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The factors that attract healthcare professionals to and retain them in rural areas in South Africa

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The factors that attract healthcare professionals to and retain them in rural areas in South Africa

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Keywords: appreciative inquiry, healthcare professionals, human resources for health, retention, rural health

Introduction

There is a global struggle to attract healthcare professionals (HCPs) to rural areas and to retain them there. The paucity of HCPs therein contributes to a reduction in the quality and type of health services offered and sustains a situation in which poor quality care is on offer in these communities.1 There is a maldistribution of health professionals between rural and urban areas within countries. The disparity between urban and rural areas further widens the health equity gap between citizens.2 It also makes the achievement of national and international goals, such as the Millennium Development Goals, more difficult.3 A crippled health system is further weakened by a lack of health professionals.4 In order to provide equitable care in underserved areas, like rural locations, it is necessary to ensure that HCPs are attracted to and retained in these areas.5 Dolea et al. argue that health teams comprising all types of health professionals are necessary for the provision of adequate services in rural areas.6

It is estimated that at least one million HCPs are required in sub-Saharan Africa.1 Several factors contribute to the shortage of health personnel in low- and middle-income countries, and South Africa is no exception.57 Contributing factors to the shortage of HCPs in rural areas include inadequate supervision, poor referral and support structures, lack of appropriate equipment and drugs, and poor management structures.8 De Villiers and de Villiers describe how factors such as remoteness, poor job satisfaction, job frustration, occupational stress and community issues, can have a negative impact on the work experience of rural doctors.8

The constraints to providing human resources for health care are described by Wyss according to five categories (individual characteristics, health service, the health sector level, training capacities and the socio-political and economic context of the country).4 The author discusses how each of these factors influences who is prepared to work in resource-constrained environments and why they are prepared to do so.4 De Vries and Ried found that medical students originating from rural areas are more likely to return to work there, and remain in general practice in these areas.9 These, together with several other strategies, are documented in the literature as ways of attracting doctors to work in rural areas and retaining their services once there. These additional strategies include financial incentives, career development, a good hospital infrastructure, the availability of adequate resources, a good management structure, and personal recognition and appreciation.10,11 Dolea et al. make a compelling argument for retention strategies in the literature.1 However, Hongoro and McPake document that there is a need to better understand the debate around the strategies that are implemented to attract and retain healthcare professionals in underserved areas; an argument that Dolea et al. highlights is particularly relevant to developing countries.5,12 In a systematic review, Grobler et al. found a paucity of studies to conclusively prove that the proposed intervention strategies had a positive effect on the retention of healthcare professionals in underserved areas.13 This strengthens the call by Hongoro and McPake for more evidence to understand the pull and push factors that affect the distribution of human resources for health in under-served areas.12
However, some HCPs willingly choose to work in rural areas, despite the challenges faced. Willis-Shattuck et al. discusses “personal recognition and appreciation” as one of the positive determinants of the retention of HCPs in underserved areas. This recognition can be obtained from colleagues, management or the community that the health professional serves. There is a need for the HCP to feel valued. Financial incentives are not sufficient in retaining professionals in rural areas. This research explored these reasons and makes a contribution to understanding important positive determinants of the retention of rural health professionals.

Despite well-developed human resource strategies to attract and retain HCPs in rural areas, the dearth of HCPs in these areas remains. This research proposes that these strategies be reconsidered and the challenge approached from a positive perspective.

**Method**

**Study design**

This was a qualitative study using focus groups, in-depth interviews and appreciative inquiry (AI). Bushe states that AI is an organisational developmental and action research method, first described by Cooperrider in 1987. The original method stated that “inquiry into the social potential of a social system should begin with appreciation, should be collaborative, should be provocative and should be applicable”. AI focuses on the best aspects of a situation and engages stakeholders in exploring what could be and to take ownership of what will be. However, AI is not just about what is positive. It seeks to engage stakeholders in formulating new ideas from within the system in order to strengthen it. The stakeholders make sense of the system and explore what is needed to change the social system. All that is exemplary within a system is considered using AI, and then an exploration is conducted to generate further excellence within the system or organisation.

