review. In this review, content validity was worried with how well or precise the questionnaire could cover every one of the factors distinguished and talked about in the writing audit in Chapter 2. The questionnaire was given to a specialist at CPUT keeping in mind the end goal to check content validity (Mrara, 2010:46). Face validity is a simple kind of legitimacy which essentially determines whether the instrument gives appearance of measuring concept. It is a natural sort of legitimacy where the researcher ask co-worker or research expert to peruse the instrument and assess the substance regarding whether reflect can't help suspecting that the researcher goals to quantify (Mateus, 2007:6-7).

3.14 Reliability

Reliability is the level of consistency or exactness with which the instrument measures the quality it is expected to assess (Polit et al, 2004:432) as referred to in Mateus (2007:23). Consistency is the degree to which a research instrument gives out reliable/expected results or data after recurring outcomes (Kawesa, 2004:57). Reliability can be measured taking into account the soundness of the instrument when the instrument gives the same results in rehashed instances, in other words, when an instrument create the same results in rehashed testing (Mateus, 2007:23). The researcher guaranteed that the instrument established was dependable by guaranteeing that the instrument used to define a few ideas plus examples would structure the items that highlight the concept or constructs. In this study, managing excellence was completed by directing a pre-test or pilot of the questionnaire on 100

respondents to ascertain the reliability and the uniformity of the things in the questionnaire using Statistical Package for Social Sciences (SPSS) software. The very same outcomes were acquired. Its dependability was along these lines checked.

3.15 Research Ethics

- The approach of this research combined matters identified with research morals and reliability, testing, information gathering and handling, and writing accessed. These are explained in the areas underneath: Ethics signify to thoughts around what was well thought-out standard otherwise reasonable conduct in the act of social research. It was worried with what is thought to be reasonable routes for the researcher to continue. Mrara (2010:60) indicate that morals was the use of universal guidelines also, standards, and the researcher's that offers behavioural hope about the most precise behaviour towards members. The researcher knew that at each period of this research procedure, she would be challenged with moral issues to determine. A number of those moral issues were direct whereas others were indirect. Thus, the researcher was constantly morally attentive as well as constantly reflective; inter alia, the interests of the members. The accompanying moral measures were considered all through this study:
- The researcher obtained consent from the Department of Health (Lesotho) Research and Ethics Committee (CPUT) prior to conducting the study (ethical clearance approval).
- The researcher explained the procedure and instructions for completing the questionnaire.
- In addition, the members were likewise educated that the questionnaire was deliberate and confidentiality statement which read (“information supplied will be used for stated purpose of academic research only and will be kept in strict professional confidence”) was included. Anonymity was assured and participants were not cheated about the objectives of the research.

The researcher ensured that all the above moral measures were mulled over all through the study. This confirmation actually included assurance of the researcher's competency, which logically included accurate and proficient contact with the members, which thus implied accomplishing their educated permission and preparation.

3.16 Literature consulted

The researcher employed the results of the study of what has been previously found/published with regards to a retention strategies implementation framework used by the Department of Health. This provided the basis for relating and classifying (WHO: 2010), which was completed within Chapter 2.

3.17 Summary

This section outlined the procedure that was undertaken in collecting data from doctors and nurses with regards to retention strategies implemented by the department of Health. Information gathered was displayed, examined and deciphered. This part further illustrated the study outline utilised during this investigation. The objective of this research, its plan and strategies, were set. All contemplations to guarantee reliability of the study was investigated and talked about while moral contemplations were likewise watched. The effects of the research was talked about in Chapter 4 and contrasted with what was composed in the writing questionnaire.

Chapter 4: Data analysis and interpretation

4.1 Introduction

The research design, methodology, research procedure, respondents of the study and the instrument used were described in chapter 3. This chapter discussed data presentation, analysis and interpretation based on responses received from respondents (doctors and nurses at the hospitals Scott, Mohlomi and Bots'abelo). Therefore the focus of this chapter seeks to answer the study inquiry and purpose of the research. As information was presented, it was crucial that the limitations perceived from the returned questionnaires be drawn.

4.2 Response rate

The study focuses on a sample size of 120 which includes doctors and nurse. 10 doctors and 62 nurses filled and restored the questionnaire making a reaction of 60%. This reaction rate was palatable to make conclusions for the study. The reaction rate was representative. According to Mugenda and Mugenda (1999) as cited in Onyango (2016:25), a response rate of 50% is adequate for study and reporting, a rate of 60% is great and a reaction rate of 70% and over is fantastic, in view of the statement, the reaction rate was viewed as great.

Table 2 beneath delineates the response rate of usable questionnaire.

Table 2: Response rate

Occupation	**Respondents**		**No. Distributed**
	Doctors	**Nurse**	
Scott hospital	5	32	40
Mohlomi hospital	3	17	40
Bots'abelo hospital	2	13	40

Total	**10**	**62**	**120**

4.3 Organisation of the questionnaire

The following biographical details from respondents were obtained from the questionnaire: place of work, length of service, age, gender, marital status, home language, position, current job status, education attainment, and length of service with current employer. The researcher was of the idea that these features could be related to the success and failure framework of the current retention strategies implemented at Department of Health in Lesotho.

4.3.1 Descriptive Statistics

This part was essential in finding the general picture of the respondents who supplied the data. It includes occupation of the respondents, their age, gender, home language, position, current job status and level of education.

Table 3: Biographical information of the respondents

Variable		Number (n)	Percentage (%)
Gender	Male	20	27.8
	Female	52	72.2
Age	<25	3	4.2
	25-29	13	18.1
	30-34	16	22.2
	35-39	6	8.3
	40-44	5	6.9
	45-49	11	15.3
	50-54	6	8.3
	55-59	6	8.3
	60<	6	8.3
Home Language	English	7	9.7
	Sesotho	57	79.2
	IsiXhosa	1	1.4
	Other	6	8.3
Current Job Status	Permanent	55	76.4
	Contract	14	19.4
	Temporary	1	1.4
	Other	1	1.4
Level of Education	National certificate	16	22.2

	National diploma	30	41.7
	Bachelor's degree	20	27.8
	Honours degree	1	1.4
	Doctorate	5	6.9
	National certificate	16	22.2
Job title	Doctor	10	13.9
	Nurse	62	86.1

A sum of 72 respondents took part in the review. Table 3 above shows that most of the members were females (72.2%); this is an indication that both genders were well involved in this study and thus the findings did not suffer from gender bias. The nursing profession is mainly female dominated hence the gender disparity. The smallest age of respondents was <25 years and the greatest age was >60 years. The greater parts of respondents were between the age group 30-34 (22.2%); this is an indication that the respondents were fairly distributed in terms of their age group. The greater parts (79.2%) of the respondents were Sesotho speakers; this implies that the respondents were in a position to give credible information relating to this study. The research demonstrated that almost seventy five percent of the respondents (76.4%) were permanently employed at this hospital; this implies that the findings of this research were fairly reached. With respect to level of education, 41.7% of the members have a National Diploma whereas 27.8% had a Bachelors Degree, this implies that majority of the respondents were well educated which implies that they were in a position to give credible information relating to this study. The bigger portions were nurses (86.1%), while the remaining 13.9% were doctors, this implies that both the respondents were fairly drawn putting into consideration of their duties.

4.4 Quantitative Findings

Respondents were asked to specify the retention strategies employed at their respective hospitals. The researcher was interested to know which strategies failed and succeeded so as to establish a new plan. The list of items depicted from retention strategies for the health workforce, implemented in 2010 by Department of Health was used for the respondents to give their views. The inquiries were replied in a 5-point Likert scale going from one to five. 1 = strongly disagreed, 2 = agreed, 3 = neutral, 4 = disagreed, 5 = strongly disagreed. The respondents needed mark off to determine how much they agree/disagree the description. The responses were grouped into eight categories as presented in tables below:-

Sub-objective 1

To address the issues of retention strategy in Lesotho health sector

Table 4: Financial Incentives

Financial Incentives		**Disagree / Strongly Disagree**	**Neutral**	**Strongly Agree/ Agree**	**No answer**	**Total**
1.1 I am provided with additional compensation for advanced qualifications	No %	51 70.8%	6 8.3%	9 12.5%	6 8.3%	72 100%
1.2 I am satisfied with my present remuneration	No %	44 61.1%	13 18.1%	11 15.3%	4 5.6%	72 100%
1.3 I am allowed to take a second job such as running private practice in order to improve my income	No %	59 82%	7 9.7%	5 7%	1 1.4%	72 100%

1.4 Educational benefit for my children is offered	No %	66 91.6%	3 4.2%	2 2.8%	1 1.4%	72 100%
1.5 I enjoy benefits such as housing loans	No %	51 70.9%	9 12.5%	11 15.3%	1 1.4%	72 100%

The responses from Table 4 presents descriptive appraisal of a possible retention strategy using financial incentives. This presentation covers different levels of satisfaction amongst respondents as follows:

1.1 Additional compensation for advanced qualification; at this level, 12.5% of the respondents agreed that they were provided with additional compensation for advanced qualification, 7.8% disagreed. However, 8 respondents representing 8.3% of the total sample did not respond. Although the 12.5 percentage agreement is low, the majority of health professionals expressed the need to be appreciated and cared for; these feelings influence their motivation and level of commitment to employment.

1.2 Satisfaction with remuneration is analysed as follows: 15.3% of the respondents concurred that they are happy with the present remuneration, 61.1% disagreed, and 18.1% remained neutral while 5.6% did not respond to the statement. In light of retention, 15.3% agreement is low; the majority of respondents indicated lack of allowances - especially risk allowance - that was withdrawn with no valid reasons and small salaries that do not meet their needs. These appear to have a large impact on why employees leave, and are a significant drawback with regards to retention issues that the organisation should capitalise on in future to enhance retention. The prizes given to staff must be significant keeping in mind the end goal to affect their views of the institute and in this manner impact its retention endeavors.