We used the AI methodology because we wanted to better understand the factors that cause healthcare professionals to be attracted to and to remain in rural areas, rather than just focus on encountered challenges. In developing an understanding of these positive determinants, a different understanding was obtained with regard to how to develop a retention strategy for HCPs in rural areas.

**Study population**

There were 14 participants in the study. The study population consisted of doctors, occupational therapists and physiotherapists who worked in rural areas. Only HCPs who were currently working in a rural area were included in the study. HCPs who had previously worked in a rural area, but then moved away were excluded. Participants had to have been working in a rural setting for at least six months.

**Interviewers**

Both researchers had previously worked in rural areas, one as a medical doctor who worked as a medical officer in a rural hospital, and the other, a medical sociologist who has worked extensively throughout South Africa in rural settings. Both researchers have worked extensively in qualitative research, and cumulatively, they have 15 years research experience.

**Sampling**

Purposive sampling was used. Participants at the Rural Doctors’ Association of Southern Africa (RUDASA) and the Public Health Association of South Africa (PHASA) Conference held in September 2012, in Bloemfontein, were likely to be people who would decide to work in a rural area, but the purpose of the study was to understand why these people willingly worked there. Doctors and a therapist who met the inclusion criteria were invited to participate in the study. Snowball sampling was also used to attract more people to participate. The number of participants was not decided on beforehand. Participants were recruited until data saturation was reached. This was decided by the interviewers when it became apparent that people were providing similar information.

**Study setting**

The study was carried out during the joint RUDASA and PHASA Conference held in September 2012, in Bloemfontein. Rural HCPs from across South Africa were present at the conference.

**Data collection**

Doctors and therapists at the conference were invited to participate in the study over the two-day conference. Announcements were made during the conference asking people to participate in the study. Individuals were approached and asked if they would be available to participate. Snowball sampling was used and participants were asked to identify people appropriate for the study. Two focus group discussions and three in-depth interviews were conducted. The initial intention was to conduct focus groups only, but interviews were performed with some participants because their time was limited and they could not join the focus group discussions when they were scheduled. An interview schedule was used. The participants were asked open-ended questions and were probed in a non-leading and neutral manner. They were asked what factors encouraged them to stay in a rural area. The discussions were audio-recorded and transcribed verbatim later. The participants signed informed consent with respect to the audio-recording and participation in the focus groups and interviews.

**Data analysis**

The researchers independently listened to the audio recordings and read the transcripts. The data were coded and themes identified, also independently. The identified themes were then discussed, and consensus reached on which themes to include in the final analysis.

**Ethics approval**

Permission to conduct the study was obtained from RUDASA and PHASA. Ethics clearance was obtained from the Free State Human Ethics Committee of the Faculty of Health Sciences, University of the Free State (Ethics Clearance Number ECUFS NR 144/2012).

**Results and discussion**

Table 1 is a summary of the demographics and characteristics of the participants.

The denominator for Table 1 is the total number of participants. Table 1 shows that half the participants were married and had children. Only one participant’s child attended a local school; a reflection of the issue of inadequate infrastructure in rural areas. A high number of family medicine specialists attended, which may reflect the South African government’s efforts to deploy specialists in district health teams.

Many participants had a strong sense of commitment to the communities in which they worked, and they felt that they had a responsibility to “give back”, either to the communities from where they originated or to less fortunate communities. “It is my
zeal to give back to the community”, one respondent stated. Many of the participants did not hail from rural areas, but felt that these communities were most in need and that their service would be most appreciated by these communities. This theme linked strongly to having a “calling”. Participants expressed strong altruistic feelings about working in their communities. This selfless devotion often correlated with the reason why they entered the health profession and is similar to the findings by Couper et al.11 Participants stated that the appreciation that they felt from the community was a strong motivating factor which sustained their commitment to remaining in a rural area. There was a sense that the community reciprocated their sacrifice with a sense of thankfulness. Tapping into this is important in lobbying people to remain within a rural area.

Participants often reported that they had developed a sense of belonging in the community. They felt they were part of community decision-making. A doctor related a scenario in which she “would meet with the clinic sister and discuss the problem, and we would see what we could do about it”. They explained that they understood how the community was structured, and were able to draw on the necessary social networks to address health issues within it. Understanding the social capital in the community and being able to utilise when treating a patient was an important “pull” factor for participants who held a holistic view to healthcare practice. The sense of belonging was aptly captured by the following response: “I can become part of the community, go to their churches, or their events or whatever, eat with the people, and become part of the whole thing. Then it’s like you become friends, and you understand better what it’s like (to be part of the community), and the challenges of the people. It’s almost like I’m not their doctor. I’m their friend. Everyone can recognise you, and they love you and you love them, and it’s almost like you become like a family. And then you feel familiar and safe, and at home among the people you know”. 

### Table 1: The characteristics of the 14 study participants

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>5 (35.7)</td>
</tr>
<tr>
<td>Male</td>
<td>9 (64.3)</td>
</tr>
<tr>
<td><strong>Median age</strong></td>
<td>36.7 (26–62)</td>
</tr>
<tr>
<td><strong>Years worked in a rural area</strong></td>
<td>7.5 (0.5–28)</td>
</tr>
<tr>
<td><strong>Do you enjoy working in a rural area?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12 (85.7)</td>
</tr>
<tr>
<td>Most times</td>
<td>2 (14.3)</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
</tr>
<tr>
<td>Single never married</td>
<td>5 (35.7)</td>
</tr>
<tr>
<td>Married</td>
<td>7 (50.0)</td>
</tr>
<tr>
<td>Divorced</td>
<td>2 (14.3)</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7 (50.0)</td>
</tr>
<tr>
<td>No</td>
<td>7 (50.0)</td>
</tr>
<tr>
<td><strong>Where do the children live and attend school?</strong></td>
<td></td>
</tr>
<tr>
<td>Live with their parents and attend a local school</td>
<td>1 (14.3)</td>
</tr>
<tr>
<td>Do not live with their parents and attend a school elsewhere</td>
<td>1 (14.3)</td>
</tr>
<tr>
<td>Live with their parents but do not attend school yet</td>
<td>1 (14.3)</td>
</tr>
<tr>
<td>Live with their parents and are home schooled</td>
<td>2 (28.6)</td>
</tr>
<tr>
<td>Are grown up and are no longer at school</td>
<td>2 (28.6)</td>
</tr>
<tr>
<td><strong>Country of origin</strong></td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td>12 (85.7)</td>
</tr>
<tr>
<td>Nigeria</td>
<td>1 (7.1)</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1 (7.1)</td>
</tr>
<tr>
<td><strong>Sector working in</strong></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>11 (78.6)</td>
</tr>
<tr>
<td>A combination of the private sector and government</td>
<td>3 (21.4)</td>
</tr>
<tr>
<td><strong>Rank</strong></td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>5 (35.7)</td>
</tr>
<tr>
<td>Medical officer</td>
<td>4 (28.6)</td>
</tr>
<tr>
<td>Principal medical officer</td>
<td>2 (14.3)</td>
</tr>
<tr>
<td>Therapist</td>
<td>2 (14.3)</td>
</tr>
<tr>
<td>Medical manager</td>
<td>1 (7.1)</td>
</tr>
</tbody>
</table>
The atmosphere of community was created among people who worked within the same institution. Participants described how a sense of institutional loyalty developed as a result of working at a particular facility: “You feel comfortable with (your colleagues) and relate to (them), and be friends outside of hours. This makes a big difference as well.” It appears that a sense of pride in working at a particular place was an important proponent in ensuring that people wanted to remain at the institution and in the rural area. This is an important advocacy tool that could be used by management structures, for example, when developing a retention strategy with respect to HCWs in rural areas.

Having a “calling” emerged strongly as a reason why many participants remained in a rural area. Having a “calling” either related to a religious conviction or to a sense of contributing to the greater good of humanity. One participant reflected on the issue of having a “calling” as follows: “For me, it’s a religious thing. I’m a Christian, I believe God wants me to work where I’m working, and I feel that that’s where I can serve Him, and so that’s what I am doing”.