1.3 Private practice involvements at this level: 5 respondents representing 7% of the total sample agreed that they are allowed to take a second job such as running a private practice, in order to improve the income; 82% disagreed and 9.7% remained neutral. However, 1 respondent representing 1.4% did not respond. The majority of

respondents disagreeing probably considered this element essential to retention, since the hospital can't accomplish its essential objectives of retention in the atmosphere of unsociability and depression. Health workers in Lesotho are paid fixed monthly salaries. They felt that they are degraded as they need to reside a low standard contrasted with the rank they possess. The submissions are in agreement with those of Amani (2010). This result confirms the finding of Dovlo (2004) that demonstrates the strong link between salary level and retention. Consequently, to acquire positive inspiration, it is important to build the basic enthusiasm for the occupation and give representatives an awareness of other's expectations, accomplishment and development, which involves improving their purchasing power.

1.4 Educational support, at this stage: 2 respondents representing 2.8% of the sampled population agreed that educational benefits for the children is provided, 91.6% disagrees, with 4.2% remaining neutral with regards to the statement. Nevertheless, 1.4% did not respond to that view. The number does not signify a decent rate that shows support in terms of monetary incentives such as provision of educational benefits to health professional’s children. Money related motivation is a great degree alluring to workforce as they get the advantage rapidly and in solid terms. They believed that providing educational benefits would compensate their low salaries.

1.5 Benefits such as house loans, at this point: 70.9% of respondents disagreed that they enjoy benefits such as house loans, 12.5% remained neutral whilst 15.3% agreed. However, 1 4% did not respond. With very low salary levels, benefits such as those for housing assume better significance. Majority of respondents suggested that the level of salary is too low to accommodate house loans. Housing is the biggest expense for health workers and most suggested that loans are inadequate due to their low salaries; this forces them to leave. The majority of them suggested that purchasing a house is one of the major objectives for relocation.

Table 5: Living Conditions

Living Conditions		Disagree / Strongly Disagree	Neutral	Strongly Agree/ Agree	No answer	Total
2.1 My residential accommodation is in good conditions	No %	47 65.3	16 22.2%	7 9.7%	2 2.8%	72 100%
2.2 My employer provides free medical care for my spouse and children	No %	47 65.3%	7 9.7%	17 23.6%	1 1.4%	72 100%
2.3 I have support of utilities(water, electricity, telephone)	No %	40 55.6%	14 19.4%	14 19.4%	4 5.6%	72 100%
2.4 This hospital provides pre-schooling and care for my children	No %	64 88.9%	2 2.8%	2 2.8%	4 5.6%	72 100%
2.5 Security is provided on and off duty	No %	50 69.4%	11 15.3%	10 13.9%	1 1.4%	72 100%

2.1. Conducive residential accommodation at this level: 9.7% of the respondents agreed that the residential accommodation is in good condition, 65.3% disagreed, only 22.2% remaining neutral to the statement. And 2.8% did not respond to the statement while the 9.7%agreement is very low, majority of nurses indicate the poor residential accommodation compared to those of doctors. They felt that they are discriminated against and not taken care of. These nurses expressed the need to be appreciated and recognised by maintaining least values for living conditions with exceptional accentuation on physical solace, because these practices can address

retention issues. The result confirms the findings of Professor Alan Brown that housing is highly important and workers accept minimum standards.

2.2 Provision for free medical care, at this stage: 23.6% of respondents agreed that free medical care for spouse and children is provided. Only 65.3% disagreed, while 9.7 % of the respondents were neutral. Nevertheless, 4 respondents on behalf of 5.6% of the whole example did not reply to the description. They feel they are not being valued. Respondents expressed that offering competitive things like medical assistance and health plans sends influential messages to human resources about their significance in the association. They indicated that when prizes given to workers are significant, it impacts on their impression of the association and in this way affect its retention endeavors. Employees need to be provided and supported by a comprehensive health insurance scheme. These advantages will enhance workforce fulfillment and retention, as a result guarantees achieving organisational objectives.

2.3 Support of utilities (water, electricity, telephone) at this level: 19.4% of the respondents agreed and neutral respectively that they have support of utilities, 55.6% disagreed, only 5 respondents representing 5.6% did not respond to the statement. While the 19.4% agreement is low, the majority of respondents indicated the lack of utilities at their residential accommodation, they spend days without running water and paying for electricity that is too expensive to afford. The respondents believe that availability of facilities can enhance retention by attracting and retaining other available labour pools, including foreign workers. Employees feel more comfortable in secure and safe housing with all the services. Management should play a leadership role by offering high quality accommodation that is an effective component to success because it can help retain workers who may struggle with the challenges of living in a distant location, away from home or family.

2.4 Provision for non-financial incentive at this level: 2.8% of the respondents are neutral and agreed respectively that they were provided with pre-schooling and care for children, 88.9% disagreed. However 4 respondents representing 5.6% of the total

sample did not respond. The 2.8% agreement is very low; the majority of health professionals expressed the necessity to be assisted. They articulated that practices, for example, making day care services accessible on the premises can help them to keep up stability amongst individual and work life, hence improve the retention, as it encourages employees to spend additional time with their kids, and accomplish strong work/life goals.

2.5 Security at this level: 13.9% of respondents agreed that security is provided on and off duty. Only 69.4% disagreed, while 15.3% of the respondents were neutral. On the other hand, 1 respondent on behalf of 1.4% of the whole example sample did not reply the description. The majority of respondents attributed insecurities. Employees indicated that their goal to stay and be focused on an association could be clarified inside the setting of Abraham Maslow's chain of command of requirements hypothesis. The theory shows that individuals are persuaded to fulfill five need levels and the second lower level of the hierarchy represents safety needs, which can be satisfied through protection from elements, security, order, law, stability, and so on. In the event that these necessities are not satisfactorily fulfilled, then the individual get on the way toward hunting down another job. In order to enhance retention, employees need a place with zero tolerance for violence; they need to be safe and comfortable enough to cope with patients and management demands on a daily basis.

Sub objective 2

To improve service delivery through improved retention strategy

Table 6: Recruitment related

Recruitment related		**Disagree / Strongly Disagree**	**Neutral**	**Strongly Agree/ Agree**	**No answer**	**Total**
3.1 A career	No	45	15	10	2	72

development programme that helps employees to become more aware of and responsible for their own career development is available	%	62.5%	20.8%	13.9%	2.8%	100%
3.2 I am allowed to work additional shifts, with pay, within my duty station	No %	64 88.9%	2 2.8%	6 8.3%		72 100%
3.3 Promotion criteria in my workplace is clear and fair	No %	40 55.5%	18 25%	14 19.4%		72 100%
3.4 Conditions of employment guarantee job security in this hospital	No %	22 30.6%	19 26.4%	31 43.1%		72 100%
3.5 I was well received by my manager when I was first employed at this hospital	No %	4 5.6%	6 8.3%	61 84.8%	1 1.4	72 100%

3.1 Available career development programme at this level: this study indicated 62.5% of the respondents who disagreed that their organisation had a profession improvement program that helped them to end up distinctly more mindful of and in charge of their profession advancement, and 13.9% agreed. Almost 20.8% were neutral while 2.8% did not respond. Though less percentage agreed, the majority of them complained about a lack of career development plan, which results in the hospital failing to retain qualified doctors and nurses.

3.2 Permission to work additional shifts, at this stage: 88.9% of the respondents disagreed that they are paid for additional shifts within their duty station. Only 8.3% agreed while 2.8% were neutral. Most participants complained about perceived higher work overload within their duty stations without additional pay, which results in failure to deliver good quality care due to lack of motivation. They suggested to be compensated as an act of recognition for additional effort invested. In this study, it was revealed that the current salary structure provides no incentives for additional shifts.

3.3 Promotion opportunities at this level: is characterised by the fact that 19.4% agreed that the promotion criteria in the workplace is clear and fair, 55.5% disagreed and 25% were neutral. In this study, participants articulated that there is lack of understandable structures at the Department of Health for promotion. The majority indicated that it is often uncertain. Health workers believe opportunities for promotion is among the mainly significant reasons why employees discontinue their employment. A comparative study was done among13 British universities and found that over a quarter of academics were in the top of their academic scale, which meant no promotion or progression beyond annual “cost of living” (Netswera, 2005). When employee’s experience that they have outgrown their assignments and that additional preparation does not upgrade their profession moves inside the organisation, they choose to depart. And also the limited self-development opportunities cause them not to remain similarly situated for the next upcoming years.

3.4 Conditions of employment at this point: revealed that 43.1% of the respondents agreed that conditions of employment guarantees job security, 30.6% disagreed while 26.4% were neutral. The 43.1% signifies a good percentage that reveals provision of job security in the hospital. The majority expressed that professional stability is functional for the inspiration of staff. Such safety keeps them away from the anxiety of becoming jobless. This result proves the findings of Nyamekye (2012) that employee will be mutual just when they are treated with sensitivity and love, warmth and pride.

3.5 First day at work, is analysed as follows: 84.8% of the respondents agreed that they were well received by their managers when they were first employed at the hospital, 5.6% disagreed, 8.3% remained neutral and 1.4% did not respond to the statement. This appears to have a large impact on employee retention. Participants indicated that early introductions are enduring; the way an employee is introduced to the organisation from the principal day at work sets the tone for how they feel regarding the organisation. Therefore, a meaningful orientation program with several sessions with follow-up is recommended. They indicate that the sooner a new employee gains a comfort level, the earlier another employee picks up a solace level, the sooner that individual will get to be distinctly gainful, also giving out data about the organisation, such as, its main goal, items, administrations, history, objectives, structure and so forth will set up a solid bond between the individual and the organisation from the onset. And, this will make it less demanding for an employee to relate to the organisation and discover significance in the work; and as a result enhance retention.

Table 7: Mentoring of Staff

Mentoring		**Disagree / Strongly Disagree**	**Neutral**	**Strongly Agree/ Agree**	**No answer**	**Total**
4.1 I am loyal to this hospital because of available support services	No %	21 29.1%	28 38.9%	21 29.2%	2 2.8%	72 100%
4.2 The hospital's appraisal system develops my confidence and trust	No %	19 26.4%	23 31.9%	28 38.9%	2 2.8%	72 100%
4.3 I am nurtured professionally through training and lifelong	No %	25 34.7%	16 22.2%	30 41.6%	1 1.4%	72 100%

learning in my workplace(transferring intangible and tacit knowledge)						
4.4 I am nurtured morally and spiritually through recollection and prayer service in my workplace	No %	19 26.4%	11 15.3%	40 55.5%	2 2.8%	72 100%

4.1 Loyalty to the hospital at this point shows: 29.2% agreed that they are loyal to the hospital because of available support services, 29.1% disagreed, and 38.9%neutral. Nevertheless, 2 respondents representing 2.8% did not respond. Although the percentage of agree and disagree about lack of loyalty were similar, those who disagreed indicated that they deserve support services, especially mentorship from this hospital. Yazinski (2009) indicated that a mentoring program integrated with a goal-oriented feedback system provides a structured mechanism for developing strong relationships within an organisation and is a solid foundation for employee retention and growth.