Participants linked the vision that they had for their lives to serving, and to serving in marginalised communities, in particular. As one participant iterated: “I’d always picture being a doctor in a rural area, you know, sort of providing health care under a tree or in a tin shack… that sort of thing”. Participants often reflected on their jobs as acts of service, rather than just work which they were required to do. Their attitude was that they were willing to extend themselves beyond what was expected or required. It is difficult to harness this characteristic as a strategy to be used to attract people to work in a particular setting and then retain their services while there, as these values are personal and may fluctuate. However, this concept could be used to appeal to people who are already thinking in that way.

All of the participants cited diversity in the work performed in rural areas as a strong factor that would influence them to remain in a rural area. They indicated that the challenge of having to deal with a variety of problems inspired them to continue to work in these communities. They felt that they were not limited to just one discipline in medicine, and were challenged by having to constantly manage a multiplicity of conditions.

This sentiment was well encapsulated in the following statements: “I’d say it’s clinical freedom, and you get a wide range of opportunities to practise for a wide range of medicine, and you are limited more by your energy than professionally” and “If for me, the attraction of rural medicine is that your hospital is general, and you do a little more than a general practitioner (GP) in a GP practice. You do a bit of surgery, you know, a gynaecologist’s Caesarian section, so it’s a bit more interesting than just treating coughs and colds. And, for me, it’s the breadth of diseases, the variety, that is very attractive”.

However, this diversity may not be universally appealing as people may want to specialise in one area. Regardless, the appeal of not being limited to just one discipline in medicine should be highlighted when embarking on the recruitment of HCPs for rural areas. This aspect should be publicised to students at undergraduate level. It has been reported that students who are recruited from rural areas are more likely to return there and to remain as generalists. This should be emphasised to medical students early on in their studies as a positive factor that might assist in influencing their decision to return to a rural area.

The challenge of working in a rural area is fraught with resource difficulties, in terms of infrastructure and human capacity. These systemic factors pose immense difficulties to HCPs in rural areas, compounded by the need to refer to larger centres, being confronted with difficult staff at the receiving institution, or having difficulty accessing transport services for their patients. Kotzee and Couper highlighted the importance of addressing systemic factors that doctors thought would influence their decision to remain in a rural area.

Several participants indicated that over time they had developed a good rapport with personnel at the referral facilities and that this had contributed to the creation of a congenial working environment which persuaded them to remain in a rural area. The establishment of a good referral network facilitated job satisfaction and willingness to continue to work in a rural area: “If you can have the network, and you feel like actually I’m doing the best I can for this person, that really makes it much easier and makes (it) rewarding as well”. Nevertheless, inadequate referral structures are not sufficient in deterring HCPs who work in these areas.

A strong referral network hinges on fostering relationships among several key role players, such as government, the referring and receiving institutions and the management structures. Good referral pathways, which are easy to access and do not hamper the work of the HCP in a rural area, contribute to strengthening the health care in these areas and assist in helping people to remain happy in their workplace: “I almost feel like rural hospitals should appoint people in teams, you know, rather than individuals, because individuals are worthless. Well… not worthless, but short term, and teams of people who can be a support to each other are essential. This is very poorly, or appears to be poorly, understood, by people who make the decisions”.

Being part of a team aided the creation of a stable work environment and willingness to reside in an area. The value of being part of a team, which included HCPs across disciplines, was strongly advocated. The interdisciplinary approach to dealing with health issues reflects an understanding that it is a community, and not just an individual, that is affected by illness and disease. This approach draws on several factors that interact simultaneously to ensure the success of health service delivery. The concept of a health team is supported by the findings of Dolea et al. and Couper et al.

Work satisfaction was also facilitated when career development was seen as a priority. It was repeatedly stated that the lure of moving to an urban area also linked to the lack of a career path within rural medicine owing to the absence of career opportunities: “There is a lifespan to the rural doctor”. The need to foster career development is supported in the literature by several authors. Currently, the opportunity to develop within the field of rural medicine is not an option within South Africa. Strong recommendations have been made that rural medicine should be developed as a discipline in its own right, and not merely viewed as an extension of Family Medicine: “There should be a separate rural speciality. Family Medicine is not rural medicine”. For example, similar shifts have been observed in Emergency Medicine, and this has contributed to the recognition and growth of this speciality. A similar move is likely to have a positive effect on the development of rural medicine as a discipline in its own right.