4.2 Development of confidence and trust at this stage indicated that 38.9% agreed that the hospital appraisal systems develop their confidence and trust, 26.4% disagreed and 31.9% were neutral. On the other hand, 2.8% did not respond to the statement. The figure represents a good percentage that reflects an environment with trust and confidence. The 38.9% indicated that performance appraisal encourage an open and trusting relationship within the hospital and as a result, increment work fulfillment by advising groups when an occupation is well done and help them improve where they went wrong.

4.3 Transfer of intangible and tacit knowledge is analysed as follows: 41.6% of the respondents agreed that they are nurtured professionally through training and lifelong learning in the workplace(transferring intangible and tacit knowledge), 34.7%

disagreed, 22.2% were neutral and only 1.4% did not respond. The majority of agreement (41.6%) indicated that mentoring is efficient between generational learning exchange instruments and might be especially imperative to an organisation experiencing retention problems. According to Frank as cited in Ghansah (2011:61), mentoring is effectively well known to most establishments as a preparation instrument; however it is likewise important in exchanging insubstantial and inferred information. The findings are in line with those of Frank as cited in Ghansah (2011:61). This outcome confirms the finding of Hom (1995) which states that mentoring is a functional way for employees to distribute “lessons learned,” as the mentoree time and again has the opportunity to profit by the coach's experimentation encounter.

4.4 Nurturing morally and spiritually at this level: 55.5% of the respondents agreed that they are nurtured through recollection and prayer service in the workplace and 26.4% disagreed. Only 15.3% were neutral, while 2 respondents on behalf of 2.8% of the entire example did not answer. From the above, it meant that the management – employee, employee– employee relationship and support is generally good. It is clear that there is stimulating interaction in the workplace. When employees are not working in isolation, the peer support and sharing of ideas will breed a professional environment and hence improve retention.

Sub objective 3

Create an attractive working environment through the development and implementation of a new retention strategy.

Table 8: Personal Development

Personal Development		**Disagree / Strongly Disagree**	**Neutral**	**Strongly Agree/ Agree**	**No answer**	**Total**
5.1 I have the	No	37	12	19	4	72

opportunity to pursue further studies through the availability of scholarships and bursaries	%	51.3%	16.7%	26.4%	5.6%	100%
5.2 Training provided is of direct relevance to my job	No %	17 23.6%	21 29.2%	31 43%	3 4.2%	72 100%
5.3 We have a library that I can use at my workplace	No %	49 68%	1 1.4%	21 29.2%	1 1.4%	72 100%
5.4 This hospital has career development activities to help me identify/improve abilities, goals, strengths and weaknesses	No %	27 37.5%	19 26.4%	25 34.7%	1 1.4%	72 100%
5.5 I have acquired expertise through seminars and training	No %	16 22.2%	14 19.4%	42 58.3%		72 100%

5.1 Availability of scholarships and bursaries at this point: 51.3% of the respondents disagreed that they have opportunities to pursue further studies through the availability of scholarships and bursaries, 26.4% agreed and 16.7% were neutral while 5.6% did not respond. These results show that the employers do not financially support health professionals to pursue further studies. The fact that there is no medical school in the country is the barrier to retention, because those awarded scholarships to study abroad produced a quantity unable to meet demand and therefore impacts negatively on service delivery. The participants mentioned that they have to take an online course which is self-sponsored, should they want to pursue additional studies, and also indicated that the experience of failing to obtain

sponsorship or bursary can be a critical obstacle to retention as they expect these training opportunities almost as a basic entitlement for the workforce in the public sector.

5.2 Provision of training at this level showed: 43% of the total sampled agreed that training provided is of direct relevance to their job, and 23.6% disagreed while 29.2% were neutral. Nevertheless 4.2%respondents did not respond to the statement. From the above it is evident that a noteworthy number of doctors and nurses are taking up duties that are in line with their preparation or potentially encounter. The submission agrees with Muula and Maseko (2005:10), who implied that preparing can be an inspiring variable that assists with retention of healthcare experts.

5.3 Access to library at this level: 68% disagreed that they have a library that they can use in the workplace, 29.2% agreed and 1.4% neutral and not responding respectively. The study showed that 68% of the respondents need a library in the workplace in order to be kept abreast with unknown and latest diseases, and to sharpen their knowledge and skills for effective service delivery.

5.4 Career development activities are analysed as follows: 34.7% agreed that the hospital has profession advancement exercises to help them recognise/enhance capacities, objectives, qualities and shortcomings; 37.5% disagreed and 26.4% were neutral. Only 1.4% did not respond. With the results above, there appears to be a great need for career development activities that is not currently being addressed. Perhaps it is merely a perception of employees that one can constantly expect to be groomed by the organisation in order to improve in the above-mentioned areas of development. Therefore, the Ministry of Health should accord these activities to employees in order to create a stimulating and challenging environment.

5.5 Acquisition of expertise at this point: 58.3% agreed that they have acquired expertise through seminars and training, 22.2% disagreed and 19.4% were neutral. The agreeing figure reflects a good percentage that reflects provision of seminars and training in the hospital. The respondents revealed that they perceived seminar places as excellent motivation for professional advancement as it is essential to

revise their knowledge with a specific end goal to address the issues of patients. The results are consistent with those of Butler (2005) as cited in Mokoka, Oosthuizen and Ehlers (2010), who maintains that the best work environment are spots where medical caretakers are furnished with preparing and chances to expand.

Table 9: Working Environment

Working Environment		Disagree / Strongly Disagree	Neutral	Strongly Agree/ Agree	No answer	Total
6.1 Equipment is well maintained in order for me to do my work effectively	No %	40 55.6%	13 18.1%	19 26.4%		72 100%
6.2 I am provided with cutting edge technology	No %	43 59.7%	10 13.9	15 20.8%	4 5.6%	72 100%
6.3 My workplace is healthy, clean and well-organised (conducive)	No %	33 45.9%	15 20.8%	23 31.9%	1 1.4%	72 100%
6.4 I have autonomy at work (i.e. little interference from my manager)	No %	22 30.6%	12 16.7%	36 50%	2 2.8%	7 100%
6.5 I have good interpersonal relationship with my colleagues	No %	2 2.8%	5 6.9%	65 90.3%		72 100%

6.1 Availability of equipment at this level: 55.6% disagreed that equipment is well maintained in order for them to do their work effectively, 26.4% agreed while 18.1% were neutral. From the information above, it is clear the performance of health professionals is negatively affected due to a lack of equipment. The overwhelming

respondents mentioned they feel that no one cared for them as they lacked support for problems like a shortage of drugs, lack of equipment and problems related to staff which they experienced on a daily basis. In this study, the respondents depicted the lack of apparatus, particularly of restorative hardware like circulatory strain machines and bed cloth as very upsetting, because it has unconstructive impact on the nature of care. According to respondents, the shortage of linen in the hospital was the reason for patients developing bed sores in hospital as it was difficult to keep patients dry at all times. The bad working conditions made it complicated for these hospitals to maintain healthcare experts.

6.2 Provision of technology at this level shows that 59.7% disagreed and 20.8% agreed that they are provided with cutting edge technology, while 13.9% were neutral. However, 5.6% did not respond. The participants mentioned that there are no computers in the workplace; absence of satisfactory innovation remains as a major hindrance to the Lesotho prescription to be aggressive and to conquer the test of the present day solution, therefore execution and the nature of care suffers. The Ministry of Health should make it a priority to provide hospitals with computers in order for healthcare professionals to be kept abreast with advances in technology to improve the quality of care. This assertion was verified in the study conducted in the North West region of Cameroon, by Tita, Waller, Kapadia and Dongmo (2005) as cited in Amani (2010:20), who found that the absence of important supplies was felt by numerous healthcare employees to delay their utilisation of proof based-and basic medication. The respondents suggested an introduction to advance technology to help them treat patients remotely.

6.3 Conducive working environment at this level: 31.9% agreed that the workplace is healthy, clean and well-organised (conducive), 45.9% disagreed while 20.8% were neutral. Conversely, 1 respondent representing 1.4% did not respond. In the present study, the working environment is not safe; the units are overcrowded, exposing the respondents and other healthcare providers to infectious diseases. In addition, the patients are also exposed to common infections because of the lack of isolation units. The hospital buildings were not up to standard.

The respondents working in female wards at mental institutions feel unsafe due to physical attacks from patients. The majority of respondents cited dangerous work environment, some working in specific areas such as low-cost wards, theatre departments and labour wards perceived that they were exposed to a higher risk of infection. Low-cost wards generally have unhygienic conditions and there is higher exposure to RIV in labour wards due to frequent needle-stick injuries and a lack of protective measures. Although the supply of gloves and gowns seem adequate, some basic protective equipment such as goggles and shoes are not provided. The risky working environment needs to be addressed, as the work of doctors and nurses is very challenging and hard work should be made to guarantee that they can carry out their employment well by utilising their insight without limitations, inside a protected location. This ought to be a fundamental component of any strategy to enhance retention of staff.

6.4 Autonomy at this stage is analysed as follows: 50% agreed that they have little interference from their manager in the workplace, 30.6% disagreed and 16.7% were neutral. However, 2.8% did not respond. This figure reflects a good percentage that shows autonomy in the workplace. This study has shown that autonomy is provided by these hospitals and also less monotony of the job which is liable to impact work fulfillment. Worker cooperation enhances inspiration through power sharing and expanded duty, which is seen as an indicator of positive reactions. Worker cooperation bear the cost of people a chance to settle on key administrative decisions that affect different workers, consequently expanding work fulfillment and execution, which in return increases retention.