Strong management structures were tantamount to ensuring job satisfaction and willingness to remain in a rural area. De Villiers and de Villiers argue strongly that improving management...
structures is crucial in retaining HCPs in rural areas. Participants continually cited that they were more likely to leave if management of the health facility was poor. Participants indicated that good management did not mean that everything ran smoothly or that there was a lack of challenges. Rather, it was associated with the support and willingness offered by management to ensure that personal and occupational matters were addressed. The role of management was seen to include the protection of staff and ensuring that the services rendered to patients were of the highest quality. One participant succinctly captured this as follows: “I think you need managers who are willing to listen, participate and be available, on the ground and be visible. That is what I think is important. Experience will come with that, but you need people who are listening, who genuinely lead by example, and are there for the patient’s best interests. That is what people look up to. People will put up with an experience if they know that their managers are on their side and that they’re also fighting the same fight, so it (is) crucial, really crucial, I think”.

Even though the participants focused on management as a determining factor, the concept of strong leadership was also pertinent. The message repeatedly conveyed through discussions on “management” was that there is a need for leadership that is caring, considerate and decisive. However, lack of adequate leadership is not limited to rural health management. The dearth of adequate leadership in all healthcare sectors in South Africa is well documented.17

The lifestyle on offer in a rural area appealed to many of the participants. Security concerns in urban settings were raised, especially by participants who had children. They said that they felt safe in the rural areas. A female participant outlined it as follows: “It is fairly safe in the whole grand scheme of South Africa. I can go out by myself. I can camp overnight if I want to”. There was also a stronger sense of connectedness to nature in the rural areas. Many participants were involved in several outdoor activities and felt that living in a rural area made this easier for them and added to the appeal of living there.

The necessary determinants to ensuring that HCPs remain within rural areas are multifaceted and intricately link to one another, as reflected in Figure 1. The attraction and retention process cannot be viewed in isolation. Factors which reflect on an intrinsic value system also need to be taken into account, and these are difficult to influence. Factors such as having a “calling” or affinity for a community, or a sense of belonging, are difficult to influence as they rely on a myriad of influences, such as education, a philosophical worldview, role models and socialisation. Extrinsic factors, such as fostering a team spirit, improving management structures or assisting in the development of better referral pathways, can be profoundly influenced. Thus, it is necessary to understand how organisational models can be used to assist in the development and growth of these factors so that they can have a positive effect on attracting HCPs to and retaining them in rural areas. The interaction between intrinsic and extrinsic factors and their relationship to one another is complex. These factors are not easy to delineate as a singular cause and effect in the establishment and maintenance of dynamics within a relationship.

Limitations
The findings cannot be generalised to the general population, but may be transferable to similar rural settings in South Africa.

Figure 1: Themes that emerged

Recommendations
The following summarises the recommendations that participants made, based on the AI:

• Health professionals with a “calling” to rural areas should be identified, and their move to these areas facilitated.
• The establishment and strengthening of collaboration between the community and the health team needs to be promoted.
• The establishment of health teams, rather than the employment of individuals, would facilitate a better work environment and encourage the retention of healthcare personnel in rural areas.
• Good referral systems and strong management would encourage health professionals to remain in rural areas.
• Rural medicine should be developed as an independent discipline.

Conclusion
Intrinsic and extrinsic factors strongly influence one another in the decision-making process by HCPs as to whether or not to remain in a rural area. Having a “calling”, engaging in team work and being affiliated to a community are strongly interrelated. The role of management and leadership is crucial in ensuring a sustainable workforce and in providing strong visionary direction. Functional clinical support and referral structures are vital with respect to the exertion of influence on the decision-making process by HCPs to stay in a rural area. Current retention strategies are based on reasons why people move, but these strategies are failing. A paradigm shift is required to understand the reasons why people stay and to focus on this instead. This research offers an insight into this required shift. The aim of future research should be to attempt to develop a deeper understanding of these concepts.

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