6.5 Interpersonal relationships at this stage: 90.3% agreed that they have great interpersonal relations with their coworker, 2.8% disagreed and 6.9% were neutral. The larger number of members noticed that connections in the work environment could impact health workers' choice to stay or leave, including fellowship and support amongst coworker and companions. The few narrated that workers occasionally ill-treated in words and even physically, by patients and their relatives. Mokoka, et.al, is

in agreement, where associations with coworkers were upbeat and collegial, workers concurred that patients likewise got great care, while medical caretakers who helped each other made the workload more endurable, adding to lower turnover rates in such hospitals.

Table 10: Implementation of current strategy

		Frequency	Percent	Valid Percent
Valid	Failure	20	27.8	27.8
	Acceptable	1	1.4	1.4
	good	8	11.1	11.1
	not attractive	7	9.7	9.7
	non existing	16	22.2	22.2
	no answer	20	27.8	27.8
	Total	72	100.0	100.0

From table 10 doctors and nurses were asked opinions about the implementation of the current retention strategy, 20 respondents representing 27.8% indicated that it is a failure, 1 respondent (1.4%) mentioned that it's acceptable, 8 respondents (11.1%) said it is good, 7 respondents (9.7%) said it is attractive, 16 respondents (22.2%) mentioned that it is non-existing and 20 respondents (27.8%) did not respond to the question. From the above, it meant that there is no retention strategy in place.

Table 11: Preference on implementation of current strategy

		Frequency	Percent
Valid	yes	48	66.7
	no	5	6.9
	no	19	26.4

	answer		
	Total	72	100.0

With reference to table 11 above, 66.7% of respondents prefer their current strategy be implemented differently, whereas 6.9% do not prefer a different implementation. Only 26.4% did not respond to the inquiry. The preference of greater part of the respondents is because of the way that the current retention strategy has failed to retain doctors and nurse in Lesotho.

Table 12: Improving retention strategy for Doctors and Nurses

		Frequency	Percent
Valid	improve financial incentives	17	23.6
	improve financial and non-financial incentives	16	22.2
	pay according to international standards	10	13.9
	no answer	13	18.1
	improve living conditions	7	9.7
	nationals should be paid similarly to non-nationals	1	1.4
	provide other incentives other than salary	3	4.2
	promote staff according to	2	2.8

	qualifications		
	career development	2	2.8
	improve work environment	1	1.4
	Total	72	100.0

As seen from table 12, different views have surfaced from this study. The most reasonable answers are: improve financial incentives according to 23.6% of the participants. Another factor is improving financial and non-financial incentives according to 22.2% of the respondents and to pay according to international standards according to 13.9% of the participants. This is identified in many studies, articles and responses from the interviews and it is believed to have some retention powers on health professionals. The different pay structures that are used by organisations in Lesotho allow flexibility for the private sector and the parastatals to set competitive pay packages, leaving government lagging behind in compensation. As a result, people leave for greener pastures.

Table 13: Work duration

		Frequency	Percent
Valid	Yes	48	66.7
	Uncertain	12	16.7
	No	5	6.9
	no answer	7	9.7
	Total	72	100.0

To this question, 66.7% of the participants will continue working in this hospital in the next 12 months, whereas 16.7% are uncertain. Only 6.9% will not continue. The choice of employees will always differ, as there are many factors involved. What may be a reason to one individual may not pertain to another. However, some of the

reasons for wanting to leave the hospital included workload, lack of service delivery, a lack of career development, a non-conducive work environment and little salary.

Table 14: Motivation

		Frequency	Percent
Valid	personal development	11	15.3
	improved living conditions	2	2.8
	increasing salaries	8	11.1
	no answer	10	13.9
	demotivated	14	19.4
	job rotation	3	4.2
	providing effective service delivery	10	13.9
	challenges of work encountered	1	1.4
	good working conditions and availability of equipment	3	4.2
	working relationships	5	6.9
	positive feedback from clients	2	2.8
	restructuring of nurses salaries	1	1.4
	co-operation between doctors and nurses	1	1.4
	add more staff	1	1.4
	Total	72	100.0

According to table 14, the essential motivational reason to stay with the hospital is personal development, as shown by 15.3% of the participants. In addition, salaries were increased as outlined by 11.1% of the respondents. However, 19.4% of the respondents were demotivated. And lack of motivation deters retention.

Table 15: Preferred change in your job

		Frequency	Percent
Valid	Yes	55	76.4
	Uncertain	1	1.4
	No	1	1.4
	no answer	15	20.8
	Total	72	100.0

This study confirms that most of the participants consent that there is something that can be changed or improved in their jobs: 76.4% of the participants believe that changes or improvements can be made in their jobs. As noted in literature at some point after the implementation strategy, some factors failed. An example of such as noted in the literature review is that the payment of incentives and allowance in Lesotho was initially inequitable and unfair. There are no medical schools in the country, which results in losing doctors to the South African healthcare system after the completion of their training. Infrastructure such as clinics and the main transfer hospital Queen Elizabeth II in Maseru was in a bad condition and the increasing population carried on applying pressure on both inadequate staff and facilities. It has also been noted that there is an unequal distribution of residences among doctors and nurses. Nurses are staying at residences that are not in good condition, while doctors are staying at better places with basic furniture.

Table 16: Effective implementation strategy framework

		Frequency	Percent
Valid	good financial incentives	12	16.7
	non-financial incentives	1	1.4
	financial and non-financial incentives	16	22.2
	pay salaries like other SADC countries	8	11.1
	no answer	24	33.3
	job rotation	3	4.2
	strategic planning and evaluation	1	1.4
	paying better salaries and recognising qualifications	3	4.2
	better living conditions	3	4.2
	more doctors and nurses	1	1.4
	Total	72	100.0

The above table shows that the most important reason to achieve desired retention strategies for doctors and nurses are good financial incentives, arrangement of monetary and non-monetary motivation and paying salaries similar to other SADC countries. (16.7% good financial incentives, arrangement of monetary and non-monetary motivation (22.2%) and salaries similar to other SADC countries, 11.1% is for effective retention pay.

Table 17: Can the framework attract Doctors and Nurses

		Frequency	Percent
Valid	Yes	43	59.7
	Uncertain	11	15.3
	No	1	1.4
	no answer	17	23.6
	Total	72	100.0

This study shows that 59.7% of respondents believe that the new implementation framework will be able to attract and retain doctors and nurses. An example that can be noted from the opinions given by respondents who has indicated that improved living conditions, a conducive working environment, financial incentives and career progression, improved salaries, a sports facility that empowers workers to exercise and live a healthy life - all of these serve to enhance retention.

4.5 Discussion of Key Findings

This study reaffirmed information from previous writings that there are various contributing factors causing retention strategies frameworks to fail. However, as indicated in literature, problems can be identified and a new implementation framework developed to deal with them.

The retention interventions, such as the provision of monetary and non-monetary benefits in terms of the retention of doctors and nurses in the health sector, has been unsuccessful as found in the writing in Lesotho and Sub-Saharan countries. the majority hospitals in Lesotho provide a lower remuneration in favor of the community division workforce helping in the country, than for individuals working in the private sector, in spite of the fact that the sum of the incentives vary amongst sectors. My review demonstrates that, though the Ministry of Health focused on both financial and non-financial incentives, retention rates are low. My findings are similar to that of

Ditlopo, Blaauw, Bidwell and Thomas (2011), a previous study that found money related motivating forces alone are lacking to hold doctors and nurses. Ditlopoet.al, also demonstrates that non-money related benefits identified with working and accommodation conditions could impact retention. Some studies recognised that doctors and nurses will dependably move, regularly for reasons past the impact of any workforce retention program, regardless of how very much outlined. Along these lines, no single measure is probably going to enhance retention if different elements are not thought about.

Findings from the Scott, Mohlomi and Bots'abelo hospitals interviews showed that the doctors and nurses are unhappy about their salary and allowance; they stated profound anxiety over unbalanced compensation of motivating forces with postponements which result in the provision of poor service delivery. They also declared a lack of satisfaction about the recent revision of allowances of risk allowances for staff dealing with psychiatric patients, HIV/AIDS patients and other infectious diseases. The revised guidelines have overlooked the risks that health workers are exposed to on a daily basis in terms of malicious disease and the physical state of patients. This without a doubt influences the retention of these employees. My research found that specific variables: absence of appropriate accommodation working conditions and career advancement, insufficient staff prompting to expanded work weights on existing staff and delays in the provision of drugs and medicines as well as different fundamentals are regions of serious concern that should be tended to in order to improve the retention rate.

In addition, I found that for retention of health professionals, monetary motivations alone are deficient: satisfactory supplies and framework are elements that can fundamentally progress retention. Research in sub-Saharan Africa has demonstrated that retention is impacted by both fiscal and non-financial motivation. Low compensation and working conditions and constrained access to preparing were the primary causal factors for health workers to leave. In addition, not enough supervision and poor observing have without a doubt influenced the retention of health professionals. This has brought about those employees performing

responsibilities below their capacities and bargaining the provision of quality service that resonate with the findings of my study. Consistent supervision is probably going to impact execution in light of the fact that these exercises give chances to associations, illuminations, and accepting input, that can go about as social paste for holding staff individuals together. These results were similar to a study conducted in Cameroon. Low salaries and poor working conditions were the general culprits as specified in the questionnaire. Additional important parts were recruitment, lack of career advancement and living conditions.

The suggestions in the above results are that concerns linked to retention strategies in Scott, Mohlomi and Bots'abelo hospitals are comparable to those in other hospitals. This also means that the retention plans and programmes effective in other countries could be studied and used in Lesotho. Proper correspondences of money related as well as non-monetary motivations, for example, enhanced accommodation, are urgent to urge qualified doctors and nurses to serve the sector.

Non-financial issues, such as improved working conditions, proper housing, helping doctors and nurses keep up a stability amongst individual and work life, practices, for example, making child care services accessible on the location in addition to flexi-time, assets/supplies, and mentorship frameworks at the neighborhood level could enhance employee inspiration and enhance retention. It was additionally found that increasing on-monetary motivation, for example, giving health professionals with basics, visit refresher preparing and steady supervision, could retain them which in addition agree with my review results.

This review has found that the Ministry of Health has been unable to achieve its objectives. It has negatively impacted the quality of service delivery. In any case, the review additionally found certain gaps in executing strategies which have caused the low retention rate. To make the retention strategy more successful, the gaps in implementation need to be addressed and monitored by government as a matter of urgency.

Studying research question number one that asked what implementation framework, would be effective in achieving the desired retention strategies for Doctors and Nurses, findings revealed suitable set of financial as well as non-monetary motivating forces, for example,: paying salaries like other SADC countries, job rotation, strategic planning and evaluation, paying better salaries and recognising qualifications, improving working conditions, better living conditions and more staffing (Doctors and Nurses)can add to accomplishing sub-goal of the study, for example to address the issues of retention strategies in the Lesotho health sector. In researching the second question, which asked: can the new implementation framework be effective when it is used to attract and retain doctors and nurses: 59.7% of the respondents agreed, while only 1.4% disagreed. They believed that the new retention strategy will change the causal feature and create a workplace with attributes that advance quality patient care, security and self-governance, which should not only retain current employees but also attract new healthcare professionals that can contribute to achieving improved service delivery and creating an attractive work environment (sub-objective 2 and 3).

4.6 Qualitative Findings

The qualitative data was examined utilising content analysis. This revealed the success and failure factors of strategies currently implemented by the Ministry of Health. Members were requested some information about their perspectives on the current retention strategies implemented and if they prefer it to be implemented differently in an effort to enhance the retention rate.

4.6.1 Working conditions

The Concise Oxford Dictionary characterises the location as the physical condition in which a person operates. That includes the people, psychosocial aspects and physical space around a person (Concise Oxford Dictionary, 2006). The results of the interviews confirmed that working conditions improve doctors and nurses retention. Workplace in this review signifies to the physical environment of doctors

and medical attendants in where they are working, and it includes physical environment, equipment drugs and resource environment.

4.6.1.1 Physical building

Doctors and nurses identify the physical building as an essential factor in retention. Having access to clean toilet facilities, effective equipment, enough wards for patients and enough sheets in the wards, were identified to encourage a conducive work condition. One participant commented as follows:

Working conditions are very nasty. Our hospital is the main referral serving the country at large. There is a lack of space right now, the hospital has the capacity of 150 beds which can only accommodate150 patients (40 females, 40 males, etc and other unit that is dysfunctional) at the moment we have admitted up to 300 and there is overcrowding of patients and this leads to infections, diarrhea, HIV infection, fleas in the hospital, sometimes water shortage. And some patients have to sleep on the floor while being treated.

Another participant:

We have the capacity of 26/27 normally, but we admit more than that. The reason being the MOU is not functional, no retention of infrastructure, the staff is missing, the toilet has no running water and the isolation room doesn't lock.

These findings show that health professionals are not happy by the physical functioning environment, moreover agree with previous research findings of Ruder (2013:64), who found that participants in his study were very despondent with the physical working conditions that does not add to patients' welfare and reasonableness for staff to work in, for example, protection, cleanliness, warmth, airing and lights.

4.6.1.2 Inadequate support equipment and supplies

During the interview with doctors and nurses, it was found that a lack of drugs, equipment, and other supplies, has a negative impact on retention in the hospitals. All efforts should be made to ensure that healthcare professionals are able to do their work effectively by using their insight without limitations, inside a secure, since their job is very demanding. This should be an essential factor of any plan to enhance retention.

One participant comment:

Sufficient drugs and equipment in a working environment should always be available at all times in the ward. At present, there is an insufficient supply of drugs in wards and it is always inefficient in pushing for newer drugs because only half of it happened, the reason being that the drugs are coming from other countries and this is the challenge. Even the replacement of drugs in wards is achieved by replacing what is used, which is not always accurate. The equipment is not always maintained and at the moment we have non-operating equipment; imagine a BP apparatus is broken and we can't even measure the patient's blood pressure and worse, other equipment have been eaten by rats. The ward administrator has other priorities, though her responsibility is to make sure equipment is always maintained.

4.6.2 Financial incentives

The responses from the interviews proved that financial incentives are important factors in retention; such as salaries and allowances. However, it has been revealed that finances alone cannot retain staff; rather there is need for a mixture of monetary and non-monetary motivation. Participants talked about a range of incentives that would enhance their retention. They mentioned salary and benefits, professional development, bonuses, recognition and respect. Increased salary and better fringe benefits were frequently mentioned in the interviews. This study has found that allowances have some retention powers for nurses and doctors in hospitals. Lesotho

is still behind in terms As Henke *et.al,* (1997:112) as cited in Kukano (2011), mentioned that schools that can't offer aggressive pay rates are probably going to be at a severe drawback with regards to holding instructors.

Participants were asked to give their views about what implementation framework would be effective in achieving desired retention strategies. Their answers centered on increased salary and fringe benefits. The contention was that health professionals ought to be given motivators plus additional benefits to hold them, for example, rewards for excellent execution. This was in line with the findings of Mona (2004: 3), as cited in Kukano (2011: 99), that the retention of attaining the most excellent educators in occupation can be accomplished through the development of pay and advantages.

One participant distinguished: I think Lesotho is still lacking in terms of paid skills, new generations of doctors are foreigners who normally await accreditation and, once obtained, they leave for South Africa. Lesotho has a problem in retaining its own doctors: manpower is very incompetent, it doesn't have an effective means of getting Lesotho doctors back to the country to serve. I think the good doctors need good salaries, therefore we should be sent abroad to participate in fellowship programs. A good salary will help me to get a good start, instead of relying on loans. Enhance the pay by advancing aptitudes or instruction or by getting advanced.

Another matron noted: I think risk allowance that was initially given to health professionals dealing with HIV patients and then stopped, has to be implemented for retaining health professionals and ethical practice, and uniformity of duty call allowance for all.

4.6.3 Personal Development

Continuing professional training has a very high bearing on the retention of health workers. Most of the literature reviewed in this study has shown that health workers need career development and lack of such leads to inward or outward migration.

According to interviews done in Scott, Mohlomi and Bots'abelo hospitals also shown the same findings. A study done in Cameroon found that 85% of the participants interviewed answered that continuing education was a driving factor for them feeling like leaving their employer.

The interviews suggested that the above hospitals had limited education opportunities, despite the policy stating that it shall provide eligible (those who have worked for the facility for a minimum of 3 years and less than 50 years of age) employees a conditioned scholarship in the form of bonding strategy for long-term training. One participant reported he/she is still working because they need a salary to survive. The majority reported that they are searching for new employees due to a lack of education opportunities.

One doctor commented:

There is no career development here that is why people leave. I also want to find an employer who could fund further studies. We are self-sponsoring to pursue a career online and there is study leave for nurses but not for doctors.
Another doctor commented:

Social workers can be sent to represent the doctors and talk about things that personally affect doctors, the hierarchy of career is not defined very well, and a nurse can be a doctor's boss. I stayed for these years to upgrade now it's time for me to get new experience and challenges. It's a dead end job, if I want to make progress I will have to move to the UK.

4.6.4 Recruitment related

The analysis found that health facilities had a recruitment strategy and HR is in charge of the process. However, recruitment was done when the need arose and the decision was prepared by the Public Service Commission with regards toward nurses and the Ministry of Health for doctors. It was reported that recruitment was

done in two ways: the first was through the Public Service Placement, whereby applicants will submit their qualifications to the Ministry of Public Service; placement, short-listing and employee selection will be done by the Public Service Placement when the need arose, this is especially true for nurses. Secondly, recruitment was done through the Ministry of Health, whereby applicants will submit their applications at the office of the Director General and the handpicking of doctors who are submitted to a test. The reason doctors are not interviewed was because of an insufficiency of doctors. The policy also states that newly recruited employees should be orientated, but there it was noted that health managers did not have an orientation plan for new recruits, despite the efforts outlined in the 2010 retention strategy.

One senior doctor commented:

To be employed as a doctor you have to pass the test. There are very few doctors in the country that is why interviews are not formally done. Where I am working now there are no specialists; all the doctors are General Practitioners (GP's) but I am doing many procedures and we are assisting Basotho. I think it's good to procure the ideal individuals in any case, engage the representatives, prepare and give them the power to complete things. Prepare human resources realise that they are the most profitable resources of the organisation, as revealed in the organisation vision proclamation.

4.6.5 Living conditions

The policy states that the hospital shall provide accommodation to key employees who must stay close to the health facility, because of the nature of their job. Moreover, the policy states that the facilities shall have a housing committee, which will be responsible for allocating houses and minor retention of the houses. However, none of the above succeeded. Despite the fact that doctors appreciated the houses provided by the health facilities, nurses are staying in the houses that are in poor

condition and also there were not enough houses to accommodate all the key health workers.

One participant commented:

To be provided with good accommodation I regard as the best retention strategy. Accommodation is a basic need that should be taken as the priority; however, the houses here are in bad shape. One of the doctor's houses has a hole; nurses are staying in the houses with cracked walls and the thatched roof leaks when it rains. These houses have not been maintained for many years and we did not have running water for a long time. We don't have enough money for repairs and retention. Tebellong has excellent accommodation. I visited Tebellong one time, it's very far, I had to cross the river and the road is not in good condition but they are staying in good houses - doctor's houses, nurse's houses - everything is nice. Many health professionals are moving to private hospitals where they can be provided with good accommodation.

4.7 Closing remarks

The aim of this section is to dissect plus translate the information acquired from the research questionnaire. The analysis and interpretation of the research result will be utilised to represent closure and suggestions in the next section. Section 5, which is the final chapter, will be focused on concluding remarks and recommendations based on the aforementioned results. The researcher shall also emphasise the limitation and opportunity for further research.

Chapter 5: Findings, conclusions and recommendations

5.1 Introduction

In section 4 the outcome of the study were analysed also interpreted with the purpose of presenting the findings of the study. The research results were also compared with what the existing literature divulges, as discussed in Chapter 2. This was done with an understanding to determine whether the research results approved or disagreed with the literature findings. In this part, conclusions are drawn in light of the study discoveries to understand what really happened. The conclusion of the study has significantly tended to the goals of the study and gave responses in the direction of the essential study questions; recommendations are provided based on this new understanding of the findings.

The next sub-headings should control this part to its conclusion:

- Conclusion derived from literature
- Conclusion on the study question
- Study objectives
- Recommendations
- Limitations of the research
- Further research

5.2 Conclusion resulting from literature

This study revealed that the implementation framework to improve the retention rate in the Lesotho health sector was unsuccessful. As mentioned in the problem statement, the current retention strategy implementation has not improved the retention rate for doctors and nurses. Therefore, a new implementation framework turns out to be necessary for the Lesotho health sector to enrich retention. The literature review was able to determine why specific factors fail to support retention and precisely how the successful ones managed. This literature has been sustained

by the result obtained from the responses to the questionnaire and interviews contacted at Mohlomi, Bots'abelo and Scott hospitals. It can be seen from the analysis that the health sector lacks an effective framework as the current situation was characterised by a lack of doctors and nurses, increased workloads, increased stress and ultimately poor service delivery. The study therefore recommends the Lesotho health sector to develop a new implementation framework in order to achieve its desired objectives.

5.3 Conclusion on the research questions

The research questions were as follows:

5.3.1 What implementation framework would be effective in achieving the desired retention strategies for doctors and nurses? A literature study was done to identify the framework that the health sector could implement to enhance the retention rate of doctors and nurses, and thus improve quality service delivery. The framework, as discussed in Chapter 2, include: paying competitive salaries to doctors and nurses, making a conducive working environment, update and upgrade doctors and nurses professional skills by building medical schools to enhance training and career development, implement recruitment policies such as formulating reasonable pay structures to attract doctors and nurses, improve living conditions by providing decent accommodation and maintaining effective communication to create social cohesion between the health professionals and management. The interviews were also conducted with the doctors and nurses from Scott, Mohlomi and Bots'abelo hospitals to increase extra understanding into the variables that could add to the development of retention rates among doctors and nurses in government and CHAL hospitals.

5.3.2 Can the new implementation framework be effective to attract and retain doctors and nurses?

To determine this question, a study among doctors and nurses at Scott, Mohlomi and Bots'abelo healing facilities was directed. A questionnaire was created in view of the aftereffects of the data exhibited in Chapter 4 of the study and the interviews led with doctors and nurses at the above-mentioned hospitals. The respondents specified that it is expected to support and promote an environment that attracts and retain doctors and nurses, encourage doctors and nurses to remain and consider their respective hospitals as an employer of choice, which is essential in attracting new staff and retaining doctors, and promote the workplace to make doctors and nurses proud to be working for such an organisation. It is also corresponds with the information obtained through the interviews with the doctors and nurses at Scott, Mohlomi and Bots'abelo hospitals which revealed that the hospitals did not have an effective framework to retain doctors and nurses, therefore the new framework will be effective to achieve the necessary success.

5.4 Study objectives

This empirical study investigated the effect of implementation framework on retention strategies of doctors and nurses in Lesotho, and this thesis presents the findings. Based on the research problem, the current retention strategy implementation framework has not improved the retention rate of doctors and nurses; therefore the study was designed to provide the new implementation framework that would improve retention rate of doctors and nurses. As a result, in response to the research questions, the result of this study shows substantial success and failure factors of the tested variables. Consequently, these factors will be incorporated in the revised framework. The definite failure of the implemented framework is now more clearly understood by the Lesotho Government and the health sector.

5.5 Recommendations

Generally hospitals worldwide depend on doctors and nurses to provide continuous quality care service. Therefore, Lesotho health sector is not an exception to this trend as there is a need to achieve its mandate of providing quality services to patients. To have the capacity to do this successfully, the health department should implement a framework that would assist in improving the retention rate of doctors and nurses whose expertise are critical to service delivery, rather than lose them to the private sector and or abroad rivals in the worldwide organisation. The accompanying proposals are recommended in perspective of the discoveries of the present study.

From the study it is clear that doctors and nurses in Lesotho are not satisfied with their salaries. For this reason, government ought to attempt a study to figure out what the market is paying and questionnaire pay rates for the entire staff structure in the country in order to avoid losing them to the competitors. Lesotho should pay rates that are focused, as well as also include allowances to create external equity to make doctors and nurses feel secure within their work environment.

Doctors and nurses ought to be perceived for the commitment they make to the association. Administration needs to set up an acknowledgment programme for its health workforce. Non-monetary incentives, such as rewards and recognition, can support doctors and nurses stay within their current healthcare organisations. These can be in the form of gift certificates, medals, publications, in-house notice boards, newsletters and journals – these offer eminent health professionals respectable encouragement for retention.

Develop the overall work environment, such as resourcing enough stock and supplies and quality equipment in working order; maintain hygienically clean wards as well as a zero tolerance policy for discourteous behavior towards any member of the healthcare team. Introduce health and wellness programmes complemented with a medicinal protection conspire and an in-house therapeutic office for doctors along

with nurses, and establish a health and wellness club within the hospital with periodic activities. Apart from retaining doctors and nurses fit in the achievement of their occupations and giving them a protected and conducive workplace, enhance social unity among health professionals also advance quality service delivery.

Government should build medical schools in the country to empower health experts to get higher capabilities broadly, without investing a significant part of the preparation energy out of the nation. Amid their nearby preparing, these health experts will likewise add to the conveyance of health administrations as opposed to giving a similar administration in a remote nation, plus mobilising resources for staff development. Upgrade skills by providing special training such as programmes tailored towards their career progression in the organisation, as well as designing self-actualisation programs with a specific end goal to speak to official health experts who are no longer roused by cash, however by their status and social standing.

Improve living conditions for doctors and nurses by providing decent accommodation nearby their workplace; transport such as hospital shuttle to address the social needs and provide material incentive. This initiative makes doctors and nurses feel worthy, which in turn builds up trust in the management.

Develop an open criticism orientated environment in which doctors and nurses are given chances to give fair and open criticism to increase the level of effective communication and a sense of decision sharing and belonging at the workforce level.

Government ought to present a retention framework arrangement that joins a few parts of the private area hones to encourage retention, such as seniority and a performance-based promotion system among doctors and nurses. Also devise opportunities for doctors and nurses to earn performance bonuses to encourage effective service delivery and enhance retention.

5.6 Limitations of the study

The study was constrained to three healing facilities in the Maseru district. Due to time limits, other hospitals in Maseru and other districts were not studied. Therefore, the little sample and center zones may limit the scope to which the findings can be generalised. However, the result could serve as an indication that the Lesotho health sector is faced with a major challenge to retain doctors and nurse.

5.7 Further research

Recommendations for future studies about retention implementation framework, is for anyone who might be interested in the subject. The researcher suggests (a) an increase in the sample estimate to provide impact to a credible overall of discoveries; (b) the research can be carried out to additional districts of Lesotho; and (c) replicate the study in private hospitals in order to identify common features and different implemented frameworks.

6. References cited

Alnaqbi, W. 2011.The Relationship between Human Resource Practices and Employee Retention in Public Organizations: An Exploratory Study Conducted in the United Arab Emirates. Thesis: Doctor of Philosophy. Edith Cowan University.

Amani, A.2010.The Health Worker Crisis in Cameroon. Thesis: Master of Public Health. Georgia State University.

Bangdiwala, S.I.Fonn, S.Okeye, O. & Tollman, S. 2010. Workforce Resources for Health in Developing Countries.Journal of Public Health Reviews, vol 32, No 1, pp 296-318.

Belbin, C.2011. Employee Perceptions of Workforce Retention Strategies in A Health System. Dissertation: Doctor of Business Administration. University of Southern Queensland.

Borgohain, S.B.2010.Key Factors and Challenges for Retention of Employees in a Public Sector Enterprise: A Case Study in Power Grid Corporation of India Limited. Thesis. Masters: Economics. University of Ljubljana.

Clemens, M.A. & Pettersson, G.2007.February. New data on African Professionals Abroad. Working Paper Number 95.Washington, DC.
Available at:
http://www.cgdev.org/publication/new-data-african-health-professionals-abroad-working-paper-95 [Accessed 03 October 2014]

Centre for Mental Health, Department of Health, Mind, NHS Confederation Mental Health Network; Rethink Mental Illness, Turning Point.2012. No Health without Mental Health: Implementation Framework. Department of Health. London.
Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216870/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf [Accessed 12 November 2014]

Chobokoane, C. 2015. Retention Strategies for Doctors and Nurses in Lesotho. Personal Communication. 16 July 2015.

Coelho, C.F. & O'Farrell, C.C.2011. "The Lesotho Hospital PPP Experience: Catalyst for Integrated Service Delivery." World Hospitals and Health Services: The Official Journal of the International Hospital Federation. 47(3):39-41.

Coelho, C.F. & O'Farrell, C.C. 2009."Breaking New Ground: Lesotho Hospital Public-Private Partnership—A Model for Integrated Health Services Delivery."International Finance Corporation (IFC) SmartLessons.

Dambisya, Y.M.2007. A Review of Non-Financial Incentives for Health Worker Retention in East and Southern Africa. University of Limpopo, South Africa. EQUINET Discussion Paper no.44.

Dambisya, Y.M.Loewenson, Chimbari, Ndetei, Munga. M, Sibandze. S. & Helen Lugina. 2009.Policies and Incentives for health worker retention in east and southern Africa: Learning from country research. [Online] Paper no.78.
Available at:
http://www.equinetafrica.org/bibl/docs/Diss78synthesisHRH09.pdf [Accessed 18 June 2014]

Dambisya, Y.M. Lipinge, S. & O Dulo, C. 2013.Assessment of the Support Needed for the Lesotho Recruitment and Posting Policy. University of Limpopo., South Africa. University of Namibia, Namibia. Mustang Management Consultants, Kenya**.**EQUINET.

Das, B.L. & Baruah, M. 2013. Employee Retention: A Review of Literature. IOSR Journal of Business and Management, vol14, No 2, pp08-16.

Ditlopo, P. Blaauw, D. Bidwell, P. & Thomas, S. 2011. Analysing the Implementation of Rural Allowance in Hospitals in North West Province, South Africa.Journal of Public Health Policy, vol 32, pp 80-93.

Dovlo, D.2004.The Brain Drain in Africa: An Emerging Challenge to Health Professionals' Education, vol. 2, No. 3, pp.1–18.

Downs S. Montagu, D. da Rita, P. Brashers, E. Feachem, R. 2013. Health System Innovation in Lesotho: Design and Early Operations of the Maseru Public Private Integrated Partnership. Healthcare Public-Private Partnerships Series, No.1. San Francisco: The Global Health Group, Global Health Sciences, University of California, San Francisco and PwC. Produced in the United States of America. First Edition, March 2013.

Gebremariam, M.K.2010.Health worker migration: what can be done? Thesis: Master Degree in International Social Welfare and Health Policy. Faculty of Social Science. Oslo University College.

Ghansah, E.2011.The Role of Employee Retention on Job Performance: A Case Study of Accra Brewery Company Limited, Accra. Thesis: Commonwealth Executive in Business Administration. Kwame Nkrumah University of Science and Technology.

Guma, P.V.2011.Organisational Factors Impacting on Employee Retention. Thesis. Master's in Business Administration. Nelson Mandel Metropolitan University

Godwin, K.2012.The retention of Rural Practice Nurses. Masters of Nursing. Thesis. School of Nursing, midwifery and indigenous health. University of Wollongong.

Government of Health Western Australia Department of Health.2012. East Perth Western Australia.

Government of Lesotho. 2013.Health Sector Strategic Plan 2012/13-2016/17. Department of Health. Maseru. Lesotho.

Health Workforce Australia.2011: National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015.

Holland, D.2015. Talent retention: an interpretive study of talent's ***pull-to-stay*** post-acquisition – a multiple case study. PHD Thesis: Management. J.E. Cairnes School of Business and Economics.

Hom, P.W. & Kinicki, A.J.2001. Towards a greater understanding of how dissatisfaction drives employee turnover. Academy of Management Journal.

Humphreys, J. Wakerman, J. Pashen. & D.Buykx, D.2010.Systematic review of effective retention incentives for health workers in rural and remote areas: Towards evidence-based policy. Australian Journal Rural Health.Vol.18, pp.102-9.

International Finance Corporation (IFC). 2009. "Lesotho: National Referral Hospital." Success Stories: Infrastructure Advisory Services.

Iwu, C.G.2012. A model of employee satisfaction amongst health-related professionals in South Africa: The case of Western Cape Province. Thesis: Doctor of Technology: Human Resource Management. Cape Peninsula University of Technology.

Kaplan, A.D. Dominis, S. Palen, J.G.H. & Quain, E. E. Human resource governance: what does governance mean for the health workforce in low- and middle-income countries.

Available at: http://www.human-resources-health.com/content/11/1/6 [Accessed 02 April 2015]

Kassa, T.2015.Employee Motivation and its Effect on Employee Retention in Ambo Mineral Water Factory. International Journal of Advance Research in Computer Science and Management Studies. Volume 3, Issue 3.Pp 10-21.
Available at:http://www.ijarcsms.com/docs/paper/volume3/issue3/V3I3-0039.pdf [Accessed 22 February 2015]

Kawesa, H.2004. Perfomance-Based Rewards and Performance of Teachers in Private Secondary Schools in Kampala District. Thesis: Master of Science in Human Resource. Makerere University.

Konlan, K.2011.Motivation and Retention of Health Workers in Deprived Districts in Ghana: a Case Study of Kassena-Nankana East District. Thesis: Common Wealth Executive in Business Administration. Kwame Nkrumah University of Science and Technology.

Kibui, A.W.2015. Effect of Talent Management on Employees Retention in Kenya's State Corporations. Thesis: Doctor of Phylosophy: Human Resource Management.
Jomo Kenyatta University of Agriculture and Technology.

Kossivi, B., Xu, M. and Kalgora, B. (2016) Study on Determining Factors of Employee Retention. Open Journal of Social Sciences, Vol 4, 261-268.

Koyana,G.P.2009.A Case Study of Strategy Implementation at a major Eastern Cape Component Supplier Company in the Automotive Industry. Thesis: Master of Business Administration. Rhodes Investec Business School.Rhodes University.

Kukano, C.2011.Implementing Personnel Retention Strategies at CorJesu College in the Philippines. Thesis:Master of Education.University of South Africa.

Lennie, G.M.2008. Retention Strategies for skilled SARS Customs Employees. Masters: Business Administration. Nelson Mandela Metropolitan University.

Lesotho-Boston Health Alliance. 2017. Stemming and reversing the out-migration of human resources for health in Lesotho. Lesotho.

Li, Y., Gouhui, S. & Eppler, M. J. (2008).Making strategy work: A literature review of factors influencing strategy implementation. ICA Working Paper 2/2008, Institute of Corporate Communication, University Della SvizzeraItaliana.

Liego, M. E.2013."Improving the Implementation of the Acute Care Nurse Practitioner (ACNP) Role: Development of ACNP Role Implementation Guidelines".Doctor of Nursing Practice (DNP) Projects.Paper 18.

Lin Yun, P. 2007.The Correlation between Management and Employee Motivation in Sasol Polypropylene Business South Africa.Thesis.Magister Commerce: Business Management. University of Pretoria.

Lipinge, S. Dambisya, Y.M. Loewenson, R.Chimbari, M. Ndetei, D. Munga, M.Sibandze. S. & Lugina, H.2009. Policies and incentives for health worker retention in east and southern Africa: Learning from country research. University of Namibia, Training and Research Support Centre University of Limpopo in the Regional Network for Equity in Health in east and southern Africa (EQUINET) and with the East, Central and Southern African Health Community (ECSA-HC)

Matamane, S.2014. Factors Affecting Turnover of Nurses in Rural Clinics of Lesotho.Thesis.Master of Business Administration.The UFS Business School University of the Free State Bloemfontein.

Mateus, G.2007.Reason for High Turnover of Nursing Professionals at Public Hospitals in Angola.Thesis. Master of Arts: Health Studies. University of South Africa.

Matope, T.2012.Health minister says regional cooperation vital. Public Eye. Available at: http://publiceye.co.ls/?p=573 [Accessed 04 June 2014]

Matope, T.2014.State to curb health sector brain drain. Public Eye. Available at: http://www.publiceyenews.com/site/2010/10/11/state-to-curb-health-sector-brain-drain/ [Accessed 05 June 2014]

Matope, T.2017.Lesotho Medical Students Stranded in Nigeria. Public Eye.

Mbah, S.E. & Ikemefuna, C.O.2012. Job Satisfaction and Employee's Turnover Intentions in Total Nigeria Plc.In Lagos State. International Journal of Humanities and Social Science, Vol. 2, no 14, July 2012, pp. 275-287.

Mellor, S.2014.An Implementation Framework for Additive Manufacturing. Thesis: Doctor of Philosophy in Engineering, University of Exeter.

Mercer, H.DalPoz, M.Adams, O.Stilwell, B.Buchan, J.Dreesch, N.Zurn, P. & Beaglehole, R.2003. Human Resource for Health: Developing policy Options for Change, Vol 21, 541 - 482.

Ministry of Health and Social Welfare, Government of Lesotho. 2009. Continuing Education Strategy 2010-2015. Maseru.Lesotho.

Ministry of Health and Social Welfare Government of Lesotho.2010. Retention Strategy for the Health Workforce
Available at: https://www.k4health.org/sites/default/files/Lesotho_Retention_Strategy.pdf [Accessed 02 July 2013]

Ministry of Health and Social Welfare Lesotho.2011.Retention Strategy for the Health Workforce. Maseru.

Ministry of Health and Social Welfare Lesotho.2013.Retention Strategy for the Health Workforce. Maseru. Lesotho.

Ministry of Health and Social Welfare Lesotho.2013.Updated Action Plan for the Implementation of the Retention Strategy for the Health Workforce. Maseru. Lesotho.

Ministry of Finance and Development Planning.2004. Lesotho National Vision 2020-2022
Available at:
http://2013.intracen.org/export-strategy-map/lesotho-national-vision-National-2022/ [Accessed 20 November 2013]

Mokoka, E. Oosthuizen, M.J. & Ehlers, V.J. 2010, Retaining professional nurses in South Africa: Nurse Managers' perspectives', *Health SA, vol*15, no.1, pp 484-493.

Moodley, T.2011. Retention and turnover policies for professional nurses at Inkosi Albert Luthuli Central Hospital.Dissertation.Master of Business Administration.University of KwaZulu Natal.

Morey, P.G.2004.Responding to a Health Information Crisis: Factors Affecting the Recruitment and Retention of nova Scotian Health Record Professionals. Thesis: Masters of Applied Health Service Research. Dalhousie University.

Morris, R.J.2009.Employee Work Motivation and Discretionary Work Effort. Thesis: Doctor of Philosophy. Brisbane Graduate School of Business.

Mrara, M.T.2010.An Investigation of Turnover and Retention Factors of Health Professional Staff within the Eastern Cape Department of Health.Thesis. Master's in Business Administration. Rhodes University.

Mtengezo, J.2008.Improving Nurse Retention: Factors Influencing Job Satisfaction of All Cadres of Nurses in MachingaDistrict.Thesis.Master of Public Health Degree. University of Malawi.

Motsoeli, N.2010.Lesotho Medical Students in Nigeria. Sunday Express.

Muula, A. & Maseko, F.2005.Survival and Retention Strategies for Malawian Health Professionals.Regional Network for Equity in Health in Southern Africa. EQUINET Discussion Paper No. 32.

Murman.D & Sullivan, S.2008.Emergency Medicine: Boston Medical Centre.Maluti Adventist Hospital. Lesotho.

Mwase, Takondwa, E. Kariisa, J. Doherty, N.Hoohlo-Khotle, P.Kiwanuka-Mukiibi, & T.Williamson. 2010. Lesotho Health Systems Assessment 2010. Bethesda, MD:Health Systems 20/20, Abt Associates Inc.

Nel, P.S.Werner, A.Haasbroek, G.D.Poisat, P, Sono, T.Schultz. & H.B.2008.Human Resource Management.7th edition. Oxford University Press. South Africa

Netcare Limited 2013 Annual Integrated Report.2013.Helping Care
for the health of humankind.SouthAfrica.Sandton.

Netswera, F.G. Rankhumise, E.M. & Mavundla, T.R.2005.Employee Retention Factors for South African Higher Education Institution: A Case Study. SA Journal of Human Resource Management, vol 3, no. 2, pp 36-40.

Nguyen, K.2012. Improvement for Recruitment and Retention Strategies Case: Aiya restaurant chain. Thesis.HAMK University of Applied Science.

Nyamekye, F.2012.Impact of Motivation on Employee Retention: A Case Study of Standard Chartered Bank Ghana Limited.Thesis.Masters Business Administration. Kwame Nkrumah University of Science and Technology.

Nyamwanza, T. Mavhiki, S. 2014.Strategy Implementation Framework Used by SMEs in Zimbabwe. Journal of Business & Management, Vol. 3, Issue no 2, , pp. 01-16.

Nwokocha,I. & Iheriohanma,E.B.J.2012. Emerging Trends in Employee Retention Strategies in a Globalizing Economy: Nigeria in Focus. Journal of Social Science, Vol. 8, No. 10.

Odgers, P.2005.Administrative Office Management, Complete Course. 13th edition. United States of America. Cengace learning.

Odubanjo, D.2015. Employee Retention Strategies in Gauff Consultants (Nigeria) Limited: A case study on Gauff Consultants Nigeria Limited. Dissertation. Masters in Business Administration. Business Management. Dublin Business School and Liverpool John Moore's University.

Okumus, F.2003. A framework to implement strategies in organisations. Management Decision, 41(9), 871 - 882.

Onyango, H.2016. The influence of Motivation and Work Environment on Nurse Retention: A Case of Shalom Hospital. Thesis.Strathmore University.

Phillips, J. J. & Connell, A. O.2003. Managing employee retention: a strategic
Available at:
http://books.google.co.za/books?id=Lzghc9e5x7AC&pg=PA134&dq=Phillips,+J.+J.,+%26+Connell,+A.+O.+(2003).+Managing+employee+retention:+a+strategic&hl=en&sa=X&ei=F6xSUuOgO-LA0QX344DwBw&ved=0CEEQ6AEwAQ#v=onepage&q=Phillips%2C%20J.%20J.%

2C%20%26%20Connell%2C%20A.%20O.%20(2003).%20Managing%20employee%20retention%3A%20a%20strategic&f=false [Accessed 28 August 2013]

Rankhone, M. 2015. Lesotho Medical Students Abroad. Personal Communication. 10 July 2015.

Radar, B.2012.Non-Monetary Strategies to Retain Key Employees.*UNLV*Theses/Dissertations/Professional Papers/Capstones.Paper 1338.

Robinson, L.J.2010.Retail Service Team Performance: The Role of Team Efficacy and Team Goal Orientation. Thesis. Doctor of Philosophy: The School of Marketing. The University of New South Wales.

Rodrigues, W.2008.An investigation into staff retention issues in a New Zealand District Health Board. Thesis. Master Degree: Business. Unitec New Zealand.

Ruder, J.C.2013.Strategies to improve the work environment of professional nurses working at a private hospital in Bloemfontein.MagisterSocietatis Scientiae in Nursing.University of Free State.

Russell, D.J. Wakerman, J. & Humphreys, S.J. 2013. What is a reasonable length of employment for health workers in Australian rural and remote primary healthcare services?. Journal compilation, vol , 37, 256–261.

Rust, B.2012.Research Methodology Notes. Cape Peninsula University of Technology.Cape Town Campus Library.

Samuel, M.O. & Chipunza, C. (2009) Employee Retention and Turnover: Using Motivational Variablesas a Panacea. African Journal of Business Management, 3, 410-415

Schwabe, C. Lerotholi, K. & McGrath, E.2004.Ministry of Health and Social Welfare. Human Resources Development & Strategic Plan 2005-2025. Maseru.

Smith, B. & Stark,R.2009. Transforming District Health Services in Lesotho:A collaborative Program of the MOHSW and LeBoHA. Boston.

Soanes, C. & Stevenson, A.11th edition.2004.Concise Oxford English Dictionary. United States. Oxford University Press.

Speculand, R. 2009. Six necessary mind shifts for implementing strategy. Business Strategy Series, 10(3), 167-172.

Sun, M.2012.Employee Retention in Chinese State-Owned Enterprises. Dissertation. Master of Business (MBus).Auckland University of Technology.

Tiam, A.2011.Determination of Prevalence of Factors Associated with Burnout among Health Professionals in Maseru District, Lesotho.Master of Family Medicine.University of the Witwatersrand, Johannesburg.

Tseng, C.2010. The retention of software development employees in the IT industry in Taiwan.Thesis.Doctor of Business Administration.The Graduate College of Management Southern Cross University, Australia.

Voola, R. and O'Cass, A. (2010).Implementing competitive strategies: The role of responsive and proactive market orientations. European Journal of Marketing, 44(1/2), 245-266.

Working Together for Health. WHO Report.2006.
Available at: www.who.int/whr/2006/en/ [Accessed 10March 2013]

World Health Organization. 2007. Strengthening Health Systems to Improve Health Outcomes. Who's Framework for Action. Geneva. World Health Organization

WHO.2010. Country Health profile of Lesotho -2006
Available at:
http://www.afro.who.int/en/lesotho/country-health-profile.html [Accessed 15 April 2014]

World Health Organization. 2006. The World Health Report: Working Together for Health. Geneva. World Health Organization.

World Health Organization.2009.WHO Country Cooperation Strategy 2008-2013.Lesotho.Brazzaville, Republic of Congo.WHO Regional Office for Africa.

WHO. 2017. Stemming and reversing the out-migration of human resources for health in Lesotho. Lesotho.

World Bank.2013. “Lesotho - New Hospital Public Private Partnership (PPP) Project”, Washington DC: World Bank.

World Bank.2005.The Kingdom of Lesotho Health Sector Reform Project: Implementation Completion Report 30317.Lesotho.

Yazinski, S.K.2009.Strategies for Retaining Employees and Minimizing Turnover. University of Scranton.

Appendices

Appendix A Survey questionnaire

Section I: Demographics

Please complete Section I by marking with an “x” where applicable. Please note that all information supplied shall be used for the stated purpose of academic research only and will be kept in strict professional confidence.

Questionnaire		
Section I		**Q1**
Demographic Information		
	I work at.....(which) hospital:	
	Scott hospital	
	Mohlomi hospital	
	Bots’abelo hospital	
	How many years have you been working at the above hospital:	**Q2**
	Years	
	Months	
	My age is:	**Q3**
	Younger than 25	
	25 - 29	
	30 - 34	
	35 - 39	
	40 - 44	
	45 - 49	
	50 - 54	
	55 - 59	
	60 or older	
	My gender is:	**Q4**
	Male	

	Female	
	My current marital status:	**Q5**
	Not married (single)	
	Married	
	Divorced or separated	
	Widowed	
	My predominant home language is:	**Q6**
	English	
	Sesotho	
	IsiXhosa	
	Other (please specify)	
	My position is:	**Q7**
	Doctor	
	Nurse	
	My current job status is:	**Q8**
	Permanent	
	Contract	
	Temporary	
	Other (please specify)	
	My Highest academic qualification is (mark one or more):	**Q9**
	National Certificate	
	National Diploma	
	Bachelor's degree	
	Honours degree	
	Master's degree	
	Doctorate	
	Post-doctoral degree/ professor	
	My length of service at my current employer is:	**Q10**
	Years	
	Months	

Section II: Retention Strategies

Please complete all questions, mark with an “x” to indicate the extent to which you agree/disagree with the following statements 1=Strongly Disagree to 5=Strongly Agree

	Statement	**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
A	**Working environment**					
1	Equipment is well maintained in order for me to do my work effectively					
2	I am provided with cutting edge technology					
3	My workplace is healthy, clean and well-organized (conducive)					
4	I have autonomy at work (i.e. little interference from my Manager)					
5	I have good interpersonal relationship with my colleagues					
B	**Financial incentives**					
6	I am provided with additional compensation for advanced qualifications					
7	I am satisfied with my present remuneration					
8	I am allowed to take a second job such as running private practice in order to improve my income					
9	Educational benefit for my children is offered					
10	I enjoy benefits such as house loans					

	Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
C	**Mentoring**					
11	I am loyal to this hospital because of available support services					
12	The hospital's appraisal system develops my confidence and trust					
13	I am nurtured professionally through training and lifelong learning in my workplace(transferring intangible and tacit knowledge)					
14	I am nurtured morally and spiritually through recollection and prayer service in my workplace					
D	**Personal Development**					
15	I have the opportunity to pursue further studies through the availability of Scholarships and bursaries					
16	Training provided is of direct relevance to my job					
17	We have a library that I can use at my workplace.					
18	This hospital has career development activities to help me identify/improve abilities, goals, strengths and weaknesses					
19	I have acquired expertise through seminars and trainings					
E	**Recruitment related**					
20	A career development programme that helps employees to become more aware of and responsible for their own career development is available					
21	I am allowed to work additional shifts, with pay, within my duty station					
22	Promotion criteria in my workplace is clear and fair					
23	Conditions of employment guarantee job security in this hospital					
24	I was well received by my manager when I was first employed at this hospital					

	Statement	**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
F	**Living conditions**					
25	My residential accommodation is in good conditions					
26	My employer provides free medical care for my spouse and children					
27	I have support of utilities(water, electricity, telephone)					
28	This hospital provides pre-schooling and care for my children					
29	Security is provided on and off duty					

What do you think of the implementation of the current retention strategy?

please explain----------

Would you prefer that the current strategy be implemented differently?

please explain----------

How can we improve the retention strategy of Doctors and Nurses?

Please explain----------

Would you still be working in the hospital in 12 months time?

Yes	Uncertain	No

If your response is No, would you kindly give reasons for your decision?

In your own words, can you state what motivated you the most in your job during the past 12 months?----------
---

Is there anything that can be changed or improved in your job?

Yes	Uncertain	No

If yes, can you highlight what aspects of your job can be improved?----------
---

What implementation framework would be effective in achieving desired retention strategies for doctor and nurses?

Please explain----------

Can the new implementation framework be effective when it is used to attract and retain doctors and nurses?

Yes	Uncertain	No

If yes, please highlight how it could be effective----------

In your own words, please state what motivated you the most in your job during the past 12 months

Please explain----------

Thank you for your time and effort in completing this questionnaire